File No. 151036 Committee Item No. 10
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance **Date** December 2, 2015

Board of Supervisors Meeting **Date** _____

Cmte Board

Cmte	Board	
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OTHER **(Use back side if additional space is needed)**

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Completed by: Victor Young **Date** November 23, 2015
Completed by: _____ **Date** _____

FILE NO. 151036 RESOLUTION NO.

[Contract Amendment - Family Service Agency of San Francisco - Behavioral Health Services - Not to Exceed $60,460,049]

Resolution approving amendment number one to the Department of Public Health contract for behavioral health services with Family Service Agency of San Francisco to extend the contract by two years, from July 1, 2010, through December 31, 2015, to July 1, 2010, through December 31, 2017, with a corresponding increase of $14,976,909 for a total amount not to exceed $60,460,049.

WHEREAS, The mission of the Department of Public Health is to protect and promote the health of all San Franciscans; and

WHEREAS, The Department of Public Health provides health and behavioral health services through a wide network of approximately 300 Community-Based Organizations and service providers; and

WHEREAS, In 2010, the Department of Public Health selected Family Service Agency of San Francisco through a Request For Proposals process to provide behavioral health services for the period of July 1, 2010, through December 31, 2015; and

WHEREAS, The Board of Supervisors approved the original agreement for these services under Resolution No. 563-10; and

WHEREAS, The Department of Public Health wishes to extend the term of that contract in order to allow the continuation of services while Requests For Proposals are administered to take into account the changes to behavioral health services business needs related to the Affordable Care Act and the State Department of Health Care Services' 1115 Demonstration Waiver pertaining to the delivery of substance abuse Drug Medi-Cal funded services; and

WHEREAS, The San Francisco Charter, Section 9.118, requires that contracts entered into by a department or commission having a term in excess of ten years, or requiring anticipated expenditures by the City and County of ten million dollars, to be approved by the Board of Supervisors; and

WHEREAS, The Department of Public Health requests approval of an amendment to the Department of Public Health contract for behavioral health services with Family Service Agency of San Francisco to extend the contract by two years, from July 1, 2010, through December 31, 2015, to July 1, 2010, through December 31, 2017, with a corresponding increase of $14,976,909 for a total not-to-exceed amount of $60,460,049; now, therefore, be it

RESOLVED, That the Board of Supervisors hereby authorizes the Director of Health and the Director of the Office of Contract Administration/Purchaser, on behalf of the City and County of San Francisco to amend the contract with Family Service Agency of San Francisco extending the term of the contract by two years, through December 31, 2017, and increasing the total, not to exceed amount of the contract by $14,976,909 to $60,460,049; and, be it

FURTHER RESOLVED, That within thirty (30) days of the contract amendment being fully executed by all parties, the Director of Health and/or the Director of the Office of Contract Administration/Purchaser shall provide the final contract amendment to the Clerk of the Board for inclusion into the official file (File No. 151036).

RECOMMENDED:

Barbara A. Garcia,
Director of Health

APPROVED:

Mark Morewitz,
Health Commission Secretary

City and County of San Francisco

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

October 5, 2015

Angela Calvillo, Clerk of the Board
Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102-4689

Dear Ms. Calvillo:

Attached please find a proposed resolution for Board of Supervisors approval for the extension of 22 behavioral health services contracts for two years, with corresponding increases in each contract amount, as shown in the resolution.

These contract amendments require Board of Supervisors approval under San Francisco Charter Section 9.118, as they have either already been approved by the Board and the proposed amendment exceeds $500,000, or they have not previously been approved by the Board and the total contract amount exceeds $10 million.

The following is a list of accompanying documents:

- Resolution
- Proposed amendments
- Original agreements and any previous amendment
- Forms SFEC-126 for the Board of Supervisors and Mayor

The following person may be contacted regarding this matter: Jacquie Hale, Director, Office of Contracts Management and Compliance, Department of Public Health, (415) 554-2609 (Jacquie.Hale@SFDPH.org).

Thank you for your time and consideration.

Sincerely,

Jacquie Hale
Director
DPH Office of Contracts Management and Compliance

City and County of San Francisco
Office of Contract Administration
Purchasing Division

First Amendment

THIS AMENDMENT (this "Amendment") is made as of July 1, 2015 in San Francisco, California, by and between **Family Service Agency of San Francisco** ("Contractor"), and the City and County of San Francisco, a municipal corporation ("City"), acting by and through its Director of the Office of Contract Administration.

RECITALS

WHEREAS, City and Contractor have entered into the Agreement (as defined below); and

WHEREAS, City and Contractor desire to amend the Agreement on the terms and conditions set forth herein to extend the performance period, increase the contract amount, and update standard contractual clauses;

NOW, THEREFORE, Contractor and the City agree as follows:

1. Definitions. The following definitions shall apply to this Amendment:

1a. Agreement. The term "Agreement" shall mean the Agreement dated July 1, 2010 from RFP 23-2009, dated July 31, 2009, Contract Numbers BPHM11000033, between Contractor and City, as amended to a Sole Source by this First amendment.

1b. Contract Monitoring Division. Effective July 28, 2012, with the exception of Sections 14B.9(D) and 14B.17(F), all of the duties and functions of the Human Rights Commission under Chapter 14B of the Administrative Code (LBE Ordinance) were transferred to the City Administrator, Contract Monitoring Division ("CMD"). Wherever "Human Rights Commission" or "HRC" appears in the Agreement in reference to Chapter 14B of the Administrative Code or its implementing Rules and Regulations, it shall be construed to mean "Contract Monitoring Division" or "CMD" respectively.

1c. Other Terms. Terms used and not defined in this Amendment shall have the meanings assigned to such terms in the Agreement.

2. Modifications to the Agreement. The Agreement is hereby amend as follows:

2a. Section 2 of the Agreement currently reads as follows:

2. Term of the Agreement

Subject to Section 2, the term of this Agreement shall be from July 1, 2010 through December 31, 2015.

Such Section is hereby amended in its entirety to read as follows:

2. Term of the Agreement

Subject to Section 2, the term of this Agreement shall be from July 1, 2010 through December 31, 2017.

2b. Section 5 of the Agreement currently reads as follows:

5. Compensation

Compensation shall be made in monthly payments on or before the 30th day of each month for work, as set forth in Section 4 of this Agreement, that the Director of the Public Health Department, in his or her sole discretion, concludes has been performed as of the 30th day of the immediately preceding month. In no event shall the amount of this Agreement exceed **Forty-Five Million Four Hundred Eighty-Three Thousand One Hundred Forty Dollars ($45,483,140).** The breakdown of costs associated with this Agreement appears in Appendix B, "Calculation of Charges," attached hereto and incorporated by reference as though fully set forth herein.

No charges shall be incurred under this Agreement nor shall any payments become due to Contractor until reports, services, or both, required under this Agreement are received from Contractor and approved by The Department of Public Health as being in accordance with this Agreement. City may withhold payment to Contractor in any instance in which Contractor has failed or refused to satisfy any material obligation provided for under this Agreement.

In no event shall City be liable for interest or late charges for any late payments.

Such section is hereby amended in its entirety to read as follows:

5. Compensation

Compensation shall be made in monthly payments on or before the 30th day of each month for work, as set forth in Section 4 of this Agreement, that the Director of the Public Health Department, in his or her sole discretion, concludes has been performed as of the 30th day of the immediately preceding month. In no event shall the amount of this Agreement exceed **Sixty Million Four Hundred Sixty Thousand Forty-Nine Dollars ($60,460,049).** The breakdown of costs associated with this Agreement appears in Appendix B, "Calculation of Charges," attached hereto and incorporated by reference as though fully set forth herein.

No charges shall be incurred under this Agreement nor shall any payments become due to Contractor until reports, services, or both, required under this Agreement are received from Contractor and approved by The Department of Public Health as being in accordance with this Agreement. City may withhold payment to Contractor in any instance in which Contractor has failed or refused to satisfy any material obligation provided for under this Agreement.

In no event shall City be liable for interest or late charges for any late payments.

2c. Insurance. Section 15 is hereby replaced in its entirety to read as follows:

15. Insurance

a. Without in any way limiting Contractor's liability pursuant to the "Indemnification" section of this Agreement, Contractor must maintain in force, during the full term of the Agreement, insurance in the following amounts and coverages:

1) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness; and

2) Commercial General Liability Insurance with limits not less than $1,000,000 each occurrence and $2,000,000 general aggregate for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; and

3) Commercial Automobile Liability Insurance with limits not less than $1,000,000 each occurrence, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

4) Professional liability insurance, applicable to Contractor's profession, with limits not less than $1,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services.

5) Blanket Fidelity Bond (Commercial Blanket Bond): Limits in the amount of the Initial Payment provided for in the Agreement

b. Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to provide:

1) Name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

2) That such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this Agreement, and that insurance applies separately to each insured against whom claim is made or suit is brought.

c. All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation for any reason, intended non-renewal, or reduction in coverages. Notices shall be sent to the City address set forth in the Section entitled "Notices to the Parties."

d. Should any of the required insurance be provided under a claims-made form, Contractor shall maintain such coverage continuously throughout the term of this Agreement and, without lapse, for a period of three years beyond the expiration of this Agreement, to the effect that, should occurrences during the contract term give rise to claims made after expiration of the Agreement, such claims shall be covered by such claims-made policies.

e. Should any required insurance lapse during the term of this Agreement, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this Agreement, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this Agreement effective on the date of such lapse of insurance.

f. Before commencing any Services, Contractor shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in form evidencing all coverages set forth above. Approval of the insurance by City shall not relieve or decrease Contractor's liability hereunder.

g. The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Contractor, its employees, agents and subcontractors.

h. If Contractor will use any subcontractor(s) to provide Services, Contractor shall require the subcontractor(s) to provide all necessary insurance and to name the City and County of San Francisco, its officers, agents and employees and the Contractor as additional insureds.

Notwithstanding the foregoing, the following insurance requirements are waived or modified in accordance with the terms and conditions stated in Appendix C Insurance.

2d. Replacing "Earned Income Credit (EIC) Forms" Section with "Consideration of Criminal History in Hiring and Employment Decisions" Section. Section 32 "Earned Income Credit (EIC) Forms" is hereby replaced in its entirety to read as follows:

32. Consideration of Criminal History in Hiring and Employment Decisions.

a. Contractor agrees to comply fully with and be bound by all of the provisions of Chapter 12T "City Contractor/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions," of the San Francisco Administrative Code (Chapter 12T), including the remedies provided, and implementing regulations, as may be amended from time to time. The provisions of Chapter 12T are incorporated by reference and made a part of this Agreement as though fully set forth herein. The text of the Chapter 12T is available on the web at www.sfgov.org/olse/fco. A partial listing of some of Contractor's obligations under Chapter 12T is set forth in this Section. Contractor is required to comply with all of the applicable provisions of 12T, irrespective of the listing of obligations in this Section. Capitalized terms used in this Section and not defined in this Agreement shall have the meanings assigned to such terms in Chapter 12T.

b. The requirements of Chapter 12T shall only apply to a Contractor's or Subcontractor's operations to the extent those operations are in furtherance of the performance of this Agreement, shall apply only to applicants and employees who would be or are performing work in furtherance of this Agreement, shall apply only when the physical location of the employment or prospective employment of an individual is wholly or substantially within the City of San Francisco, and shall not apply when the application in a particular context would conflict with federal or state law or with a requirement of a government agency implementing federal or state law.

c. Contractor shall incorporate by reference in all subcontracts the provisions of Chapter 12T, and shall require all subcontractors to comply with such provisions. Contractor's failure to comply with the obligations in this subsection shall constitute a material breach of this Agreement.

d. Contractor or Subcontractor shall not inquire about, require disclosure of, or if such information is received, base an Adverse Action on an applicant's or potential applicant for employment's, or employee's: (1) Arrest not leading to a Conviction, unless the Arrest is undergoing an active pending criminal investigation or trial that has not yet been resolved; (2) participation in or completion of a diversion or a deferral of judgment program; (3) a Conviction that has been judicially dismissed, expunged, voided, invalidated, or otherwise rendered inoperative; (4) a Conviction or any other adjudication in the juvenile justice system; (5) a

Conviction that is more than seven years old, from the date of sentencing; or (6) information pertaining to an offense other than a felony or misdemeanor, such as an infraction.

e. Contractor or Subcontractor shall not inquire about or require applicants, potential applicants for employment, or employees to disclose on any employment application the facts or details of any conviction history, unresolved arrest, or any matter identified in subsection 32 above. Contractor or Subcontractor shall not require such disclosure or make such inquiry until either after the first live interview with the person, or after a conditional offer of employment.

f. Contractor or Subcontractor shall state in all solicitations or advertisements for employees that are reasonably likely to reach persons who are reasonably likely to seek employment to be performed under this Agreement, that the Contractor or Subcontractor will consider for employment qualified applicants with criminal histories in a manner consistent with the requirements of Chapter 12T.

g. Contractor and Subcontractors shall post the notice prepared by the Office of Labor Standards Enforcement (OLSE), available on OLSE's website, in a conspicuous place at every workplace, job site, or other location under the Contractor or Subcontractor's control at which work is being done or will be done in furtherance of the performance of this Agreement. The notice shall be posted in English, Spanish, Chinese, and any language spoken by at least 5% of the employees at the workplace, job site, or other location at which it is posted.

h. Contractor understands and agrees that if it fails to comply with the requirements of Chapter 12T, the City shall have the right to pursue any rights or remedies available under Chapter 12T, including but not limited to, a penalty of $50 for a second violation and $100 for a subsequent violation for each employee, applicant or other person as to whom a violation occurred or continued, termination or suspension in whole or in part of this Agreement.

2e. Protection of Private Information. Section 64 is hereby added to the Agreement, as follows:

64. Protection of Private Information. Contractor has read and agrees to the terms set forth in San Francisco Administrative Code Sections 12M.2, "Nondisclosure of Private Information," and 12M.3, "Enforcement" of Administrative Code Chapter 12M, "Protection of Private Information," which are incorporated herein as if fully set forth. Contractor agrees that any failure of Contactor to comply with the requirements of Section 12M.2 of this Chapter shall be a material breach of the Contract. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract, bring a false claim action against the Contractor pursuant to Chapter 6 or Chapter 21 of the Administrative Code, or debar the Contractor.

2f. Health Care Accountability Ordinance. Section 44 is hereby replaced in its entirety to read as follows:

44. Health Care Accountability Ordinance.

Contractor agrees to comply fully with and be bound by all of the provisions of the Health Care Accountability Ordinance (HCAO), as set forth in San Francisco Administrative Code Chapter 12Q, including the remedies provided, and implementing regulations, as the same may be amended from time to time. The provisions of section 12Q.5.1 of Chapter 12Q are incorporated by reference and made a part of this Agreement as though fully set forth herein. The text of the HCAO is available on the web at www.sfgov.org/olse. Capitalized terms used in this Section and not defined in this Agreement shall have the meanings assigned to such terms in Chapter 12Q.

a. For each Covered Employee, Contractor shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Contractor chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission.

b. Notwithstanding the above, if the Contractor is a small business as defined in Section 12Q.3(e) of the HCAO, it shall have no obligation to comply with part (a) above.

c. Contractor's failure to comply with the HCAO shall constitute a material breach of this agreement. City shall notify Contractor if such a breach has occurred. If, within 30 days after receiving City's written notice of a breach of this Agreement for violating the HCAO, Contractor fails to cure such breach or, if such breach cannot reasonably be cured within such period of 30 days, Contractor fails to commence efforts to cure within such period, or thereafter fails diligently to pursue such cure to completion, City shall have the right to pursue the remedies set forth in 12Q.5.1 and 12Q.5(f)(1-6). Each of these remedies shall be exercisable individually or in combination with any other rights or remedies available to City.

d. Any Subcontract entered into by Contractor shall require the Subcontractor to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section. Contractor shall notify City's Office of Contract Administration when it enters into such a Subcontract and shall certify to the Office of Contract Administration that it has notified the Subcontractor of the obligations under the HCAO and has imposed the requirements of the HCAO on Subcontractor through the Subcontract. Each Contractor shall be responsible for its Subcontractors' compliance with this Chapter. If a Subcontractor fails to comply, the City may pursue the remedies set forth in this Section against Contractor based on the Subcontractor's failure to comply, provided that City has first provided Contractor with notice and an opportunity to obtain a cure of the violation.

e. Contractor shall not discharge, reduce in compensation, or otherwise discriminate against any employee for notifying City with regard to Contractor's noncompliance or anticipated noncompliance with the requirements of the HCAO, for opposing any practice proscribed by the HCAO, for participating in proceedings related to the HCAO, or for seeking to assert or enforce any rights under the HCAO by any lawful means.

f. Contractor represents and warrants that it is not an entity that was set up, or is being used, for the purpose of evading the intent of the HCAO.

g. Contractor shall maintain employee and payroll records in compliance with the California Labor Code and Industrial Welfare Commission orders, including the number of hours each employee has worked on the City Contract.

h. Contractor shall keep itself informed of the current requirements of the HCAO.

i. Contractor shall provide reports to the City in accordance with any reporting standards promulgated by the City under the HCAO, including reports on Subcontractors and Subtenants, as applicable.

j. Contractor shall provide City with access to records pertaining to compliance with HCAO after receiving a written request from City to do so and being provided at least ten business days to respond.

k. Contractor shall allow City to inspect Contractor's job sites and have access to Contractor's employees in order to monitor and determine compliance with HCAO.

l. City may conduct random audits of Contractor to ascertain its compliance with HCAO. Contractor agrees to cooperate with City when it conducts such audits.

m. If Contractor is exempt from the HCAO when this Agreement is executed because its amount is less than $25,000 ($50,000 for nonprofits), but Contractor later enters into an agreement or agreements that cause Contractor's aggregate amount of all agreements with City to reach $75,000, all the agreements shall be thereafter subject to the HCAO. This obligation arises on the effective date of the agreement that causes the cumulative amount of agreements between Contractor and the City to be equal to or greater than $75,000 in the fiscal year.

2g. Add Appendices A-1 through A-13 dated 7/1/15 to Agreement as amended.

2h. Delete Appendix B-Calculation of Charge and replace in its entirety with Appendix B-Calculation of Charge dated 7/1/15 to Agreement as amended.

2i. Add CBHS Budget Documents/Appendices B–1 through B-13 dated 7/1/15 to Agreement as amended.

2j. Delete Appendix D-Additional Terms and replace in its entirety with Appendix D- Additional Terms dated 7/1/15 to Agreement as amended.

2k. Delete Appendix E-HIPAA Business Associate Agreement and replace in its entirety with Appendix E- HIPAA Business Associate Agreement dated 5/19/15 to Agreement as amended.

3. Effective Date. Each of the modifications set forth in Section 2 shall be effective on and after July 1, 2015.

4. **Legal Effect.** Except as expressly modified by this Amendment, all of the terms and conditions of the Agreement shall remain unchanged and in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day first mentioned above.

CITY

Recommended by:

BARBARA A. GARCIA, MPA.
Director of Health

/ Date

Approved as to Form:

DENNIS J. HERRERA
City Attorney

By: KATHY MURPHY
Deputy City Attorney

/ Date

Approved:

JACI FONG
Director of the Office of Contract Administration, and Purchaser

/ Date

CONTRACTOR

Family Service Agency of San Francisco

ROBERT BENNETT
Executive Director
1500 Franklin Street
San Francisco, CA 94109

City vendor number: 07426

Date

1. **Identifiers:**
   Program Name: Geriatric Services West
   Program Address: 6221 Geary Blvd
   City, State, ZIP: San Francisco, CA 94121
   Telephone: 415-386-6600 FAX: 415-751-3226
   Website Address: www.felton.org

   Contractor Address: 1500 Franklin Street
   City, State, ZIP: San Francisco, CA 94109
   Person Completing this Narrative: Cathy Spensley, Senior Division Director
   Telephone: 415-474-7310, ext. 435
   Email Address: cspensley@felton.org

   Program Code: 89903

2. **Nature of Document:**
   ☐ New **Renewal** ☒ Modification

3. **Goal Statement:**
This program is part of FSA's full and seamless range of behavioral health services to older adults directly addressing the highest levels of need citywide by providing a Full Service Partnership, Intensive Case Management, Geriatric Outpatient Services, Older Adult Day Support Center/Community Integration, and a Senior Peer-Based Wellness and Recovery Center. This continuum of care enhances the capacity of older adult consumers, with an overall goal to assist clients to move out of specialty mental health services and into mainstream peer services and supports in the community. The Geriatric Services West provides outpatient services in Catchment Area 5, in close collaboration with other city/county and community-based programs. The clinic is located at 6221 Geary, and clients are seen in the clinic, as well as in their homes and in the community, as needed.

4. **Target Population:**
The target population for Geriatric Service West is clients aged 60 and older living in Catchment Area 5 (Western Richmond and Sunset) who need specialized geriatric mental health services beyond what is available through the Adult System of Care in the Catchment Area 5. These clients may have multiple disabilities, complex medical needs, dual diagnoses, or other specialized needs related to mental health and aging, and are best served by clinicians with geriatric mental health expertise. The population also has additional needs related to engagement, language, cultural awareness, stigma, social isolation, substance abuse, or cognitive deficits. The program works in close coordination with the city's Older Adult System of Care providing psychiatric services and clinical case management for monolingual Cantonese, Mandarin, and Russian clients.

5. **Modality(s)/Intervention(s):**
   Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community

services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Plan Development: "Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biological which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

6. Methodology:

A. Outreach, recruitment, promotion, and advertisement.

Outreach is conducted with all collaborative partners, including primary care clinics, substance abuse treatment providers, residential care providers, residential behavioral health providers, hospitals, homeless shelters and adult correctional system, emergency crisis services, and other partners. All levels of service conduct direct outreach to older adults in communities where service connection is needed the most and in locations where the various populations feel the safest, such as cultural centers, senior centers, religious organizations, and other formal and

informal support systems. Peer Case Aides, called Community Specialists are an essential part of outreach, engagement, and retention because of their direct experience as clients of the treatment system. Other outreach to the most fragile and disconnected consumers may be by a FSA Psychiatric Nurse Practitioner (PNP). Consumers otherwise distrustful of treatment services are often willing to receive health care, if it is offered in a non-institutional setting, so the PNP is an important element of the engagement strategy. The PNP provides health screening and first aid, dispenses minor medications (such as over-the-counter painkillers and analgesics, and topical skin medications), and unless already linked, will arrange for medical treatment through primary care partners. In addition to street outreach, referrals are accepted from multiple sources, including SF General, Project Homeless Connect, APS, senior centers, Project Open Hand, other mental health and substance abuse agencies, PES, Sheriff, SFPD, hospital emergency rooms, and family referrals. All outreach materials for FSA's Senior Division, including the agency website, include descriptions of these programs.

B. Admission, enrollment and/or intake criteria and process.

Intake occurs in the Geary Boulevard offices, at client homes, in hospitals, or wherever best meets a client's needs. At screening, it is determined if clients have a safe place to live, enough to eat, and medical care for acute conditions, before proceeding to assessment. Clients may also get assistance with food, clothing needs, and primary care examinations, and pressing health needs are treated through FSA's primary care partners. With basic health and safety assured, clients receive assessment using a comprehensive, strength-based, assessment tool designed to give care managers and consumers an understanding of the consumer's goals, aspirations, and challenges across all life domains. Elements of the toolkit include a number of evidence-based scales relevant to assessing a particular client, but all clients receive assessment with:

The ANSA: An assessment tool designated by CBHS that assesses strengths and challenges in a number of essential domains.

The Montreal Cognitive Assessment Scale: Administered annually as a test for cognitive impairment.

C. Service delivery model and how each service is delivered.

Overview of the Service Model:

The program provides older adults with a full and seamless range of behavioral health services, directly addressing the highest levels of need citywide, and in close partnership with the other two specialized geriatric mental health outpatient clinics, Central City and Southeast Mission. The program partners closely with Curry Senior Center, for specialized substance abuse outpatient services for older adults in the North of Market/Tenderloin/South of Market neighborhoods, as well as Golden Gate for Seniors residential substance abuse treatment. Primary Care Partnerships also exist with Curry Senior Center and other primary care clinics across the city. With these collaborating partners, services are dual diagnosis-competent at all levels and provide a full range of evidence-based, culturally and linguistically competent, recovery-oriented services throughout the spectrum of behavioral and physical health needs. The aim is to enhance the capacity of older adult consumers, so that as many as appropriate are able to move out of specialty mental health services and into mainstream, peer services, and supports in the community, including aging services. The levels of care are:

Screening and Assessment: Our Centralized Intake conducts appropriate risk assessments and other brief screenings; provides intake interviews in the clinics or in the home or in the

community; and develops an initial care plan to include additional psychiatric and medication assessments.

Care Planning, Care Management, and Services Linkage: After Intake, an assigned clinical case manager begins work with the client. At the core of all services is strength-based recovery-oriented care management. FSA has developed a rigorous approach to care management built on motivational interviewing and wrap-around principles. Each FSA team member (including community staff and medical staff) receives intensive training on assessment, care planning, and culturally competent service delivery, motivational interviewing, and working in a multidisciplinary team, as well as intensive training on outreach, engagement, and re-engagement. In addition, staff members who work in the senior programs receive ongoing specialized training in geriatric mental health. Each client has an assigned case manager as the primary point of contact, and together they develop a strength-based plan of care with measurable outcome objectives. Case management includes brokerage services, as well as brief, evidence-based treatment therapy, when appropriate. Daily living support services are offered as part of the care coordination process and may include problem solving, skills training, and assistance -- often by peers and case aides -- to help clients carry out personal hygiene and grooming tasks; perform household activities; housing supports including working with board and care operators; improving money-management skills; using available transportation; and finding and using healthcare services. Every client is linked to primary care through clinic partners.

Outpatient Case Management and Treatment: Outpatient treatment is in Catchment 5, including the use of peers and partnerships. This program serves individuals who require fewer than four visits per month, and offers integrated care management, medication management, and evidence-based mental health and substance abuse treatment.

Outcome-guided medication regimens: All clients needing medication management have access to an FSA psychiatrist or a nurse practitioner, who assesses, prescribes, monitors, treats, documents symptoms or side effects, and educates. All case managers assess and document client symptoms and behavior in response to medication. Medication policies and procedures identify all processes and safety procedures around medications.

Evidence based, integrated behavioral health treatment: Case managers and clients can access an extensive, organized system of treatments and supports to promote and sustain recovery. FSA, through its Felton Institute, provides national-caliber faculty to train, supervise, and certify staff in a range of evidence-based treatments that span the spectrum of diagnoses of clients. In most cases, FSA has staff with diverse linguistic competencies trained in each of these approaches. These include:

Substance Abuse: FSA clinicians are trained in Motivational Interviewing and offer adjunct substance abuse group therapy. In addition, FSA partners with Curry Senior Center and Golden Gate for Seniors to provide more extensive substance abuse outpatient and residential treatment. In collaboration, these partners continue to develop more accessible and effective treatment strategies for clients with substance abuse issues. **Other Evidence-Based Practices:** FSA has trained staff in numerous evidence-based practices including PST for depression, PST for psychosis, CBT for Depression, CBT for Psychosis, Trauma-focused CBT, DBT, Life Review, and Multifamily Psycho-education Groups. Many treatments are available in Spanish and Cantonese.

Peer Support and Volunteer Opportunities: Older consumers interested and able to participate in meaningful competitive employment are assisted in that effort. For many others, making a meaningful contribution remains important and is a key to maintaining robust physical and mental health throughout the lifespan. FSA offers its clients a range of volunteer opportunities both within the agency and at other partner programs throughout the community.

FSA's Senior Programs participate in the CBHS Advanced Access initiative, including timely data measurement at the site and reporting of data to CBHS as required. They provide and document the initial risk assessment using the CBHS IRA form within 24-48 hours of request for service, and adhere to CBHS guidelines regarding assessment and treatment of uninsured clients. All services are ADA compliant. Clinic services are provided in the client's home, other senior sites (health clinics, Adult Day Health, senior centers, etc.), and at FSA offices.

D. Discharge Planning and exit criteria and process.

Guidelines for discharge include CBHS definitions of medical necessity, stabilization of debilitating psychiatric symptoms, resolving of problems on plan of care and successfully linking client to alternative services for care (i.e. PCP, Adult Day Health, etc.). Clients are stepped-down to less intensive services upon meeting CBHS exit criteria. Clients are continuously assessed in their recovery process, and when appropriate, stepped down along a continuum of care that best meets their needs, through FSA's Community Integration Services, when appropriate. Also, when appropriate, clients are discharged to other programs in the community that can best meet their current needs in recovery and allow for less dependence on mental health services.

E. Program Staffing

- Senior Division Director, provides administrative oversight and leadership of program operations and development.
- Director of Clinical Supervision and Internship Program, provides oversight of clinical supervision and interns, including direct supervision for clinician licensing hours.
- Centralized Intake Manager, provides centralized intake and timely access, as well as information and referral.
- Program Manager, provides operational oversight, as well as clinical case management and therapy.
- Clinical Case Manager, Provides clinical case management and therapy.
- Clinical Case Manager, Provides clinical case management and therapy.
- Clinical Case Manager, (Cantonese speaking) – Provides clinical case management and therapy.
- Clinical Case Manager, (Cantonese speaking) – Provides clinical case management and therapy.
- Clinical Case Manager, (Russian speaking) – Part-time, provides clinical case management and therapy.
- NP – Part-time, provides medical support services.
- NP (Cantonese, Mandarin, Vietnamese speaking) – Part-time, provides medication support services.
- MD – Part-time, provides medical support services.
- Office Manager, (Russian-speaking) – provides admin support.
- Program Administrator, (Mandarin, Cantonese – speaking) provides receptionist support.

7. Objectives and Measurements:

A. Standard Objectives

All objectives, and descriptions of how objectives will be measured, are contained in the CBHS document entitled CBHS *Performance Objectives FY 15-16*..

8. Continuous Quality Improvement:

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:

Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to

monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:

FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr. McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit process which is conducted as follows:
Monthly:
* There is a Quality Assurance meeting with all program directors across the agency to review "Chart Health" metrics and productivity in each program. This meeting is also a forum to discuss policy changes and issues as they relate to the interface of CIRCE and AVATAR.
* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual TxPOC and PURQC. This audit includes a review of all chart components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.
* All program directors meet to audit a mental health program utilizing the attached internal audit sheets. One or two charts are audited thoroughly by the group in order to generate questions about changes in policy or other nuances about our evolving QA process.

Quarterly:
All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing:
All staff working for CBHS Contracts is required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services

All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services

FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.

FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment

reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc., as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. Required Language:

N/A

1. Identifiers:

Program Name: Geriatric Services Older Adult Day Support Center/Community Integration
Program Address: 6221 Geary Blvd
City, State, ZIP: San Francisco, CA 94121
Telephone: 415-474-7310 FAX: 415-751-3226
Website Address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Person Completing this Narrative: Cathy Spensley, Senior Division Director
Telephone: 415-474-7310, ext. 435
Email Address: cspensley@felton.org

Program Code: 89903MH

2. Nature of Document:

☐ New **Renewal** [X] Modification

3. Goal Statement:

This program is part of FSA's full and seamless range of behavioral health services to older adults directly addressing the highest levels of need citywide by providing a Full Service Partnership, Intensive Case Management, Geriatric Outpatient Services, Older Adult Day Support Center/Community Integration, and a Senior Peer-Based Wellness and Recovery Center. This continuum of care enhances the capacity of older adult consumers, with an overall goal to assist clients to move out of specialty mental health services and into mainstream peer services and supports in the community. The Older Adult Day Support Center/Community Integration Program is located at 6221 Geary Boulevard, and it serves clients at that location

4. Target Population:

The target population for the Older Adult Day Support Center is clients aged 60 and older who need specialized geriatric mental health services beyond what is available through the Adult System of Care, and who can benefit from specialized group therapy for older adults, as well as community integration to reduce isolation. The program serves clients citywide. Clients can receive case management and medication support services from this program, if they do not have these services from other programs in the city. These clients may have multiple disabilities, complex medical needs, dual diagnoses, or other specialized needs related to mental health and aging, and are best served by clinicians with geriatric mental health expertise. The population also has additional needs related to engagement, language, cultural awareness, stigma, social isolation, substance abuse, or cognitive deficits. The program works in close coordination with the city's Older Adult System of Care.

5. Modality(s)/Intervention(s

Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Plan Development: "Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biological which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

6. Methodology:

A. Outreach, recruitment, promotion, and advertisement.

Outreach is conducted with other FSA Senior Division programs, as well as all collaborative partners, including other geriatric mental health programs, adult protective services, primary care clinics, substance abuse treatment providers, residential care providers, residential behavioral health providers, senior centers, hospitals, and homeless shelters. Direct outreach to older adults is conducted in communities where service connection is needed the most and in locations where the various populations feel the safest, such as cultural centers, senior centers, religious organizations, and other formal and informal support systems. Peer Case Aides, called Community Specialists are an essential part of outreach, engagement, and retention because of their direct experience as clients of the treatment system. Referrals are accepted from multiple sources, including the CBHS Older Adult System of Care, Office on Aging case managers, SF General, Project Homeless Connect, APS, senior centers, Project Open Hand, other mental health and substance abuse agencies, and family and self-referrals. All outreach materials for FSA's Senior Division, including the agency website, include descriptions of programs.

B. Admission, enrollment and/or intake criteria and process.

Intake occurs in the Geary Boulevard offices, at client homes, in hospitals, or wherever best meets a client's needs. At screening, it is determined if clients have case management services and medication support services or if they need these additional services from the program. It is also determined if clients need Paratransit transportation to get to the group site, or other transportation support. An assessment is conducted to determine which group therapy program the clients would best be served, as well as additional individual interests which match with community integration opportunities. The program follows a client-centered approach in all stages of engagement, assessment, and treatment planning. Clients may also get assistance with food, clothing needs, and primary care examinations, and pressing health needs are treated through FSA's primary care partners. With basic health and safety assured, clients receive comprehensive assessment using a strength-based, assessment tool designed to give care managers and consumers an understanding of the consumer's goals, aspirations, and challenges across all life domains. Elements of the toolkit include a number of evidence-based scales relevant to assessing a particular client, but all clients receive assessment with:

The ANSA: An assessment tool designated by CBHS that assesses strengths and challenges in a number of essential domains.

The Montreal Cognitive Assessment Scale: Administered annually as a test for cognitive impairment.

C. Service delivery model and how each service is delivered

Overview of the Service Model:

This program provides specialized group therapy and community integration services in conjunction with other mental health and case management programs. Partners may include specialized geriatric mental health outpatient clinics in CBHS's Older Adult System of Care, including FSA, Central City, and Southeast Mission, providing clinical case management and medication support services, or it may include other case management programs specializing in older adults. If clients are not receiving needed case management and medication support services from other city programs, OADSC will provide these services inside the program or connect the client with those services. Therefore, in collaboration with other partnering programs, OADSC provides older adults with a full and seamless range of behavioral health services, directly addressing the highest levels of need citywide.

Along with providing this specialized service in conjunction with other clinical case management programs, in its role of providing specialized group therapy and community integration services, OADSC provides a unique service in the city by offering a step-down from more intensive mental health services, as well as a step-up in mental health services for those fitting more appropriately in the SMI population. The program partners closely with FSA's Senior Drop-In Center, a Senior Peer-Based Wellness and Recovery Center at the Curry Senior Center, by offering supportive and welcoming access to mental health services. In addition, over the years many clients from specialized SMI case management programs have been able to step down their clients to this group therapy program, thus providing the appropriate level of services and saving significant resources in our system of care.

For 2014-15, OADSC will operate at 6221 Geary on Thursdays from 9:30-2:30, and 280 Turk on Mondays from 9:30am-2:30pm. Both days include 2 group therapy sessions, a hot lunch, and community integration activities. It is anticipated that in early 2015, OADSC will begin operating a similar schedule 1-2 days a week at 1099 Sunnydale, in Visitation Valley. Additional group therapy community integration activities are currently occurring at San Francisco Senior Center, and in several residential care facilities.

In addition, the program partners closely with Curry Senior Center and specialized substance abuse outpatient services for older adults in the North of Market/Tenderloin/South of Market neighborhoods, as well as Golden Gate for Seniors residential substance abuse treatment. Primary Care Partnerships also exist with Curry Senior Center and other primary care clinics across the city. With these collaborating partners, services are dual diagnosis-competent at all levels and provide a full range of evidence-based, culturally and linguistically competent, recovery-oriented services throughout the spectrum of behavioral and physical health needs. The aim is to enhance the capacity of older adult consumers, so that as many as appropriate are able to move out of specialty mental health services and into mainstream, peer services, and supports in the community, including aging services. The levels of care are:

Screening and Assessment: Our Centralized Intake conducts appropriate risk assessments and other brief screenings; provides intake interviews in the clinics or in the home or in the community; and develops an initial care plan to include additional psychiatric and medication assessments. When appropriate, clients will be referred to the Older Adult Day Support Center for group therapy and case management, instead of a higher level of care in our Geriatric Outpatient Mental Health Services.

Care Planning, Care Management, and Services Linkage: After Intake, if the client does not have case management through other services, an OADSC assigned clinical case manager begins work with the client. At the core of all services is strength-based recovery-oriented care management. FSA has developed a rigorous approach to care management built on motivational interviewing and wrap-around principles. Each FSA team member (including community staff and medical staff) receives intensive training on assessment, care planning, and culturally competent service delivery, motivational interviewing, and working in a multidisciplinary team, as well as intensive training on outreach, engagement, and re-engagement. In addition, staff members who work in the senior programs receive ongoing specialized training in geriatric mental health. Case management includes brokerage services, as well as brief, evidence-based treatment therapy, when appropriate. Daily living support services are offered as part of the care coordination process and may include problem solving, skills training, and assistance -- often by peers and case aides -- to help clients carry out personal hygiene and grooming tasks; perform household activities; housing supports including working with board and care operators; improving money-management skills; using available transportation; and finding and using healthcare services. Clients may also receive medication support services from FSA, and every client is linked to primary care through clinic partners.

Peer Support and Volunteer Opportunities: Older consumers interested and able to participate in meaningful competitive employment are assisted in that effort. For many others, making a meaningful contribution remains important and is critical to maintaining robust physical and mental health throughout the lifespan. FSA offers its clients a range of volunteer opportunities both within the agency and at other partner programs throughout the community. Many graduates of OADSC, as well as clients from other FSA programs, volunteer with OADSC to assist with the center programming and other community integration opportunities.

Community Integration Services and Wellness Promotion: Participants in all levels of care are offered opportunities in community integration and wellness promotion as an integral part of the recovery process. These services are designed to help clients transition to other support systems in the community, as well as provide effective outreach and engagement for individuals who are socially isolated, need mental health services, and benefit from evidence-based and innovative group therapy. Full assessments, preventive screening, and care plans lead to appropriate transitions and treatment options. Transition and escort services, often by case aides and peer volunteers, help clients feel comfortable going to senior centers, or make appointments at primary care clinics. Other services include education and assistance for more

healthy living, including smoking cessation assistance and exercise, and meaningful joint activities in the community. To assist older adult clients overcome social isolation, improve social and personal skills, and become better integrated in their communities, a variety of opportunities are available in the Older Adult Day Support Center, partnering senior centers, and adult day health care centers, and other senior programs in the city, including connections to natural supports and peer opportunities. Group therapy is a large part of this model, as research has shown it offers additional benefits to older adults, such as mutual aid and a sense of belonging.

FSA's Senior Programs participate in the CBHS Advanced Access initiative, including timely data measurement at the site and reporting of data to CBHS as required. They provide and document the initial risk assessment using the CBHS IRA form within 24-48 hours of request for service, and adhere to CBHS guidelines regarding assessment and treatment of uninsured clients. All services are ADA compliant. Clinic services are provided in the client's home, other senior sites (health clinics, Adult Day Health, senior centers, etc.), and at FSA offices.

D. Discharge Planning and exit criteria and process.

Guidelines for discharge include CBHS definitions of medical necessity, stabilization of debilitating psychiatric symptoms, resolving of problems on plan of care and successfully linking client to alternative services for care (i.e. PCP, Adult Day Health, etc.). Clients are stepped-down to less intensive services upon meeting CBHS exit criteria. Clients are continuously assessed in their recovery process, and when appropriate, stepped down along a continuum of care that best meets their needs, through FSA's Community Integration Services, when appropriate. Also, when appropriate, clients are discharged to other programs in the community that can best meet their current needs in recovery and allow for less dependence on mental health services.

E. Program staffing

- Senior Division Director, provides administrative oversight and leadership of program operations and development.
- Director of Clinical Supervision and Internship Program, provides oversight of clinical supervision and interns, including direct supervision for clinician licensing hours.
- Program Director, provides operational oversight, as well as clinical case management, group therapy, community integration services, and oversight of volunteers.
- Clinical Case Manager, provides clinical case management, group therapy, and community integration services.
- Community Specialist, provides peer support and community integration services.

7. Objectives and Measurements:

A. Standard Objectives

All objectives, and descriptions of how objectives will be measured, are contained in the CBHS document entitled CBHS Performance Objectives FY 15-16.

B. Continuous Quality Improvement (CQI):

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

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B. Quality of documentation, including a description of the frequency and scope of internal chart audits:

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* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual TxPOC and PURQC. This audit includes a review of all chart

components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.
* All program directors meet to audit a mental health program utilizing the attached internal audit sheets. One or two charts are audited thoroughly by the group in order to generate questions about changes in policy or other nuances about our evolving QA process.

Quarterly:
All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing:
All staff working for CBHS Contracts is required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services

All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services

FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer

Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.

FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc., as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. Required Language:

N/A

1. **Identifiers:**
Program Name: Geriatric Services at Franklin, Geriatric Outpatient Intensive Case Management
Program Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Telephone: 415-474-7310 FAX: 415-447-9805
Website Address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Person Completing this Narrative: Cathy Spensley, Senior Division Director
Telephone: 415-474-7310, ext. 435
Email Address: cspensley@felton.org

Program Code: 38223MH and 382213

2. **Nature of Document:**
3. ☐ New **Renewal** [X] Modification

4. **Goal Statement:**
This program is part of FSA's full and seamless range of behavioral health services to older adults directly addressing the highest levels of need citywide by providing a Full Service Partnership, Intensive Case Management, Geriatric Outpatient Services, Older Adult Day Support Center/Community Integration, and a Senior Peer-Based Wellness and Recovery Center. This continuum of care enhances the capacity of older adult consumers, with an overall goal to assist clients to move out of specialty mental health services and into mainstream peer services and supports in the community. The Geriatric Outpatient Services at 1500 Franklin provides outpatient services in Catchment Area 2, in close collaboration with other city/county and community-based programs. The Geriatric Outpatient Intensive Case Management program provides services citywide, with the overall goal to stabilize and provide step-down transitions to a lower level of care. The Community Aftercare Psychiatrist support provides medication support to a population of clients living in residential care homes that need this level of medication oversight, including injections, to remain living successfully in the community.

5. **Target Population:**
The target population for Geriatric Outpatient Services is clients aged 60 and older living in Catchment Area 2 (Western Addition/Marina/Presidio) who need specialized geriatric mental health services beyond what is available through the Adult System of Care. These clients may have multiple disabilities, complex medical needs, dual diagnoses, or other specialized needs related to mental health and aging, and are best served by clinicians with geriatric mental health expertise. The population also has additional needs related to engagement, language, cultural awareness, stigma, social isolation, substance abuse, or cognitive deficits. The program works in close coordination with the city's Older Adult System of Care providing psychiatric services and clinical case management for monolingual Mandarin and Spanish clients. The Intensive Case Management Program serves older adults across the city with severe functional impairments and very complex needs, requiring intensive case management (ICM) in order to remain safely in the community. ICM clients come through CBHS referrals and meet the ICM criteria, such as multiple recent Crisis/PES visits or

hospitalizations, homelessness, and other high risk criteria. The Community Aftercare Psychiatrist support provides medication support to a population of clients living in residential care homes that need this level of medication oversight, including injections, to remain living successfully in the community.

6. Modality(s)/Intervention(s)

Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Plan Development: "Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biological which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute

psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

7. Methodology:

A. Outreach, recruitment, promotion, and advertisement.

Outreach for Geriatric Outpatient Services at 1500 Franklin is conducted with all collaborative partners, including primary care clinics, substance abuse treatment providers, residential care providers, residential behavioral health providers, hospitals, homeless shelters and adult correctional system, emergency crisis services, and other partners. All levels of service conduct direct outreach to older adults in communities where service connection is needed the most and in locations where the various populations feel the safest, such as cultural centers, senior centers, religious organizations, and other formal and informal support systems. Peer Case Aides, called Community Specialists are an essential part of outreach, engagement, and retention because of their direct experience as clients of the treatment system. Other outreach to the most fragile and disconnected consumers may be by a FSA Psychiatric Nurse Practitioner (PNP). Consumers otherwise distrustful of treatment services are often willing to receive health care, if it is offered in a non-institutional setting, so the PNP is an important element of the engagement strategy. The PNP provides health screening and first aid, dispenses minor medications (such as over-the-counter painkillers and analgesics, and topical skin medications), and unless already linked, will arrange for medical treatment through primary care partners. In addition to street outreach, referrals are accepted from multiple sources, including SF General, Project Homeless Connect, APS, senior centers, Project Open Hand, other mental health and substance abuse agencies, PES, Sheriff, SFPD, hospital emergency rooms, and family referrals. Referrals for Intensive Case Management and Community Aftercare Program come through CBHS, and all outreach materials for FSA's Senior Division, including the agency website, include descriptions of these programs.

B. Admission, enrollment and/or intake criteria and process.

Intake occurs in the 1500 Franklin Street offices, at client homes, in hospitals, or wherever best meets a client's needs. At screening, it is determined if clients have a safe place to live, enough to eat, and medical care for acute conditions, before proceeding to assessment. Clients may also get assistance with food, clothing needs, and primary care examinations, and pressing health needs are treated through FSA's primary care partners. With basic health and safety assured, clients receive comprehensive assessment using a comprehensive, strength-based, assessment tool designed to give care managers and consumers an understanding of the consumer's goals, aspirations, and challenges across all life domains. Elements of the toolkit include a number of evidence-based scales relevant to assessing a particular client, but all clients receive assessment with:

The ANSA: An assessment tool designated by CBHS that assesses strengths and challenges in a number of essential domains.

The Mini Mental Status Exam or Blessed Roth Dementia Scale: Administered annually as a test for cognitive impairment.

C. Service delivery model and how each service is delivered

Overview of the Service Model:

The program provides older adults with a full and seamless range of behavioral health services, directly addressing the highest levels of need citywide, and in close partnership with the other two specialized geriatric mental health outpatient clinics, Central City and Southeast Mission.

The program partners closely with Curry Senior Center, for specialized substance abuse outpatient services for older adults in the North of Market/Tenderloin/South of Market neighborhoods, as well as Golden Gate for Seniors residential substance abuse treatment. Primary Care Partnerships also exist with Curry Senior Center, Lakeside, and other primary care clinics across the city. With these collaborating partners, services are dual diagnosis-competent at all levels and provide a full range of evidence-based, culturally and linguistically competent, recovery-oriented services throughout the spectrum of behavioral and physical health needs. The aim is to enhance the capacity of older adult consumers, so that as many as appropriate are able to move out of specialty mental health services and into mainstream, peer services, and supports in the community, including aging services. The levels of care are:

Screening and Assessment: Our Centralized Intake conducts appropriate risk assessments and other brief screenings; provides intake interviews in the clinics or in the home or in the community; and develops an initial care plan to include additional psychiatric and medication assessments.

Care Planning, Care Management, and Services Linkage: After Intake, an assigned clinical case manager begins work with the client. At the core of all services is strength-based recovery-oriented care management. FSA has developed a rigorous approach to care management built on motivational interviewing and wrap-around principles. Each FSA team member (including community staff and medical staff) receives intensive training on assessment, care planning, and culturally competent service delivery, motivational interviewing, and working in a multidisciplinary team, as well as intensive training on outreach, engagement, and re-engagement. In addition, staff members who work in the senior programs receive ongoing specialized training in geriatric mental health. Each client has an assigned case manager as the primary point of contact, and together they develop a strength-based plan of care with measurable outcome objectives. Case management includes brokerage services, as well as brief, evidence-based treatment therapy, when appropriate. Daily living support services are offered as part of the care coordination process and may include problem solving, skills training, and assistance -- often by peers and case aides -- to help clients carry out personal hygiene and grooming tasks; perform household activities; housing supports including working with board and care operators; improving money-management skills; using available transportation; and finding and using healthcare services. Every client is linked to primary care through clinic partners.
Outpatient Case Management and Treatment: Outpatient treatment in Catchment 5, including the use of peers and partnerships. This program serves individuals who require fewer than four visits per month, and offers integrated care management, medication management, and evidence-based mental health and substance abuse treatment.
Outcome-guided medication regimens: All clients needing medication management have access to an FSA psychiatrist or a nurse practitioner, who assesses, prescribes, monitors, treats, documents symptoms or side effects, and educates. All case managers assess and document client symptoms and behavior in response to medication. Medication policies and procedures identify all processes and safety procedures around medications.
Evidence based, integrated behavioral health treatment: Case managers and clients can access an extensive, organized system of treatments and supports to promote and sustain recovery. FSA, through its Felton Institute, provides national-caliber faculty to train, supervise, and certify staff in a range of evidence-based treatments that span the spectrum of diagnoses of clients. In most cases, FSA has staff with diverse linguistic competencies trained in each of these approaches. These include:
Substance Abuse: FSA clinicians are trained in Motivational Interviewing and offer adjunct

substance abuse group therapy. In addition, FSA partners with Curry Senior Center and Golden Gate for Seniors to provide more extensive substance abuse outpatient and residential treatment. In collaboration, these partners continue to develop more accessible and effective treatment strategies for clients with substance abuse issues. **Other Evidence-Based Practices:** FSA has trained staff in numerous evidence-based practices including PST for depression, PST for psychosis, CBT for Depression, CBT for Psychosis, Trauma-focused CBT, DBT, Life Review, and Multifamily Psycho-education Groups. Many treatments are available in Spanish and Cantonese.

Peer Support and Volunteer Opportunities: Older consumers interested and able to participate in meaningful competitive employment are assisted in that effort. For many others, making a meaningful contribution remains important and is key to maintaining robust physical and mental health throughout the lifespan. FSA offers its clients a range of volunteer opportunities both within the agency and at other partner programs throughout the community.

Community Integration Services and Wellness Promotion: Participants in all levels of care are offered opportunities in community integration and wellness promotion as an integral part of the recovery process. These services are designed to help clients transition to other support systems in the community, as well as provide effective outreach and engagement for individuals who are socially isolated, need mental health services, and benefit from evidence-based and innovative group therapy. Full assessments, preventive screening, and care plans lead to appropriate transitions and treatment options. Transition and escort services, often by case aides and peer volunteers, help clients feel comfortable going to senior centers, or make appointments at primary care clinics. Other services include education and assistance for more healthy living, including smoking cessation assistance and exercise, and meaningful joint activities in the community. To assist older adult clients overcome social isolation, improve social and personal skills, and become better integrated in their communities, a variety of opportunities are available in the day support center, partnering senior centers, and adult day health care centers, and other senior programs in the city, including connections to natural supports and peer opportunities. Group therapy is a large part of this model, as research has shown it offers additional benefits to older adults, such as mutual aid and a sense of belonging.

FSA's Senior Programs participate in the CBHS Advanced Access initiative, including timely data measurement at the site and reporting of data to CBHS as required. They provide and document the initial risk assessment using the CBHS IRA form within 24-48 hours of request for service, and adhere to CBHS guidelines regarding assessment and treatment of uninsured clients. All services are ADA compliant. Clinic services are provided in the client's home, other senior sites (health clinics, Adult Day Health, senior centers, etc.), and at FSA offices.

D. Discharge Planning and exit criteria and process.

Guidelines for discharge include CBHS definitions of medical necessity, stabilization of debilitating psychiatric symptoms, resolving of problems on plan of care and successfully linking client to alternative services for care (i.e. PCP, Adult Day Health, etc.). Clients are stepped-down to less intensive services upon meeting CBHS exit criteria. Clients are continuously assessed in their recovery process, and when appropriate, stepped down along a continuum of care that best meets their needs, through FSA's Community Integration Services, when appropriate. Also, when appropriate, clients are discharged to other programs in the community that can best meet their current needs in recovery and allow for less dependence on mental health services.

E. Program staffing.

- Senior Division Director, provides administrative oversight and leadership of program operations and development.
- Director of Clinical Supervision and Internship Program, provides oversight of clinical supervision and interns, including direct supervision for clinician licensing hours.
- Centralized Intake Manager, provides centralized intake and timely access, as well as information and referral.
- Program Manager, provides operational oversight of GOS and ICM programs, as well as clinical case management and therapy.
- Clinical Case Manager, provides clinical case management and therapy for ICM program.
- Clinical Case Manager, provides clinical case management and therapy for ICM program.
- Clinical Case Manager, (Polish-speaking) – provides clinical case management and therapy for GOS program.
- Clinical Case Manager (Spanish-speaking) – provides clinical case management and therapy for GOS Program.
- Clinical Case Manager, (Spanish-speaking) – provides clinical case management and therapy for GOS Program.
- Clinical Case Manager, (Mandarin-speaking) – Part-time, provides clinical case management and therapy for GOS Program.
- Lead Community Specialist, provides peer services for ICM and GOS program.
- Senior Division Medical Director, Part-time, provides oversight of medical staff, as well as medication support services.
- NP, Part-time, provides medication support services.
- Administrative Manager & QA, Part-time, provides oversight of program admin support across the Senior Division.
- Administrative Assistant, part-time, provides billing and admin support across the Senior Division.

8. Objectives and Measurements:

A. Standard Objectives

All objectives, and descriptions of how objectives will be measured, are contained in the CBHS document entitled CBHS Performance Objectives FY 15-16.

B. Continuous Quality Improvement (CQI):

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:
Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:
FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due

dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr. McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit process which is conducted as follows:
Monthly:
* There is a Quality Assurance meeting with all program directors across the agency to review "Chart Health" metrics and productivity in each program. This meeting is also a forum to discuss policy changes and issues as they relate to the interface of CIRCE and AVATAR.
* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual TxPOC and PURQC. This audit includes a review of all chart components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.
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C. Cultural competency of staff and services
All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services
FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc., as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. Required Language:

N/A

1. **Identifiers:**
Program Name: **Older Adult Full Service Partnership at Turk**
Program Address: 280 Turk Street
City, State, ZIP: San Francisco, CA 94102
Telephone: 415-474-7310 FAX: 415-474-9934
Website Address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Person Completing this Narrative: Cathy Spensley, Senior Division Director
Telephone: 415-474-7310, ext. 435
Email Address: cspensley@felton.org

Program Code(s): 38JWFSP

2. **Nature of Document:**
☐ New **Renewal** ☒ Modification

3. **Goal Statement:**
This program is part of FSASF's full and seamless range of behavioral health services to older adults directly addressing the highest levels of need citywide by providing a Full Service Partnership (FSP) program, Intensive Case Management, Geriatric Outpatient Services, Older Adult Day Support Center/Community Integration, and a Senior Peer-Based Wellness and Recovery Center. This continuum of care enhances the capacity of older adult consumers, with an overall goal to assist clients to move out of specialty mental health services and into mainstream peer services and supports in the community. The Older Adult FSP Program serves those highest in need and continues to operate as a model program in meeting recovery goals and demonstrating its strongest commitment to the vision of the Mental Health Service Act and its systems transformation.

4. **Target Population:**
The target population for the Older Adult FSP program is clients citywide, aged 60 and older, who need specialized, intensive geriatric mental health services beyond what is available through other systems. Referrals comes through CBHS and meet the SMI diagnosis and other criteria, which may include being currently homeless, dually diagnosed, involvement by multiple public agencies, or never known and new to the CBHS Services, among other criteria. With severe functional impairments and very complex needs, these clients require extensive outreach and intensive services in order to stabilize, live safely in housing, and pursue essential recovery goals.

5. **Modality(s)/Intervention(s)**
Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Plan Development: "Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biological which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

INDIRECT SERVICES: In addition to the above direct services, the program conducts staff training and community outreach (promotion) activities as indirect services.

6. Methodology:

A. Outreach, recruitment, promotion, and advertisement.

Referrals for the Older Adult FSP Program come from CBHS, but outreach about the program is conducted with all collaborative partners, including primary care clinics, substance abuse treatment providers, residential care providers, residential behavioral health providers, hospitals, homeless shelters and adult correctional system, emergency crisis services, and other partners. Outreach to older adults referred to the program can occur at any location citywide, including the street, homeless shelters, meal sites, to name just a few. Peer Case Aides, called

Community Specialists, are an essential part of outreach, engagement, and retention because of their direct experience as clients of the treatment system. Other outreach efforts may be made by a FSASF Psychiatric Nurse Practitioner (PNP). Consumers otherwise distrustful of treatment services are often willing to receive health care, if it is offered in a non-institutional setting, so the PNP is an important element of the engagement strategy. The PNP provides health screening and first aid, dispenses minor medications (such as over-the-counter painkillers and analgesics, and topical skin medications), and unless already linked, will arrange for medical treatment through primary care partners. All outreach materials for FSA's Senior Division, including the agency website, include descriptions of these programs.

B. Admission, enrollment and/or intake criteria and process.

Intake occurs in the 280 Turk Street offices, or anywhere in the community that best meets a client's needs. At screening, it is determined if clients have a safe place to live, enough to eat, and medical care for acute conditions, before proceeding to assessment. Those who cannot be placed in housing immediately receive temporary housing while the assessment and housing placement process continues. Clients may also get assistance with food, clothing needs, and primary care examinations, and pressing health needs are treated through FSASF's primary care partners. Once the client is engaged in services, the clinical case manager will conduct a clinical assessment (ANSA), which will form a foundation of knowledge about the client's psychosocial history. Those that are flagged by the CAGE screen for substance abuse issues will also be referred on for additional substance abuse assessment and treatment focus. After the assessment, the clinical case manager will meet with the client to discuss treatment goals. The finalized treatment plan will be a collaborative effort between the client, the primary case manager, and the rest of the multidisciplinary team, including the Community Specialists and the Psychiatric Nurse Practitioner. This plan will follow a strengths based, client centered approach, in which the client is the primary driver of the treatment goals. In addition to the ANSA, The Mini Mental Status Exam or Blessed Roth Dementia Scale, administered annually as a test for cognitive impairment.

C. Service delivery model and how each service is delivered

Overview of the Service Model:

The Older Adult Full Service Partnership (FSP) offers FSASF's Senior Division's highest level of care within the continuum of care, which also includes Intensive Case Management, Geriatric Outpatients Services, an Older Adult Day Support Center/Community Integration Services, and a Senior Peer-Based Wellness and Recovery Center. The FSP program's key components include Peer Outreach and Engagement, Targeted Case Management, Mental Health Services, Medication Support Services, Crisis Intervention, Vocational Training, and Wellness and Recovery, with the overall goal to pursuing recovery goals and facilitating graduation from the program to successful transition to a lower level of service and supports.

Caseloads are approximately 13-1, with multiple interactions among the participant and treatment team every week. Services are provided by a multidisciplinary team: a psychiatrist, psychiatric nurse practitioner, mental health clinician/care managers, substance abuse counselor, and community specialists (peer case aides), and the team maintains fidelity to the assertive community treatment model. Engagement—and particularly re-engagement after a treatment relapse—is best accomplished through gentle persistence, personal connections with staff, maintained even through a period of non-compliance, by being willing to help clients at whatever their level of readiness. Core program activities may need to be delivered in non-office settings, wherever clients may be found.

In addition to the above direct services, the program conducts staff training and community outreach (promotion) activities as indirect services. The FSP program can also utilize **Mode 60** functions, either services provided to clients that do not meet Medi-Cal standards for reimbursement, such as, transportation, shopping, or socialization activities; in addition to in-kind services that are purchased for clients out of this program's flex fund budget. Flex spending may be used for basic needs and other items to assist participants to stabilize and remain engaged in the program.

The program partners with a number of housing, substance abuse, and primary care partners. With these collaborating partners, services are dual diagnosis-competent at all levels and provide a full range of evidence-based, culturally and linguistically competent, recovery-oriented services throughout the spectrum of behavioral and physical health needs. The aim is to enhance the capacity of older adult consumers, so that as many as appropriate are able to move out of specialty mental health services and into mainstream, peer services, and supports in the community, including aging services. The program has actively recruited staff to fulfill the cultural and linguistic needs of the population, and the program can currently serve monolingual Cantonese, Mandarin, Korean, Russian, and Spanish clients. Other languages may also be provided through other FSA programs.

Levels of care include:

1. ***Screening and Assessment:*** Our treatment team conducts appropriate risk assessments and other brief screenings; provides intake interviews in the clinics or in the community; and develops an initial care plan to include additional psychiatric and medication assessments.

2. ***Care Planning, Care Management, and Services Linkage:*** After Intake, an assigned clinical case manager begins work with the client, along with an assigned community specialist (peer case aide) and the nurse practitioner. At the core is strength-based, recovery-oriented care management. FSASF has developed a rigorous approach to care management built on motivational interviewing and wrap-around principles. Each FSASF team member (including community staff and medical staff) receives intensive training on assessment, care planning, and culturally competent service delivery, motivational interviewing, and working in a multidisciplinary team, as well as intensive training on outreach, engagement, and re-engagement. In addition, staff members who work in the senior programs receive ongoing specialized training in geriatric mental health. The client and the treatment together develop a strength-based plan of care with measurable outcome objectives. Case management includes benefits enrollment, brokerage services, and mental health services include individual and group evidence-based, treatment therapy and medication support. Daily living support services are offered as part of the care coordination process and may include problem solving, skills training, and assistance -- often by the community specialists -- to help clients carry out personal hygiene and grooming tasks; perform household activities; housing supports including working with SRO Operators; improving money-management skills; using available transportation; and finding and using healthcare services. Every client is linked to primary care through clinic partners.

3. ***Outpatient Case Management and Treatment:*** Outpatient treatment in at 280 Turk or in the community and consists of integrated care management, medication management, and evidence-based mental health and substance abuse treatment.

4. ***Outcome-guided medication regimens:*** All clients needing medication management have access to an FSA psychiatrist or a nurse practitioner, who assesses, prescribes, monitors, treats, documents symptoms or side effects, and educates. All case managers assess and document client symptoms and behavior in response to medication. Medication policies and procedures identify all processes and safety procedures around medications.

5. ***Evidence based, integrated behavioral health treatment:*** Case managers and clients can access an extensive, organized system of treatments and supports to promote and sustain recovery. FSASF, through its Felton Institute, provides national-caliber faculty to train, supervise, and certify staff in a range of evidence-based treatments that span the spectrum of diagnoses of clients. In most cases, FSASF has staff with diverse linguistic competencies trained in each of these approaches. These include: **Substance Abuse:** FSASF clinicians are trained in Motivational Interviewing and offer adjunct substance abuse group therapy. In addition, FSASF partners with Curry Senior Center and Golden Gate for Seniors to provide more extensive substance abuse outpatient and residential treatment. In collaboration, these partners continue to develop more accessible and effective treatment strategies for clients with substance abuse issues.

6. **Other Evidence-Based Practices:** FSASF has trained staff in numerous evidence-based practices including PST for depression, PST for psychosis, CBT for Depression, CBT for Psychosis, Trauma-focused CBT, DBT, and Life Review.

7. ***Older Adult Day Support Center/Community Integration Services and Wellness Promotion:*** Participants in the FSP Program are offered opportunities in community integration and wellness promotion as an integral part of the recovery process. The Older Adult Day Support Service currently operates one day a week at the 280 Turk Street location, and this co-location has allowed many of the FSP participants to engage in group therapy, as well as other socialization activities. Research has shown that group therapy offers additional benefits to older adults, such as mutual aid and a sense of belonging.
   The Community Integration Services helps participants access other formal and informal supports and socialization opportunities in the city, such as senior centers. Wellness promotion includes education and assistance for more healthy living, including smoking cessation assistance and exercise, and meaningful joint activities in the community. To assist older adult clients overcome social isolation, improve social and personal skills, and become better integrated in their communities, a variety of opportunities are shared with participants, including connections to natural supports and peer opportunities.

8. **Vocational Training:** A number of FSP participants have benefitted from FSASF Works, which provides vocational training for those who have identified this as part of their recovery process. The participants develop the specifics of the training with their treatment team and receive a small stipend while in training. Often this is an important part of their recovery, and provides the structure that allows the participant to graduate and pursue workforce or other training opportunities in the community.

FSASF's Senior Programs participate in the CBHS Advanced Access initiative, including timely ddata measurement at the site and reporting of data to CBHS as required. They provide and document the initial risk assessment using the CBHS IRA form within 24-48 hours of request for service, and adhere to CBHS guidelines regarding assessment and treatment of uninsured clients. All services are ADA compliant. Clinic services are provided in the client's home, other

senior sites (health clinics, Adult Day Health, senior centers, etc.), and at FSASF offices.

D. Discharge Planning and exit criteria and process.

Guidelines for discharge include CBHS definitions of medical necessity, stabilization of debilitating psychiatric symptoms, resolving of problems on plan of care and successfully linking client to alternative services for care (i.e. PCP, Adult Day Health, etc.). Clients are stepped-down to less intensive services upon meeting CBHS exit criteria. Clients are continuously assessed in their recovery process, and when appropriate, graduated (stepped down) along a continuum of care that best meets their needs, through FSASF's Community Integration Services, when appropriate. Also, when appropriate, clients are discharged to other programs in the community that can best meet their current needs in recovery and allow for less dependence on mental health services. Graduation is an important part of the FSP Program and recovery process, and the entire treatment team celebrates with the graduate along with invited peers by the participant.

E. Program's staffing.

- Senior Division Director, provides administrative oversight and leadership of program operations and development.
- Director of Clinical Supervision and Internship Program, provides oversight of clinical supervision and interns, including direct supervision for clinician licensing hours.
- Program Manager, provides operational oversight, as well as clinical case management and therapy.
- Korean-speaking Lead Clinical Case Manager, provides clinical case management and therapy.
- Mandarin-speaking Clinical Case Manager, provides clinical case management and therapy.
- Russian-speaking Clinical Case Manager, provides clinical case management and therapy.
- Lead Community Specialist, provides peer support and outreach.
- Spanish Speaking Community, provides peer support and outreach.
- Community Specialist – Provides peer support and outreach.
- NP – Part-time, provides medication support.
- Administrative Assistant, Part-time, provides admin support.

F. Mental Health Service Act Program Modalities
Indirect Services.

Indirect services for this program include outreach and ongoing staff training. Outreach is conducted according to methods described in this document Section 6A. Outreach activities are not billable in the way that other client-level services are, but they are an important element in program design as they help to ensure that needed services reach the highest-risk, most vulnerable, un-served, and underserved populations. FSASF also conducts regular staff training in evidence-based practices, strengths-based approaches, cultural competency, and other skill sets that help ensure that services are delivered according to the state of the art. For the most part, staff development and training are provided by the Felton Institute. This work is also not billable, but is essential to maintaining high quality service and promoting positive client outcomes. Hours required for both outreach and training are a written into job descriptions and part of a full-time employee's expected 1055 hours of work per year.

The FSP program can also utilize **Mode 60** functions. Examples of Mode 60 services purchased and delivered for clients include: dental and vision assistance, which are contracted from local providers; housing assistance (e.g., first/last/deposit), which is paid directly to landlords; and occasional clothing and food assistance, paid directly to vendors. In all cases indirect services are paid from MHSA flex funds directly to service providers, and service delivery is followed up on by care coordinators.

7. Objectives and Measurements:

A. Standard Objectives

All objectives, and descriptions of how objectives will be measured, are contained in the CBHS document entitled CBHS *Performance Objectives FY 15-16*..

8. Continuous Quality Improvement:

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:

Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:

FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr. McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit process which is conducted as follows:
Monthly:
* There is a Quality Assurance meeting with all program directors across the agency to review "Chart Health" metrics and productivity in each program. This meeting is also a forum to discuss policy changes and issues as they relate to the interface of CIRCE and AVATAR.
* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual TxPOC and PURQC. This audit includes a review of all chart components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.
* All program directors meet to audit a mental health program utilizing the attached internal audit sheets. One or two charts are audited thoroughly by the group in order to generate questions about changes in policy or other nuances about our evolving QA process.

Quarterly:
All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing:
All staff working for CBHS Contracts are required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services

All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services

FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.

FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc, as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. Required Language:

N/A

1. Identifiers:

Program Name: Senior Drop-In Center at Curry Senior Center
Program Address: 333 Turk Street
City, State, ZIP: San Francisco, CA 94102
Telephone: 415-292-1081
Website Address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Person Completing this Narrative: Cathy Spensley, Senior Division Director
Telephone: 415-474-7310, ext. 435
Email Address: cspensley@felton.org

Program Code(s): 3822SD

2. Nature of Document

☐ New **Renewal** ☒ Modification

3. Goal Statement

FSA's Senior Drop-In Center is a Senior Peer-Based Wellness and Recovery Center that links older adults with treatment, medical care, support services, and resources in the community, while providing a supportive, low-threshold, non-judgmental environment in which elders proceed at their own pace. The aim is to connect elders to the support they need. This program is part of FSA's full and seamless range of behavioral health services to older adults directly addressing the highest levels of need citywide by providing a Full Service Partnership, Intensive Case Management, Geriatric Outpatient Services, Older Adult Day Support Center/Community Integration, and the Senior Peer-Based Wellness and Recovery Center. This continuum of care enhances the capacity of older adult consumers, with an overall goal to assist clients to move out of specialty mental health services and into mainstream peer services and supports in the community.

4. Target Population:

The target population is older adults 60 and older who currently have mental health and/or substance abuse issues, who may be homeless or episodically homeless, and who may or may not have been connected to the behavioral health services before. Some may have cognitive impairments, severe disabilities, chronic health conditions, substance abuse issues, or may be living with HIV/AIDS. The Tenderloin and surrounding neighborhood in San Francisco have large numbers of isolated older adults, with severe mental illness and co-occurring disorders. The center serves an average of 40 clients per day in FY 2014/15. About 30% are white, 34% African American, 15% Asian/Pacific Islander; 9% Latino/a, and 12% Other, with 15% estimated to be LGBTQ. About 20% are women. The center is located in the 94102 zip code. Outreach and service delivery is conducted citywide, but participants tend to come from the immediate area, including South of Market and the Western Addition neighborhoods.

5. Modality(s)/Intervention(s)

The Drop-In Center offers a gathering place, peer-based support, resources to help guests access services and advocacy. The following MHSA modalities best describe the work of the program.

Outreach and Engagement: The program establishes and maintains relationships with individuals and introduces them to available services; or facilitate referrals and linkages to health and social services. Last year a new weekly coaching component to outreach and engagement was introduced, that focused on following up on specific tasks as identified by guests and staff together. A specific focus was also around meeting housing needs. Staff also reviews monthly housing lists with guests and has regular coaching sessions around housing and housing issues, including assistance with submitting applications. By the end of the current fiscal year.

- FSA will conduct 12 outreach presentations at SRO hotels and Project Homeless Connect to reach 50 staff and 25 older adults, as documented by outreach signed-in sheets stored in the Outreach Binder.

Wellness Promotion: Increase problem-solving capacities; or develop or strengthen networks that community members trust. This includes activities for individuals or groups intended to enhance protective factors, reduce risk factors and/or support individuals in their recovery.

- By the end of the current fiscal year, this promotion will reach 150 unduplicated individuals. This will be implemented before center activities with the highest level of attendance. On the 'Social Connected' scale, as evidenced by question 1 and 2 on the guest feedback form. 30% of the consumers will report an increase in 'social connectedness.

Service Linkage: Staff goes to SROs, Project Homeless Connect, and mental health and social services agencies, providing information about our services, and learning about those. This information will be disseminated to guests before bingo and other activities.

- By the end of FY, 30 guests will be connected to behavioral health services, and 50 guests included in the care management binder will have a care plan.

6. Methodology

A. Outreach, recruitment, engagement, and retention.

Outreach and Community Speakers: Staff contact community agencies and arrange outreach visits a minimum of twice a month, and community agencies are encouraged to speak at the Center from two to four times a month. Staff makes appointments with community based agencies to conduct outreach up to three times per month. These efforts can lead to new guests attending the center, getting new ideas for groups, and lead to agencies sending out guest speakers to the Drop-In Center.

Recruitment: The Senior Peer Recovery Center operates in conjunction with the Curry Senior Center. The first point of recruitment is the meal program and its attraction of regular attendees. Through regular contact with both staff and peer counselors, the program builds rapport and engages the participants in Recovery Center programming. FSA also recruits via flyers, brochures, and through direct connection with the many agencies serving elderly clients, and information passed through external peer networks. Because guests have a need for housing the program offers applications for housing lists that TNDC, CHP and other housing

non-profits offer on a regular basis. By addressing their needs, the program ensures that guests are more likely to return and engage. The Drop In Center also uses peer staff who hear about issues that guest have on an informal basis. The Center works with Project Open Hand and Project Homeless Connect and conducts repeated engagement to identify potential participants. The Center has established a non-threatening, ultra-low threshold of service free of intrusive sign-in practices. Staff use logs (such as peer assistance or referral logs) to track participation.

Engagement: Peer staff and their supervisor at the meal site introduce themselves and engage with the clients to establish a trusting relationship, recognizing that trust and rapport take time and require skills and sensitivity. As recommended by the focus groups, a friendly system has been developed by peer staff and volunteers that allow people to be introduced warmly when they "drop in," and a great amount of effort is made to make everyone feel welcome and comfortable. There are group activities in the meal room between breakfast and lunch that allows participants to feel that they are part of a community. Repeated attempts are made to engage clients, without imposing value judgments on those individuals who choose not to participate.

Retention: Retention is the goal only if the participant continues to gain benefit from the community, but efforts toward community integration are pursued for all participants, so that they can meet their needs and find greater fulfillment within the neighborhood community or beyond.

B. Admission, enrollment and/or intake criteria and process.

Admission: Based on low threshold engagement to bring the targeted population into a comfortable area of engagement, so that services can be offered and more easily accepted.
Assessment: Staff provides a Welcome Packet. The packet includes the monthly activities calendar, the center rules, and a Curry Center brochure. Staff and volunteers use this time to engage, listen, and assess through an informal welcoming interview process. Staff are encouraged to "meet the client where they are" when assessing for service needs. Even if a new guest declines services, the individual knows when they have questions or are ready for services that staff are happy to meet and help them get services they need. Service delivery model and how each service is delivered.

C. Service delivery model and how each service is delivered.

Since 2007, FSA has been providing a drop-in senior peer-based wellness and recovery center at the Curry Senior Center at 333 Turk Street, in the Tenderloin section of the city, in conjunction with the congregate meal program provided by Project Open Hand for breakfast and lunch. The Senior Drop-In offers programming Wednesday through Friday, from 9am-3pm, and Saturday and Sunday, from 9am-1pm. Essential to this program are the weekend hours, when little is available for troubled and isolated seniors in the Central City. The program provides group and one-to-one activities, peer support mentoring and assistance, socialization, and skill development, as well as a safe place to be with friends. The program works to link seniors with treatment, medical care, support services, and other resources in the community, while providing a supportive, low-threshold, non-judgmental environment in which elders can proceed at their own pace. A range of volunteer, stipend, and regular employment opportunities are provided for consumers. Consumers offer ideas that are then integrated into operation by program staff. Volunteers help to set up and run the groups with constant staff over-site with most of the activities being planned and carried out by consumers themselves, including self-help support groups. The program conducts extensive outreach to recruit participants, as well as peer counselors and other volunteers. Peer support provides assistance with activities of daily living as well as other necessary and beneficial supports.

An average of **Twenty participants** attend the center daily, participating in various capacities. Core services include the above descriptions of outreach and assessment, and:

Case Management: Staff will refer to appropriate services upon request. Peers can escort to appointments, when appropriate, either on foot or on MUNI.

Treatment: Staff utilizes a Harm Reduction approach coupled with Motivational Interviewing techniques to engage the individual where they are in their decision to seek out treatment services. If needed, staff or volunteers meet individually with a client on a regular basis to build report and support the client in their decision to seek out appropriate treatment services. Wellness and Recovery is always promoted during the process.

Individual Advocacy: Through the process of building group and individual supportive relationships with guests, staff and peers promote and encourage individual advocacy to guests. This is done through monthly Community meetings, as well as through encouraging guests to approach staff and/or volunteers with questions, concerns and needs they may have. By encouraging and supporting individual and group advocacy, the Peer-Based Wellness Center is helping to reduce the individual's feeling of stigma through Strength-Based empowerment.
Policy and Systemic Advocacy: Reduction of stigma and the promotion of ideas incorporated in wellness and recovery. This contributes to a systems change in service delivery, particularly in reaching underserved and unidentified older persons in need.

A Welcoming Hub to Services
All older adults in the city, aged 60 and older are welcomed into the Wellness and Recovery Center. Following the "Every Door is the Right Door" approach, one of the goals of this project is to encourage older adults to seek treatment for mental health or substance abuse issues, as well as be provided medical services at a primary care home. All new participants are given an orientation to the center on an individual basis, including information about activities, Curry Center rules and guidelines, and a tour of the center and the Project Open Hands meal site. If the consumer expresses a desire for case management or mental health services, they are referred to appropriate services at Family Service Agency, Curry Senior Center, or other partnering agencies. All participants who do not already have a primary care home are connected to Curry Senior Center's medical clinic or to another appropriate primary care clinic. Participants requesting assistance with substance abuse are connected to Curry Senior Center's substance abuse program or other partnering treatment providers. Those needing housing services are connected to Curry Senior Center's Housing Services, or other housing services provided by partnering agencies. All participants are offered these connections to services in a non-threatening, low-key approach; In addition, the door remains open to revisit the discussion towards connecting to services at any time. All participants are asked to sign a log sheet for attendance for safety reasons, as well as program tracking purposes, and these records are used to track unduplicated attendance each quarter

The Recovery Model
Although some view recovery from a more traditional medical definition of the absence of illness, the psych-rehabilitative recovery model definition is understood as an ongoing, individualized process for persons with mental illness to be able to live their lives as fully as possible, even while enduring the symptoms and issues involved with their illness. The Wellness and Recovery Center fully embraces this second model and seeks to assist participants in locating jobs, meaningful activities and hope in their lives.

Peer Volunteers
The Peer Volunteer Program is an essential component of the center. Volunteers support the needs of the all participants of the center. The program helps the volunteers reach goals in building self-confidence, esteem, and other aspects of the Recovery Model. Monthly meetings are held with the Peer Volunteer Staff for planning and information sharing. Basic training in Motivational Interviewing is offered to give peers greater skills for assisting center participants. Peer Volunteers also help plan group activities. The Peer Volunteers solicit feedback from guests around activities they would like to see implemented at the Center and report back to staff.

Group Activities
Group activities are available for outreach, socialization, education, community integration, health and wellness at the Older Adult Day Support Center, connected to the FSP Program, across the street at 280 Turk, as well as the group activities at the Curry Senior Center. Hospitality House is another referral source. Accessible, low-key therapeutic groups begin to address mental health, co-occurring disorders and substance abuse from a Harm Reduction perspective.

Activities that assist with Outreach
Peer volunteers and center participants, through focus groups, decide what activities they would like to attend at the center. So far, these have included Music Appreciation, Current Events, Cooking with a Microwave, and Educational Documentaries with Post-Film Discussion.

Socialization
Participants enjoy interactive games, allowing opportunities to develop interpersonal skills, make friends, and have fun. Many of the participants do not live in housing that promotes a sense of well-being and relaxation. Following the Recovery Model, hope and joy are a goal that the center strives to promote by providing a safe, friendly, and warm environment. The games and opportunities for socialization help increase motivation for on-going attendance. Games have included various organized board games, memory games, historical quizzes, "Do You Remember" discussions, arts and crafts, etc.

Education
The center's lead peer case aide has been very active in soliciting other programs and resources in the neighborhood to come to the center and present opportunities. These guest speakers provide information about resources, health issues, and community opportunities, including:
- Curry Nursing Staff: Education about important health issues
- Tom Waddell: Education about healthy eating
- RAMS: About job opportunities in their HireAbility Program
- Hospitality House, where participants are linked to creative expression through the arts
- Office on Aging, Case Manager: To provide information about housing opportunities
- The Living Room, for socialization opportunities

Substance Abuse Treatment
The center strives to provide greater access to service needs by the participants. It is the Wellness and Recovery Center's goal to create an environment that emphasizes awareness of substance abuse issues and encourages entry into treatment, but does not stigmatize or drive away those participants who are not ready to address their substance abuse problems. Education is offered about co-occurring issues (including smoking), from guest speakers and videos, which follow with open discussions and encourage individuals to accept referrals for treatment. Participants are informed and encouraged to attend AA and NA groups when they

are ready to attend treatment, as well as Curry Senior Center's range of substance abuse treatment programs on-site. The Center requires sobriety among participants and asks obviously intoxicated or participants under the influence of substances to leave the premises immediately. Participants are allowed to return to the Center, however, at which time attempts are made to provide clients with targeted outreach and follow-up with additional linkages to other services.

Community Integration
Community Integration of the mentally ill is viewed as a benchmark for success of community mental health. The Wellness and Recovery Center fosters community integration with opportunities to engage in activities outside the center. Outside activities have included:
- Joint parties with Family Service Agency's Day Support Center
- Participating in an elder abuse awareness rally at City Hall or another advocacy effort on behalf of older adults
- Joining an art class at Hospitality House - Free museum outings, cultural activities in the community like the African American Cultural Center, and community plays like Night Out At the Black Hawk

Providing additional meaningful opportunities for community integration will continue to be an important goal for the Center.

Health and Wellness
Many studies have shown that exercise is important for improving mental health as well as higher medical outcomes and longevity of life. The Center strives to connect all clients to primary care services, but to also provide opportunities for more healthy living, including a daily exercise program, walking, healthy eating, and relaxation methods. There are also trips to the Farmers' Market at Civic Center, where consumers are encouraged to explore where they can get fresh green vegetables in the community.

Ongoing Training for FSA Staff, including Peer Case Aides
All Center staff and peer case aides will take part in FSA's extensive training offered through the FSA's Felton Institute. FSA has placed a high priority on training staff in evidence-based practices to meet the needs of their clients. In collaboration with experts at UCSF, UC Berkeley, UC San Diego, clinicians working with older adults have been trained in Strengths-Based Care Management, Problem-Solving Therapy, Motivational Interviewing, and Cognitive Behavioral Therapy. Through the Felton Institute, FSA has been offering geriatric training for its clinicians and other older adult mental health providers. Topics include issues around delirium, depression and dementia; medical conditions and complications; substance abuse; elder abuse, cognitive impairment, and cultural diversity.

In addition, FSA has been a leader in providing services to clients with hoarding and cluttering issues through its work on the Hoarding and Cluttering Task Force, as well as support group. The Center's staff will continue to attend hoarding and cluttering conferences and training.

D. Discharge Planning and exit criteria and process
The goal of this program is to connect participants to whatever services can meet their needs, and, rather than devising an exit process, the program continues to welcome participants on an ongoing basis.

E. Program staffing

- Senior Division Director, provides administrative oversight and leadership of program operations and development.

- Program Director, Part-time, provides operational oversight.
- Lead Community Specialist, Part-time, provides peer leadership, including programming and outreach.
- Community Specialist, Part-time, provides peer support.
- Community Specialist, Part-time, provides peer support.
- Community Specialist, on-call, provides peer support.
- Community Specialist, on-call, provides peer support.

F. MHSA Programs – Additional requirements.

1. Consumer participation and engagement

   FSA's Drop-In Center @ The Curry gets feedback and evaluation of our programs by doing at least two(2) consumer surveys' during the fiscal year. The survey is used to ask questions about what they like and dislike about the Drop-In Center programs. We also have a suggestion box in the room that they can use to give us feedback without talking to us. We discuss these findings with the guests by having a discussion with them before BINGO, printing all of their suggestions and results and putting it up on the community billboard in the room. We write down their feedback from the discussion group to get clarity about what responses we got from them.

2. MHSA Principles:

   Principle: Consumers are supported to determine and achieve their own goals and lead fulfilling and productive lives.

   - *FSA's Drop-In Center staff and volunteers present ideas and programs to our guest through presentations from other programs and providers. If they are interested in the presentations and want to hear more, we make a list of guests who want to hear more information in order to make it their personal goal to either access their services or take part in their programs. We help them walk each step they need to do and document every successful step they take in order to accomplish their identified goal.*

   Principle: Collaboration with different systems to increase opportunities for jobs, education, housing, etc.

   - *FSA's Staff and volunteers identify and recruit different programs that offer job's, educational opportunities and housing to present at our morning meetings before our program's activities. We maintain an ongoing relationship with these presenting programs to get materials like a monthly housing list that compiles any new listing for senior and/or disabled housing or educational opportunities, like an ongoing group on computer literacy for seniors or art classes and other workshops offered in the community. These collaborations have been happening on an ongoing basis and we sometimes make visits to their programs and have a personal contact within their staff in case we have any questions from guest that need to be answered.*

7. Objectives and Measurements

A. Standardized Objectives

N/A

B. Individualized Objectives

Objective Goal 1, Outreach and Engagement: *N/A. It was decided in the Quality Assurance group that an outcome was not need for this goal.*

Objective Goal 2, Wellness Promotion: *By the end of the Current FY. 30% of BINGO participants will report that they have maintained or increased feelings of social connectedness as evidenced by social connectedness items on the guest feedback form, and analyzed and summarized in the activities binder and MHSA Year End Report.*

Objectives for Goal 3, Service Linkage: *By the end of the current FY. 20 guests receiving case management services will have accomplished at least one care plan goal.*

8. Continuous Quality Improvement (CQI):

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:

Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR,

CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:
FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit process which is conducted as follows:
Monthly:
* There is a Quality Assurance meeting with all program directors across the agency to review "Chart Health" metrics and productivity in each program. This meeting is also a forum to discuss policy changes and issues as they relate to the interface of CIRCE and AVATAR.
* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual TxPOC and PURQC. This audit includes a review of all chart components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.

* All program directors meet to audit a mental health program utilizing the attached internal audit sheets. One or two charts are audited thoroughly by the group in order to generate questions about changes in policy or other nuances about our evolving QA process.

Quarterly:
All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing:
All staff working for CBHS Contracts are required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services
All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services
FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc, as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. Required Language:
N/A

1. **Identifiers:**
   Program Name: Adult Care Management and Adult Full Service Partnership (FSP)
   Program Address: 1500 Franklin Street
   City, State, Zip Code: SAN FRANCISCO, CA 94109
   Telephone: (415)-474-7310 **FAX:** (415)-922-9418
   Website Address: www.felton.org

   Contractor Address: 1500 Franklin Street
   City, State, ZIP: San Francisco, CA 94109
   Person Completing this Narrative: Charles Brigham, LCSW, Adult Division Director
   Telephone: (415) 474-7310 ext. 480
   Email Address: cbrigham@felton.org

   Program Codes: 3822A3 and 3822OP

2. **Nature of Document**
   ☐ New **Renewal** ☒ Modification

3. **Goal Statement**
   The primary goal of FSASF Adult FSP-CARE is to assist and encourage vulnerable adults, 18-60, with serious and persistent mental illness and other physical and substance abuse challenges, to reduce significantly their dependence on inpatient and emergency services, to stabilize in their lives, housing and overall functioning, and to become more independent, productive, and satisfied members of their communities.

4. **Target Population**
   The target population is adults ages 18 to 60 with severe mental illness and/or substance abuse problems. Some will have HIV/AIDS; some may be homeless. We work with family members, significant others, and support persons in the clients' lives. FSASF Adult Full Service Partnership FSP-CARE provides an integrated recovery and treatment approach to vvulnerable adult San Franciscans living with serious mental illness or dual/multiple diagnoses.

5. **Modality(ies)/Interventions**
   Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

   Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive Service activities may include are not limited to assessment, plan development, therapy, rehabilitation and collateral.
   - Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or

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

- Plan Development: "Plan Development" means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, distributing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

Indirect Services:
In addition to the above direct services, the program conducts staff training and community outreach (promotion) activities as indirect services.
The FSP program can also utilize **Mode 60** functions, either services provided to clients that do not meet Medi-Cal standards for reimbursement, such as, transportation, shopping, or socialization activities; in addition to in-kind services that are purchased for clients out of this program's flex fund budget.

6. Methodology

A. Outreach, recruitment, promotion, and advertisement.

Members of the program team may conduct street outreach to homeless encampments, parks, homeless shelters and food programs, and other service locations. Primary responsibility for outreach resides with the team's consumer-professional Outreach Workers and Clinical Case Managers. The Outreach Workers have personal experience with mental health or substance abuse issues, and may be currently in recovery. They work in conjunction with the Clinical Case Managers to engage the client and begin to build a therapeutic relationship. Engagement with clients includes careful, systematic attempts to engage the most difficult and wary clients, involving multiple contacts and a willingness to serve clients on whatever level they are willing to receive assistance. In addition to street outreach, referrals are accepted from multiple

sources, including SF General, Project Homeless Connect, other homeless programs, other mental health and substance abuse agencies, PES, Sheriff, SFPD, hospital emergency rooms, and self and family referrals. The availability of FSASF's FSP-CARE/ACM services is publicized to these referral sources and to the public through the FSA website, the FSA newsletter, and literature on the program. All referrals are authorized by CBHS.

B. Admission, enrollment and/or intake criteria.

Once the client is engaged in services, the clinical case manager will conduct a clinical assessment (ANSA) which will form a foundation of knowledge about the client's psychosocial history. Those that are flagged by the CAGE screen for substance abuse issues will also be referred on for additional substance abuse assessment and treatment focus. After the assessment, the clinical case manager will meet with the client to discuss treatment goals. The finalized treatment plan will be a collaborative effort between the client, the primary case manager, and the rest of the multidisciplinary team. This plan will follow a strengths based, client centered approach, in which the client is the primary driver of the treatment goals. FSP program criteria require that clients have an SMI diagnosis and are currently underserved or unserved by mental health services.

C. Service delivery model and how each service is delivered.

General Model Description

Family Service Agency of San Francisco's *Adult Full Service Partnership Integrated Full Service Outpatient* (FSP-CARE/ACM) provides an integrated recovery and treatment approach for vulnerable San Franciscans, between the ages of 18 and 60. FSASF will serve 135 unduplicated client slots utilizing an AB34 model of intensive service provision. A staff team will work with clients 24/7 to provide a comprehensive array of recovery-oriented services and supports. Services include securing housing and basic needs, linking to assistance (utilizing a housing first/harm reduction model), strength-based individualized care planning and care management, referrals to physical health care, benefits assistance, vocational rehabilitation, employment services, peer support, and integrated mental health and substance abuse treatment services. Actual levels of client service are determined by each client's needs and desires, with service intensity being extremely high in the beginning and reduced as the client is stabilized. At a minimum, clients receive one weekly contact from the team. Additional services will be purchased through flexible funding or as part of the in-kind services each partner brings to this program. FSASF Adult FSP has mental health treatment, medication management, substance abuse treatment, employment assistance, benefits assistance and advocacy, and peer support integrated into a single service team. Housing will be provided through Tenderloin Neighborhood Development Corporation and through Community Housing Partnership. We will continue to work with property management and on site social workers to ensure our clients are successful in housing. The Adult FSP Team will have a substantial pool of flexible funding to purchase specialized services and supports, including support services for HIV+ individuals, for victims of violence and sexual exploitation, for LGBT clients, and for developmentally or physically disabled clients.

PHASES OF TREATMENT

Engagement and Basic Needs (3 – 6 months): During this phase of treatment, we are building a relationship with clients, assessing their needs and strengths, and creating action plans around making sure basic needs are being met.

Interventions during this phase:

- Linkage to emergency housing
- Linkage to income
- Creating a food plan (e.g., providing Safeway cards or going grocery shopping)
- Linkage to a primary care clinic
- Creating safety plans for stabilizing mental health crises
- Medication evaluation and management
- Engagement strategies such as taking the client to lunch, coffee, etc.
- Purchasing clothing, at modest prices, modeling budgeting skills
- Getting identification (Social Security, Medi-Cal card, birth certificate, ID card)

Treatment and Maintenance (6 months – 3 years): During this phase of treatment, we are exploring clients' goals, and actively setting and achieving those goals. During this time, clients are expected to come into the office for regular appointments with their case managers. **All financial support given from FSA during this phase should be planned for in these weekly meetings.**

Interventions during this phase:

- Continued support with medical / dental / vision needs
- Goal setting around education / employment
- Psycho-education around mental health issues
- Addressing substance abuse issues (referral to substance abuse counselor, motivational interviewing, groups, outpatient, inpatient)
- Linkage to permanent housing
- Planning around economic self-sufficiency
- Recreation / building of social network in the community
- Teaching daily living skills (cleaning room, cooking, laundry, hygiene) with more support, gradually building and encouraging independence in these skills
- Teaching of new coping skills and strategies
- Formal therapy, if appropriate

Step Down and Graduation (last 3 – 6 months in our program): During this phase of treatment, we are reviewing accomplishments and successes, identifying any remaining treatment goals, and preparing clients for a more independent life. **Financial support given from FSA during this phase should be minimal** and paced to none, as clients will be without such a resource when stepped down.

Interventions during this phase:

- Review of the client's progress, and reviewing what they have learned, praise
- Linkage to community supports (e.g., drop in center, AA/NA)
- Planning for financial self sufficiency
- Linkage to step down program (if necessary), or other supports (therapist)
- Processing feelings about the end of services at FSASF
- Celebration and graduation ritual

ADULT FSP PROGRAM INTERVENTION DETAIL

Care Coordination: Each client will be assigned a primary Care Coordinator who coordinates and monitors the activities of the team and has primary responsibility to work with the client in developing his/her own individual treatment plan, to ensure immediate changes are made in treatment plans as client's needs change, and to advocate for client rights and preferences. The Care Coordinator is also the first staff person called on when the client is in crisis and is the primary support person and educator to the client's family. Members of the treatment team share these tasks with the Care Coordinator and are responsible to perform the tasks when the Care Coordinator is not working. As part of the strengths-based assessment and case planning model, we will help the client to develop a Wellness and Recovery Action Plan.

Crisis Assessment and Intervention: Crisis assessment and intervention is provided 24 hours per day, seven days per week. These services include telephone and face-to-face contact. During normal working hours, an available Adult FSP team member responds. After hours and on weekends, an Adult FSP team member is on call and carries the team's crisis phone or pager. This number is available to emergency service providers. During nights and weekends, the on-call staff assesses the situation and provides whatever intervention is clinically indicated.

Mental Health Treatment: Dual-Diagnosis: The Adult FSP Team will be prepared to identify and address a range of substance abuse issues and multiple mental health disorders, ranging from moderate depression to schizophrenia. Our team has trained and/or certified in several different modalities, including Problem Solving Therapy, Dialectical Behavioral Therapy, and Cognitive Behavioral Therapy. Treatment for mental illness will include:

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

-Education of the client regarding his/her illness and the effects and side effects of prescribed medications, where appropriate;

-Symptom-management efforts directed to help each client identify the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen their effects; and -Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals and to cope with the stresses of day-to-day living;

-The team has DBT certified case managers who lead a DBT group weekly.

Substance Abuse Treatment: Adult FSP provides both one-to-one and group substance abuse treatment, integrated with mental health treatment. The Adult FSP team provides substance abuse treatment in stages throughout the service period, depending on the client's level of readiness for treatment. Staff is continuously trained in Treatment planning appropriate to the stage of recovery our partner is in. Clients will also be referred to and encouraged to participate in NA and AA. They will also be referred for residential substance abuse treatment when appropriate through our partnership with Walden House/Haight Ashbury.

Medication Prescription, Administration, Monitoring, and Documentation: Our psychiatric nurse practitioner and/or psychiatrist will assess each client's mental illness and prescribe appropriate medication; regularly review and document the client's symptoms as well as his or her response to prescribed medication treatment; educate the client regarding his/her mental illness on the effects and side effects of medication prescribed to regulate it; and monitor, treat, and document any medication side effects. Our psychiatric nurse distributes medications as often as daily (M-F). All Adult FSP team members assess and document clients' symptoms and behavior in response to medication and monitor for medication side effects. The FSP program also has medication policies and procedures that identify processes to: record

physician orders; order medication; arrange for all clients' medications to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules; and provide security for medications.

Employment Services: Our employment specialist oversees our internal pre-vocational program "FSA Works". The goal behind FSA Works is to build basic employment skills in our clients, such as: arriving to work on time, keeping a schedule, and working with others. Clients are placed in internal or offsite volunteer positions. The FSA Works program is a 6-month program. During this time, clients meet with the employment specialist at least monthly to discuss how their placement is working, and to discuss any barriers to success. The goal for this program is to get clients ready for the next step in the employment process, and many of our clients have graduated out of FSA Works into more formal employment assistance programs in the community, such as Richmond Area Multi-Services Hire-ability program or Community Vocational Enterprises.

Activities of Daily Living: Services to support activities of daily living in community-based settings include individualized assessment, problem solving, side-by-side assistance and support, skill training, ongoing supervision (e.g., prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to: carry out personal hygiene and grooming tasks; perform household activities, including house cleaning, cooking, grocery shopping, and laundry; manage housing-related tasks, including finding a roommate, landlord negotiations, cleaning, furnishing and decorating, procuring necessities (such as telephone, furnishings, linens); develop or improve money-management skills; use available transportation; and find and use healthcare services. Adult FSP also offers a Surviving the Streets Life Skill Building Group. A Wellness Group is also lead by the staff.

Social, Interpersonal Relationship, and Leisure-Time Skill Training: Services to support social, interpersonal relationship, and leisure-time skill training; side-by-side support and coaching; and organizing individual and group social and recreational activities. In addition, there will be monthly community meetings and cookouts for our clients to participate in. Social rehabilitation groups include Meditation, Art, and Exercise Group.

Education, Support and Consultation to Clients' Families and Other Major Supports: With client agreement or consent, services to clients' families and other major supports can include education about the client's illness and the role of the family in the therapeutic process; intervention to resolve conflict; and ongoing, face-to-face, and telephone communication and collaboration between the Adult FSP team, the family, and other major supports.

Wraparound Services: The program provides clients a comprehensive range of services. These services include but are not limited to: supportive and cognitive therapies, case management brokerage (e.g., linkage to services such as housing, benefits and medical care), substance abuse treatment, medication services, vocational and pre-vocational assistance. Any services, supports, or products needed to complete the Care Plan and not readily available through the service constellation will be acquired through flexible funding.

Gender-Related and Sexual Orientation Issues: The Adult FSP has a LGBT Support Group. This is a safe place for members of the LGBT community a safe place for clients to discuss trauma issues and to build supportive relationships with one another, and the group is

facilitated by staff. LGBT identified Case Managers are available for assignment when clients prefer.

Aftercare: After clients have been discharged from services, they will receive 6 months of aftercare services. During this time they can continue to use the FSP team for support as needed. If circumstances change and they need FSP level services again, they could be expedited back into the program. We will work with clients' supports in the community to assist in a smooth transition out of services.

OPERATIONAL DETAILS

Hours of operation: FSASF at 1500 Franklin Street opens at 8:30 AM to 7:00 PM for staff and operates from 9:00 AM to 5:00 PM (or other times as needed for assisting clients for appointments or responding to emergencies) for client care. Two Adult FSP staff (for both CARE and ACM) is open to deal with consumer emergencies 24 hours a day, 7 days per week. Clients can reach an on-call clinician by calling an emergency phone number.
Location: most services are provided at the FSASF building at 1010 Gough Street, San Francisco. FSASF's partnering programs are located throughout the city and clients may be receiving services at their sites in addition.
Average Length of Stay: There is a range of length of stay depending on the individual needs of the client. The FSPs have only been around for about five years and there are some clients that have been with us since the beginning, but the average length of stay in CARE appears to be 2-3 years; clients in ACM have had considerably longer lengths of stay, but more focus is being directed toward increasing stabilization and referring clients when possible to maintain this to a lower level of outpatient care.
Strategies for service delivery: Our theory of change is that with the appropriate treatment and support our clients' quality of life will improve. Additionally, as our clients' lives improve so do the lives of each member of the larger community.

D. Discharge Planning and exit criteria and process.

Treatment consists of three phases: basic needs and engagement phase, a treatment phase, and a transition phase. The transition phase begins when clients have completed and demonstrated capacity for maintaining their treatment goals. This phase fosters and reinforces clients' strengths, highlighting all they have accomplished in treatment, helping them to link with the wider community, and includes referral to lower level of care when appropriate. FSASF's FSP-CARE/ACM follows discharge guidelines as established by DPH. Typical guidelines for discharge include CBHS definitions of medical necessity, stabilization of debilitating psychiatric symptoms, resolving of problems on plan of care, and successfully linking clients to alternative services for care. As stated above, clients can also receive up to 6 months of aftercare services post discharge for support.

E. Program's staffing.

- Case Manager, duties include individual, group therapy, and intensive case management.
- Adult Division Director, administrative oversight of MAP/CARE programs, including clinical oversight of programs, & clinical supervision of staff.
- Case Manager, duties include individual, group therapy, and intensive case management

- Case Manager, MAP/CARE duties include individual, group therapy, and intensive case management.
- Program Manager, CARE/MAP supervisor of case manager's, oversight, administrative of MAP/CARE program, including clinical supervision of these programs.
- Case Manager, provides intensive case management, individual, and group therapy.
- Program Manager, provides leadership oversight of ACM program, including clinical supervision duties.
- Case Manager, CARE/MAP duties include individual, group, and intensive case management.
- Case Manager, CARE/MAP duties include individual, group and intensive case management.
- Case Manager, CARE/MAP duties include intensive case management, individual, and group therapy.
- Case Manager, CARE/MAP duties include intensive case management, individual, and group therapy to clients.
- MSW, Case Manager, ACM provides intensive case management, individual, and group therapy.
- Case Manager, CARE/MAP provides intensive case management, individual, and group therapy.
- Outreach, vocational program coordinator, CARE provides leadership of FSA Works program, and duties include outreaching to potential clients.
- Nurse Practitioner, CARE provides psychiatric assessment, evaluation, and medication monitoring.
- TBD-Register Nurse provides medication management, medical evaluation of clients.
- Consultant Psychiatrist- MD, CARE provides psychiatric evaluation, assessment, and medication management.
- TBD- Case Manager Position to hire

F. Indirect Services.

Indirect services for this program include outreach and ongoing staff training. Outreach is conducted according to methods described in this document Section 6A. Outreach activities are not billable in the way that other client-level services are, but they are an important element in program design as they help to ensure that needed services reach the highest-risk, most vulnerable, un-served, and underserved populations. FSA also conducts regular staff training in evidence-based practices, strengths-based approaches, cultural competency, and other skill sets that help ensure that services are delivered according to the state of the art. Much staff development and training is provided by FSASF's Felton Institute; and staff also regularly take SF DPH/CBHS/SOC sponsored trainings (e.g., HIPAA, Compliance, Cultural Competency). This work is also not billable, but is essential to maintaining high quality service and promoting positive client outcomes. Hours required for both outreach and training are a written into job descriptions and part of a full-time employee's expected 1055 hours of work per year.

The FSP program can also utilize **Mode 60** functions. Examples of Mode 60 services purchased and delivered for clients include: dental and vision assistance, which are contracted from local providers; housing assistance (e.g., first/last/deposit), which is paid directly to

landlords; and occasional clothing and food assistance, paid directly to vendors. In all cases indirect services are paid from MHSA flex funds directly to service providers, and service delivery is followed up on by care coordinators.

7. Objectives and Measurements

A. Standard Objectives

All objectives, and descriptions of how objectives will be measured, are contained in the CBHS document entitled CBHS *Performance Objectives FY 15-16*..

8. **Continuous Quality Improvement (CQI)**

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:
Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to

monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:
FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr. McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit process which is conducted as follows:
Monthly:
* There is a Quality Assurance meeting with all program directors across the agency to review "Chart Health" metrics and productivity in each program. This meeting is also a forum to discuss policy changes and issues as they relate to the interface of CIRCE and AVATAR.
* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual TxPOC and PURQC. This audit includes a review of all chart components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.
* All program directors meet to audit a mental health program utilizing the attached internal audit sheets. One or two charts are audited thoroughly by the group in order to generate questions about changes in policy or other nuances about our evolving QA process.

Quarterly:
All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing:
All staff working for CBHS Contracts is required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services
All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services
FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.
FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment

reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc., as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. **Required Language**
N/A

1. **Program Name: Transitional Age Youth (TAY) Full Service Partnership (FSP)**
   Program Address: 1500 Franklin Street
   City, State, Zip Code: SAN FRANCISCO, CA 94109
   Telephone: (415)-474-7310 **FAX:** (415)-922-9418
   Website Address: www.felton.org

   Contractor Address: 1500 Franklin Street
   City, State, Zip: San Francisco, CA 94109
   Person Completing this Narrative: Charles Brigham, LCSW, Adult Division Director
   Telephone: (415) 474-7310 ext. 480
   Email Address: cbrigham@felton.org

   Program Code: 3822T3

2. **Nature of Document**
   ☐ New **Renewal** ☒ Modification

3. **Goal Statement**
   FSASF's Full Service Partnership for Transitional Age Youth (TAY FSP) assists vulnerable transitional age youth, 16-25, with serious and persistent mental illness, to significantly reduce their dependence on inpatient and emergency services, to stabilize their lives, and to become more independent, productive, and satisfied members of their communities. The program partners with consumers to assist them in meeting their multidimensional life goals, including those concerning education, employment, social skills, relationships, housing, overall functioning, life satisfaction, self-sufficiency and creative pursuits.

4. **Target Population**
   Approximately 46 transitional-age youth, ages 16 to 25, with significant mental illness, substance abuse, homelessness, HIV/AIDS or other serious impediments which result in frequent referrals for inpatient, residential or PES services, receive specialized and targeted assistance to help them stabilize and make transitions to satisfying and constructive adulthood. The program also works with family members, significant others, and support-persons in the clients' lives. Program services are provided citywide.

5. **Modality(ies)/Interventions**
   Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

   Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive Service activities may include are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Plan Development: "Plan Development" means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, distributing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

INDIRECT SERVICES:
In addition to the above direct services, the program conducts staff training and community outreach (promotion) activities as indirect services.
The FSP program can also utilize **Mode 60** functions, either services provided to clients that do not meet Medi-Cal standards for reimbursement, such as, transportation, shopping, or socialization activities; in addition to in-kind services that are purchased for clients out of this program's flex fund budget.

6. Methodology

A. Referrals, Outreach, recruitment, and Promotion.

FSASF receives predominately Referrals from CBHS TAY, including collaboration between CBHS, and FSA that leads to Assessment by FSASF. CBHS and FSASF ascertain if the client requires Outreach for engage the client to utilize services. In addition, members of the program team may conduct street outreach to homeless encampments, parks, homeless shelters and food programs, and other service locations. Primary responsibility for outreach resides with the team's consumer-professional Outreach Workers and Clinical Case Managers. The Outreach Workers have personal experience with mental health or substance abuse issues,

and may be currently in recovery. They work in conjunction with the Clinical Case Managers to engage the client and begin to build a therapeutic relationship. Engagement with clients includes careful, systematic attempts to engage the most difficult and wary clients, involving multiple contacts and a willingness to serve clients on whatever level they are willing to receive assistance. In addition to street outreach, referrals are accepted from multiple sources, including SF General, Project Homeless Connect, other homeless programs, other mental health and substance abuse agencies, PES, Sheriff, SFPD, hospital emergency rooms, and self and family referrals. The availability of FSASF's FSP-CARE/ACM services is publicized to these referral sources and to the public through the FSA website, the FSA newsletter, and literature on the program. All referrals are authorized by CBHS.

B. Admission, enrollment and/or intake criteria and process.

Once the client is engaged in services, the clinical case manager conducts a clinical assessment (ANSA) which forms a foundation of knowledge about the client's psychosocial history. Those that are flagged by the CAGE screen for substance abuse issues are also referred on for additional substance abuse assessment with an FSA substance abuse counselor. After the assessment, the clinical case manager meets with the client to discuss treatment goals. Following the FSP model, the program criteria require that clients have an SMI diagnosis and are currently underserved or unserved by mental health services. If a potential client meets these criteria, he or she is admitted into the program. If the client does not meet these criteria, he or she is referred to other FSA programs that meet his or her needs.

The treatment plan is a collaborative effort between the client, the primary case manager, and the rest of the multidisciplinary team. This plan follows a strengths based, client centered approach, in which the client is the primary driver of the treatment goals.

C. Service delivery model and how each service is delivered.

GENERAL MODEL DESCRIPTION

Family Service Agency of San Francisco's *TAY Full Service Partnership* provides an integrated recovery and treatment approach for vulnerable San Franciscan transitional age youth, between the ages of 16 and 25. FSASF will serve at least 43 unduplicated client slots utilizing an AB34 model of intensive service provision. A staff team will work with clients 24/7 to provide a comprehensive array of recovery-oriented services and supports. Services include securing housing and basic needs, linking to assistance (utilizing a housing first/harm reduction model), strength-based individualized care planning and care management, referrals to physical health care, benefits assistance, vocational rehabilitation, employment services, peer support, and integrated mental health and substance abuse treatment services. Actual levels of client service are determined by each client's needs and desires, with service intensity being extremely high in the beginning and reduced as the client is stabilized. At a minimum, clients receive one weekly contact from the team. Additional services are purchased through flexible funding or as part of the in-kind services each partner brings to this program. FSASF TAY FSP has mental health treatment, medication management, substance abuse treatment, employment assistance, benefits assistance and advocacy, and peer support integrated into a single service team. Housing is provided through Larkin Street Youth Services, Routz Program. Program staff also works with property management and on site social workers to ensure clients are successful in housing. The TAY FSP Team will have a substantial pool of flexible funding to purchase specialized services and supports, including support services for HIV+

individuals, for victims of violence and sexual exploitation, for LGBT clients, and for developmentally or physically disabled clients.

PHASES OF TREATMENT

Engagement and Basic Needs (3 – 6 months): During this phase of treatment, clinicians are building a relationship with clients, assessing their needs and strengths, and creating action plans around making sure basic needs are being met.

Interventions during this phase:

- Linkage to emergency housing
- Linkage to income
- Creating a food plan (e.g., providing Safeway cards or going grocery shopping)
- Linkage to a primary care clinic
- Creating safety plans for stabilizing mental health crises
- Medication evaluation and management
- Engagement strategies such as taking the client to lunch, coffee, etc.
- Purchasing clothing, at modest prices, modeling budgeting skills
- Getting identification (Social Security, Medi-Cal card, birth certificate, ID card)

Treatment and Maintenance (6 months – 3 years): During this phase of treatment, clinicians are exploring clients' goals, and actively setting and achieving those goals. During this time, clients are expected to come into the office for regular appointments with their case managers. All financial support given from FSA during this phase should be planned for in these weekly meetings.

Interventions during this phase:

- Continued support with medical / dental / vision needs
- Goal setting around education / employment
- Psychoeducation around mental health issues
- Addressing substance abuse issues (referral to substance abuse counselor, motivational interviewing, groups, outpatient, inpatient)
- Linkage to permanent housing
- Planning around economic self-sufficiency
- Recreation / building of social network in the community
- Teaching daily living skills (cleaning room, cooking, laundry, hygiene) with more support, gradually building and encouraging independence in these skills
- Teaching of new coping skills and strategies
- Formal therapy, if appropriate

Step Down and Graduation (last 3 – 6 months in the program): During this phase of treatment, program staff is reviewing accomplishments and successes, identifying any remaining treatment goals, and preparing clients for a more independent life. **Financial support given from FSA during this phase should be minimal** and paced to none, as clients is without such a resource when stepped down.

Interventions during this phase:

- Review of the client's progress, and reviewing what they have learned, praise
- Linkage to community supports (e.g., drop in center, AA/NA)
- Planning for financial self sufficiency

- Linkage to step down program (if necessary), or other supports (therapist)
- Processing feelings about the end of services at FSASF
- Celebration and graduation ritual

TAY FSP PROGRAM INTERVENTION DETAIL

Care Coordination: Each client is assigned a primary Care Coordinator who coordinates and monitors the activities of the team and has primary responsibility to work with the client in developing his/her own individual treatment plan, to ensure immediate changes are made in treatment plans as client's needs change, and to advocate for client rights and preferences. The Care Coordinator is also the first staff person called on when the client is in crisis and is the primary support person and educator to the client's family. Members of the treatment team share these tasks with the Care Coordinator and are responsible to perform the tasks when the Care Coordinator is not working. As part of the strengths-based assessment and case planning model, staff help the client to develop a Wellness and Recovery Action Plan.

Crisis Assessment and Intervention: Crisis assessment and intervention is provided 24 hours per day, seven days per week. These services include telephone and face-to-face contact. During normal working hours, an available TAY FSP team member responds. After hours and on weekends, a TAY FSP team member is on call and carries the team's crisis phone. This number is available to emergency service providers. During nights and weekends, the on-call staff assesses the situation and provides whatever intervention is clinically indicated.

Mental Health Treatment: The TAY FSP Team is prepared to identify and address a range of substance abuse issues and multiple mental health disorders, ranging from moderate depression to schizophrenia. The team has trained and/or certified in several different modalities, including Problem Solving Therapy, Dialectical Behavioral Therapy, and Cognitive Behavioral Therapy. Treatment for mental illness includes:

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

-Education of the client regarding his/her illness and the effects and side effects of prescribed medications, where appropriate;

-Symptom-management efforts directed to help each client identify the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen their effects; and

-Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals and to cope with the stresses of day-to-day living.

Substance Abuse Treatment: TAY FSP provides both one-to-one and group substance abuse treatment, integrated with mental health treatment. The TAY FSP team provides substance abuse treatment in stages throughout the service period, depending on the client's level of readiness for treatment. Staff is trained in treatment planning appropriate to the stage of recovery. Clients will also be referred to and encouraged to participate in NA and AA. They will also be referred for residential substance abuse treatment when appropriate through FSA's partnership with Walden House/Haight Ashbury.

Medication Prescription, Administration, Monitoring, and Documentation: The psychiatric nurse practitioner and/or psychiatrist will assess each client's mental illness and prescribe appropriate medication; regularly review and document the client's symptoms as well as his or her response to prescribed medication treatment; educate the client regarding his/her mental illness on the effects and side effects of medication prescribed to regulate it; and monitor, treat, and document any medication side effects. Our psychiatric nurse distributes psychiatric medication as often as daily (M-F). All TAY FSP team members assess and document clients'

symptoms and behavior in response to medication and monitor for medication side effects. The FSP program also has medication policies and procedures that identify processes to: record physician orders; order medication; arrange for all clients' medications to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules; and provide security for medications. FSASF's partnership with Walden House/Haight Ashbury.

Employment Services: The employment specialist oversees internal pre-vocational program "FSA Works." The goal behind FSA Works is to build basic employment skills in clients, such as: arriving to work on time, keeping a schedule, and working with others. Clients are placed in internal or offsite volunteer positions. The FSA Works program is a 6-month program. During this time, clients meet with the employment specialist at least monthly to discuss how their placement is working, and to discuss any barriers to success. The goal for this program is to get clients ready for the next step in the employment process, and many clients have graduated out of FSA Works into more formal employment assistance programs in the community, such as Richmond Area Multi-Services Hire-ability program or Community Vocational Enterprises.

Activities of Daily Living: The TAY population is going through the developmental task of separating from their caregivers and learning to be independent. Services to support activities of daily living in community-based settings include individualized assessment, problem solving, side-by-side assistance and support, skill training, ongoing supervision (e.g., prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to: carry out personal hygiene and grooming tasks; perform household activities, including house cleaning, cooking, grocery shopping, and laundry; manage housing-related tasks, including finding a roommate, landlord negotiations, cleaning, furnishing and decorating, procuring necessities (such as telephone, furnishings, linens); develop or improve money-management skills; use available transportation; engage educational opportunities and supports; find healthcare services. TAY FSP also offers Current Events and Surviving the Streets Groups.

Social, Interpersonal Relationship, and Leisure-Time Skill Training: Services are directed to TAY clients to support social, interpersonal relationship, and leisure-time skill training; side-by-side support and coaching; and organizing individual and group social and recreational activities. There are clearly a number of special needs that TAY clients have: In regards to interpersonal relationships TAY consumers are dealing with a great deal of rejection from family, school and their peer group(s). There are numerous groups and activities for clients to practice their interpersonal and leisure time skills. The FSP program provides weekly groups, such as Art Group, Movie Group, Meditation, and Harm Reduction Substance Abuse Group. Other activities have included: urban hikes (around town), Muir Woods visits (monthly), weekend outings to the movies and baseball games, and gardening in the community. Participants have performed slam poetry at open mike nights at cafes around town and others have performed in rock bands at Yerba Buena and other youth oriented venues.

Education, Support and Consultation to Clients' Families and Other Major Supports: With client agreement or consent, services to clients' families and other major supports can include education about the client's illness and the role of the family in the therapeutic process; intervention to resolve conflict; and ongoing, face-to-face, and telephone communication and collaboration between the TAY FSP team, the family, and other major supports.

Wraparound Services: The program provides clients a comprehensive range of services. These services include but are not limited to: supportive and cognitive therapies, case management brokerage (e.g., linkage to services such as housing, benefits and medical care), substance abuse treatment, medication services, vocational and pre-vocational assistance. Any services, supports, or products needed to complete the Care Plan and not readily available through the service constellation is acquired through flexible funding.

Gender-Related and Sexual Orientation Issues: The TAY FSP has a Women's Group, Safe and Strong, based on the Seeking Safety Curriculum. This is a safe place for female clients to discuss trauma issues and to build supportive relationships with one another, and the group is facilitated by female staff. TAY FSP has had an LGBT support group, run by a peer outreach employee; this group has currently been suspended, but three LGBT identified Case Managers are available for assignment when clients prefer this, and this support group will be restarted when the interest and need arises again.

Aftercare: After clients have been discharged from services, they will receive 6 months of aftercare services. During this time they can continue to use the FSP team for support as needed. If circumstances change and they need FSP level services again, they can be expedited back into the program. Staff works with clients' supports in the community to assist in a smooth transition out of services.

OPERATIONAL DETAILS

Hours of operation: FSASF at 1010 Gough opens at 8:30 AM to 7:00 PM for staff and operates from 9:00 AM to 5:00 PM (or other times as needed for assisting clients for appointments or responding to emergencies) for client care. Two Adult FSP staff (for both CARE and ACM) is open to deal with consumer emergencies 24 hours a day, 7 days per week. Clients can reach an on-call clinician by calling an emergency phone number.
Location: most services are provided at the FSASF building at 1010 Gough Street, San Francisco. FSASF's partnering programs are located throughout the city and clients may be receiving services at their sites in addition.
Average Length of Stay: There is a range of length of stay depending on the individual needs of the client. The FSPs have only been around for about five years and there are some clients that have been with us since the beginning, but the average length of stay here appears to be 2-3 years.
Strategies for service delivery: The theory of change is that with the appropriate treatment and support clients' quality of life will improve. Additionally, as clients' lives improve so do the lives of each member of the larger community.

D. Discharge Planning and exit criteria and process.

FSASF's TAY FSP treatment consists of three phases: basic needs and engagement phase, a treatment phase, and a transition phase. The transition phase begins when clients have completed and demonstrated capacity for maintaining their treatment goals. This phase fosters and reinforces clients' strengths, highlighting all they have accomplished in treatment, helping them to link with the wider community, and includes referral to lower level of care when appropriate. FSASF's TAY FSP follows discharge guidelines as established by DPH. Typical guidelines for discharge include CBHS definitions of medical necessity, stabilization of

debilitating psychiatric symptoms, resolving of problems on plan of care, and successfully linking clients to alternative services for care. As stated above, clients can also receive up to 6 months of aftercare services post discharge for support.

E. Program Staffing.

- Program Director, responsible for oversight of TAY program including evaluation of case manager's clinical duties, clinical supervision, and other administrative duties of the TAY program.
- Lead -Case Manager, duties include individual, group therapy, provides clinical support, ensures compliance, and documentation standards, and represents the program with CBHS partners.
- Case Manager, duties include individual, group therapy, may assist with family, parenting, marital problems provides case management, mental health services, and including crisis intervention for mentally ill clients. Maintains accurate detailed clinical records for electronic billing/data entry
- Case Manager, duties include individual, group therapy, crisis intervention may assist with family, parenting, marital problems, case management, mental health services, and including crisis intervention for mentally ill clients. Maintains accurate detailed clinical records for electronic billing/data entry
- Outreach Worker- provides outreach to target difficult to engaged clientele, may assist with client advocacy, and helping client apply for social services needs. Maintains accurate records detailed in progress notes.
- Case Manager, duties include individual, group therapy; crisis intervention may assist with family, parenting, and marital problems, case management, mental health services, including crisis intervention for mentally ill clients. Maintains accurate detailed clinical records for electronic billing/data entry
- Case Manager, duties include individual, group therapy, may assist with family, parenting, marital problems. Case management, mental health services, including crisis intervention for mentally ill clients. Maintains accurate detailed clinical records for electronic billing/data entry
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F. Indirect Services.

Indirect services for this program include outreach and ongoing staff training. Outreach is conducted according to methods described in this document Section 6A. Outreach activities are not billable in the way that other client-level services are, but they are an important element in program design as they help to ensure that needed services reach the highest-risk, most vulnerable, un-served, and underserved populations. FSA also conducts regular staff training in evidence-based practices, strengths-based approaches, cultural competency, and other skill sets that help ensure that services are delivered according to the state of the art. Much staff development and training is provided by FSASF's Felton Institute; and staff also regularly take SF DPH/CBHS/SOC sponsored trainings (e.g., HIPAA, Compliance, Cultural Competency). This work is also not billable, but is essential to maintaining high quality service

and promoting positive client outcomes. Hours required for both outreach and training are a written into job descriptions and part of a full-time employee's expected 1055 hours of work per year.

The FSP program can also utilize **Mode 60** functions. Examples of Mode 60 services purchased and delivered for clients include: dental and vision assistance, which are contracted from local providers; housing assistance (e.g., first/last/deposit), which is paid directly to landlords; and occasional clothing and food assistance, paid directly to vendors. In all cases indirect services are paid from MHSA flex funds directly to service providers, and service delivery is followed up on by care coordinators.

7. Objectives and Measurements

A. Standardized Objectives

All objectives, and descriptions of how objectives will be measured, are contained in the CBHS document entitled Performance Objectives FY 15-16.

8. Continuous Quality Improvement (CQI)

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:
Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:
FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr. McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit process which is conducted as follows:
Monthly:
* There is a Quality Assurance meeting with all program directors across the agency to review "Chart Health" metrics and productivity in each program. This meeting is also a forum to discuss

policy changes and issues as they relate to the interface of CIRCE and AVATAR.
* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual Typo and PURQC. This audit includes a review of all chart components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.
* All program directors meet to audit a mental health program utilizing the attached internal audit sheets. One or two charts are audited thoroughly by the group in order to generate questions about changes in policy or other nuances about our evolving QA process.

Quarterly:
All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing:
All staff working for CBHS Contracts are required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services
All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services
FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or

FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.

FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc., as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. Required Language
N/A

1. **Program Name: Provider Outpatient Psychiatric Services/Administrative Service Organization (POPS/ASO)**
Program Address: 1500 Franklin Street
City, State, Zip Code: San Francisco, CA 94109
Telephone: (415)-474-7310 **FAX:** (415)-922-9418
Website address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, Zip: San Francisco, CA 94109
Person Completing this Narrative: Charles Brigham, LCSW, Adult Division Director
Telephone: (415) 474-7310 ext. 480
Email Address: cbrigham@felton.org

Program Code: FI

2. **Nature of Document** (check one)

☐ New **Renewal** ☒ Modification

3. **Goal Statement**
The primary goals set for this program are of two folds: 1.) To provide high quality administrative support to the Department of Public Health Compliance Office (DPH Compliance) in the areas of verification, credentialing, assigning of Staff IDs to enable Community Programs/Community Behavioral Health Services System of Care (CBHS/SOC) and their contractors to service and treat clients and bill appropriately, in accordance with the Office of Inspector General (OIG), Centers of Medicare Services (CMS), Department of Health Care Services (DHCS) and Medicaid mandates. Verification and Credentialing is also done for DPH Primary Care and DPH Population Health Staff. 2) To provide on-site, cost-efficient, high quality mental health clerical support to the San Francisco Department of Public Health Private Provider Network (PPN) staff, with a focus on intake and referral of patients to the PPN providers to be done in a timely manner. Staff matches qualified providers with client referral sources that equates to high satisfaction with referral and treatment experiences among consumers.

4. **Target Population**
The target population includes consumers of all ages living in San Francisco in need of mental health services, including youth and adults, children and seniors, men/women, LGBTQQ, homeless, multiply diagnosed, and all clients served by the San Francisco Department of Public Health, which includes Primary Care, Population Health Prevention, Community Programs/ Community Behavioral Health Services. Providers are San Francisco area Clinicians and Institutions providing primary care, prevention, mental health and substance abuse services through DPH Community Programs, and Population Health. POPS/ASO program serves thousands of clients and thousands of providers yearly.

5. **Modality(ies)/Interventions**
POPS/ASO provides on-site quality administrative support services to the DPH Compliance Office, CBHS (Provider Relations) and SFMHP (ACCESS) with several focus: Credentialing,

verification, assignment of Staff IDs and clinical privileges; Provider Relations intake and referral of patients to the Preferred Providers Network (PPN) and overall administrative and clerical support to the SF-DPH Compliance Office and Community Programs Provider Relations office staff.

6. Methodology

A. Outreach, recruitment, promotion, and advertisement.

POPS/ASO staff supports the work of SF-DPH Provider Relations and Credentialing and SFMHP ACCESS. SF-DPH maintains websites to outreach to clients through Treatment ACCESS Program (TAP) and providers through SFMHP Providers Manual. FSASF POPS/ASO is not otherwise responsible for outreach, recruitment, promotion or advertisement.

B. Admission, enrollment and/or intake criteria and process.

POPS/ASO's PPN Placement Coordinator receives referrals of clients who have been authorized for care and matches these clients with certified preferred providers within the SFMHP Provider Network, based on the clients' specialty mental health needs and the skills, availability of locations, accessibility, and clinical knowledge of the preferred providers. The Coordinator works closely with SFMHP Provider Relations, Central Access Team and Provider Systems to assure effective and rapid placement of clients in treatment with providers who have openings in their practice and relevant clinical skills.

C. Service delivery model and how each service is delivered.

Administration

The administrative offices for the POPS/ASO program are located in the Family Service Agency of San Francisco at 1500 Franklin Street, San Francisco, California, 94109. POPS/ASO staff perform hiring, supervision and administrative responsibilities. The FSA Adult Division Director and Program Director oversee this contract and report to the Executive Director.

PPN Placement Coordination

The POPS/ASO program provides for a staff person to work at 1380 Howard St, San Francisco, CA 94103 to refer clients who have been authorized for care through the SFMHP and match them with certified preferred providers in the SFMHP network. This position requires familiarity and understanding of the referral needs of psychiatric clients and with the SFMHP Provider Network. The position requires a minimum of one year experience performing the above, knowledge of clinical psychiatric terminology, excellent telephone skills, and knowledge of computer programs inclusive of Microsoft Word, Excel, and a data base program such as Access. This position requires the ability to work with multidisciplinary personnel, both internally and externally, establishing and maintaining "customer-focused" relationships.

Credentialing Coordination

POPS/ASO also provides for a credentialing coordinator to work at the 1380 Howard location. This person assists in tracking, verifying and entering provider credentials in accordance with National Credential Quality Association (NCQA) standards in accordance with all SFMHP credential requirements by the SFMHP. This includes querying various institutions, facilities, licensing boards and insurance companies to verify the credentials of providers. This involves data entry into the SFMHP's credentialing software and provider

tracking software, mass mailings, and frequent contact with providers, and continuous updating of provider electronic and paper files. Minimum requirements to fill this position include familiarity with NCQA credentialing and re-credentialing standards, understanding of managed care certification and re-certification procedures, and knowledge, experience and use of credentialing software.

Administrative Assistance/Credentialing Coordination
POPS/ASO includes clerical support to the Provider System's office staff at 1380 Howard. This includes answering telephones, filing, research, problem solving with providers, word processing and data entry. This also includes credentialing work for individual providers.

D. Discharge Planning and exit criteria and process.
For POPS/ASO, clients are Professionals and Institutions seeking to be credentialed by SF-DPH and consumers seeking to be matched to mental health/substance abuse services. Because POPS/ASO does not deliver treatment services, program exit and discharge are not applicable.

E. Program staffing
Credentialing Coordinator - Enrolls new Providers for SFMHP Provider Pool. Maintains provider profiles in database on the SFMHP Providers Pool, including sub-contractor agreements, providers referral information, provider survey information, Licensure, DEA and ADA related information.
Credentialing Coordinator - Enrolls new Providers for SFMHP Provider Pool. Maintains provider profiles in database on the SFMHP Providers Pool, including sub-contractor agreements, providers referral information, provider survey information, Licensure, DEA and ADA related information.
Intake and referral Coordinator – Handles the various aspects of intake and referrals to Private Providers in the Providers Network

F. Indirect Services - N/A

7. **Objectives and Measurements –** N/A - Fiscal Intermediary

8. **Continuous Quality Improvement (CQI) -** N/A - Fiscal Intermediary

9. **Required Language -** N/A - Fiscal Intermediary

1. Identifiers

Program Name: Prevention and Recovery in Early Psychosis - PREP
Program Address: 6221 Geary Blvd.
City, State, ZIP: San Francisco, CA 94121
Telephone: (415) 386-6600 FAX: (415) 751-3226
Website Address: prepwellness.org

Contractor Address: 1500 Franklin St.
City, State, ZIP: San Francisco, CA 94104
Person Completing this Narrative: Adriana Furuzawa, MFTI, PREP Division Director
Telephone: (209) 483-3670
Email Address: afuruzawa@felton.org

Program Code: 8990EP

2. Nature of Document

☐ New **Renewal** X☐ Modification

3. Goal Statement

The Prevention and Recovery in Early Psychosis (PREP) Partnership delivers comprehensive, conscientious, and evidence-based services to individuals and families suffering from signs and symptoms of schizophrenia and early psychosis. It supports symptom remission, active recovery, and full engagement in their community and with co-workers, peers, and family members. PREP has a significant outreach component designed to reduce the stigma of schizophrenia and psychotic disorders, promote awareness that psychosis is treatable, and obtain referrals.

4. Target Population

The priority target population for the PREP Program consists of individuals ages 14-35 who have had their first psychotic episode within the previous five years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years. Within this group, PREP will serve transitional age youth (ages 16-24), reflecting the ethnical, cultural, and socio-economic diversity of the City and County of San Francisco, with focused outreach to increase services to low-income youth and families. PREP will provide services on-site or at off-site locations (e.g. client's home, school, etc.) throughout the city, meeting clients where they are.

5. Modality(s)/Intervention(s)

Outreach and Engagement (MHSA Activity Category)

- Revise and distribute printed informational materials to a minimum of 125 programs and community stakeholder groups
- Conduct a minimum of 24 outreach presentations (2 per month) during FY 2015-2016

Screening and Assessment (MHSA Activity Category)

- Conduct at least 50 phone screens and 25 diagnostic assessments to determine PREP eligibility.

Training and Coaching (MHSA Activity Category)

- Conduct cognitive-behavioral therapy for early psychosis (CBTp) training and coach staff to clinical competence in CBTp techniques as evidenced by a score of 50% or great on the Revised Cognitive Behavioral Therapy Scale (CTS-R) on 3 consecutive taped CBTp sessions.

***Individual* Therapeutic Services** (MHSA Activity Category)

- Provide 2000 hours of direct and indirect treatment services annually.

***Group* Therapeutic Services** (MHSA Activity Category)

- Enroll 2 new cohorts of families in year-long Multi-Family Groups (MFGs).

6. Methodology

Direct Client Services

A. *Outreach, recruitment, promotion and advertisement when necessary.*

The PREP outreach efforts targets San Francisco's diverse communities providing education about the PREP program, behavioral health, stigma, wellness, and signs of early psychosis, as well as eligible referrals. Extensive outreach will continue to be conducted across San Francisco, consisting of outreach presentations, distribution of brochures and/or promotional materials, as well as through the PREP website.

Outreach presentations will be conducted in settings including neighborhood centers, schools, churches, after-school organized sports activities, libraries, and shopping centers. Special efforts will be taken to engage and reach out to traditionally underserved population groups through our partnership with Sojourner Truth – reaching out to those who would not typically receive or who would experience a delay in services due to such factors as limited access, stigma, poverty, and cultural and linguistic barriers.

PREP will also provide outreach presentations to other mental health and social services organizations in order to increase referrals and educate professionals about psychosis early intervention.

B. Admission, enrollment and/or intake criteria and process where applicable.

All individuals are screened by phone to determine appropriateness for PREP services. Those who are clearly not appropriate for, or in need of, early psychosis services will receive support to connect with needed services. Appropriate referrals (individuals age 14-35 experiencing signs and symptoms of psychosis within the previous five years) will receive a comprehensive diagnostic assessment, the Structural Clinical Interview for DSM Diagnosis (SCID) to determine eligibility for PREP services. The comprehensive assessment will also include collateral information from family, existing service providers (if applicable), and others involved in the individual's recovery process as designated by client and/or family. In addition, a strengths-based assessment of the biological, psychological, and social factors that affect the individual's ability to interact with his or her environment will be completed.

Assessments will be provided at whatever location is most convenient and comfortable for the youth and family to encourage service engagement. Once assessments are completed, individuals who meet full eligibility criteria will continue with PREP services, while those who do not meet criteria will receive support to access appropriate services.

C. *Service delivery model*

The PREP Program provides an integrated package of evidence-based treatments designed for remission of early psychosis. There is a strong evidence base for this array of treatments in promoting positive outcomes for people suffering from early psychosis. Collectively, they address the spectrum of impacts caused by psychosis. Core services include:

- **Algorithm based medication management:** Algorithm developed by Dr. Demian Rose, adapted from the Texas Medication Algorithm to focus specifically on medication for young adults in the early stages of psychosis. PREP does not prescribe antipsychotic medication for clients who have not yet experienced full-onset of schizophrenia; however, PREP will provide medication to treat other conditions that may co-occur, such as depression.
- **Cognitive Rehabilitation:** Computer-based cognitive rehabilitation program developed by nationally renowned UCSF brain plasticity researcher, Dr. Michael Merzenich. With this software, clients are actually rehabilitating brain function that has been lost to the disease.
- **Cognitive Behavioral Therapy for Psychosis:** Evidence-based approach offered to all PREP clients to teach coping techniques for specific symptom clusters (positive symptoms, negative symptoms, depression, skills for emotion regulation, etc.).
- **Multifamily Groups (MFG):** Multifamily group therapy, based on the PIER model of early intervention treatment for young adults. Individual family therapy based on this model (problem-solving skills, psycho education and support) will be provided to individual families whose cultural values prohibit sharing family problems in a group setting.
- **Strength-based care management:** Intensive care management will ensure that the broad spectrum of clients and family needs are addressed.
- **Education and vocational services:** Individual Placement and Support (IPS) is an evidence-based approach of supported employment for individuals with severe mental illness. An IPS specialist will support clients in returning to work, school, or volunteer activities.

Clients are offered all modalities above, based on their individual needs and willingness to participate. Services are offered intensively, often weekly with client centered treatment plans which are reviewed during the course of treatment and measured against an array of baseline measures taken during the assessment. Engagement and treatment progress will be reviewed weekly at clinical case conference and frequency of services is determined by individual needs and phase of treatment (assessment, stabilization, implementation, reinforcement, wellness planning). Services will be provided on-site and/or in community locations, as determined by client and/or family. The length of treatment is based on outcome data that is shared continuously with the client and his or her family, with a maximum of up to two years for prodromal clients/families and up to two years for recent-onset clients/families.

D. Discharge planning and exit criteria and process.

PREP exit criteria differ based on the service modalities employed in the treatment. Discharge planning is a collaborative process between PREP staff and the youth and, when possible, the family. Process is determined by intervention outcomes identified throughout the clients' treatment and measured against an array of baseline measures taken during the assessment. Treatment aims to integrate clients to a functioning status, either working or in school, and ensures that, at discharge, each youth and his or her family have a thorough contingency plan and are able to transition from the program to other levels of care (as indicated).

E. Program staffing

- Felton Training and Research Institute Director: The PREP program is a component of the Felton Training and Research Institute at FSA. Dr. Moore is also adjunct faculty for the UCSF CARTA Project.
- PREP Division Director- Provides administrative oversight and leadership of program operations, program development, training, and fidelity to PREP model.
- Felton Research Director - Provides Oversight of PREP research objectives and reporting.
- PREP Lead RA – Supervises RAs and PREP data collection and reporting
- Medical Director and Psychiatrist: serves as 25% time Medical Director and psychiatrist on the PREP Project.
- PREP Associate Director - Provides operational oversight.
- UCSF Director of the PART program: assists with program development and ensures adherence to evidence-based treatment approaches
- Clinical Director: oversees clinical coordination across the PREP sites and oversees CBT for Psychosis training.
- SF PREP Program Manager: Provides administrative oversight, as well as individual therapy and case coordination.
- Spanish Speaking – Nurse Practitioner: provides medication support at PREP under the supervision of MD.
- Spanish Speaking – Clinical Supervisor at PREP SF: responsible to ensure staff adherence to the PREP model, facilitate MFG, provides individual psychotherapy, care coordination, and case management.
- Part time therapist at PREP, CBTp Trainer & consultant. Provides individual therapy, case coordination, and case management.
- PREP Therapist, CBTp Trainer & consultant. Provides individual therapy, case coordination, and case management.
- Part time Therapist at PREP, CBT for Bipolar Trainer & consultant. Provides individual therapy, case coordination, and case management.
- Care Advocate (lived experience). Provides peer support, individual, group rehabilitation, from a strength-based and recovery-oriented perspective.
- Vocational Case Manager – Provides individualized educational and vocational support, under the IPS (Individual Placement and Support) Model for supported employment adapted for youth.
- TBD- Family Partner (lived experience). Provides support to families from a peer perspective, as well as linkage to community resources.

• Research Assistant, Coordinates evaluations, collects outcome data.

Throughout the year, PREP will have volunteer trainees, clinical interns on licensure track (PhD/Speed, ASW, MFTI), as well as volunteer research assistants. Through partnership with Sojourner Truth, one part-time therapist/case manager will provide support with engaging youth coming from the Foster Care system.

F. MHSA Programs – Additional requirements.

1) Consumer participation and engagement

PREP clients and families actively participate in assessment (feedback session), treatment and program evaluations. During assessment, besides integrating family in structured clinical interview, a collaborative meeting closes this phase of treatment (feedback session) when staff shares clinical views, diagnosis, treatment options, and empowers clients and families in their decision-making process. Throughout treatment, clients and families actively participate in services, including regular treatment evaluations (consumer evaluations and MFG evaluations), and their input is sought to improve service delivery.

PREP is integrating individuals with lived experience in the team (care advocate and family partner), to enhance recovery-oriented views and role-model consumer engagement in system transformation.

2) MHSA Principles:

The concepts of recovery and resilience are widely understood and evident in programs and service delivery.

- PREP promotes recovery and resilience through its use of strength-based care management and recovery based language. PREP has also designed a medication approach that supports the concept of a sustainable medication treatment that works over time. Our clinicians bring multiple psychosocial treatments to bear to treat the whole individual.
- The progress of the client is tracked through weekly case conference where every client is discussed each week. Each client is reviewed based on their level of need with those clients presenting with the greatest level of need receiving the most time for discussion. Problem solving allows the team to consider ways in which the client might move down the risk level. Each case conference ends with a review of positives from the week including skills clients may have learned, activities they may have engaged in or feedback they may have given.
- Monthly review of the 'phase of treatment' that the client currently occupies with identification of goals and steps to aid the client to move to the next phase of treatment and ultimately towards discharge.
- CBTp strongly emphasizes normalization as a key element of the approach. Normalization allows the client to decatastrophize their experience and begins to formulate this within a recovery and resiliency framework.

Consumers are supported to determine and achieve their own goals and lead fulfilling and productive lives.

- CBT goals are set collaboratively and frequently include age-appropriate goals (e.g. attending school, gaining employment, dealing with family conflict, etc.) for any TAY.
- The IPS model emphasizes that the vocational choices of the client should reflect their interests and supports clients to make steps to return to work, or school, at the earliest possible point.

7. Objectives and Measurements

A. Standardized Objectives
N/A

B. Individualized Objectives

MHSA Goal: Increased identification of emerging mental health issues, especially the earliest possible identification of potentially severe and disabling mental illness.

- **Individualized Performance Objective:** At least 70% of new clients will maintain engagement for at least 60 days so that clients and families are at minimum, aware of resources and have developed support and safety plans, as evidenced by documentation in CIRCE and AVATAR records.

MHSA Goal: Increased ability to manage symptoms and/or achieve desired quality-of-life-goals as set by program participants.

- **Individualized Performance Objective:** In FY 15/16, at least 40% of clients enrolled in the program for 12 months or more will be engaged in new employment or education, as measured by enrollments documented in CIRCE and AVATAR records.

- **Individualized Performance Objective:** In FY 15/16, at least 50% of clients enrolled in the program for 12 months or more will demonstrate at least 30% decrease in total number of acute inpatient setting episodes and/or decrease in acute inpatient setting days, compared to the number of acute inpatient setting episodes and/or days by these same clients in the 12 months prior to PREP, as documented by Avatar and CIRCE records.

- **Individualized Performance Objective:** In FY 15/16, at least 40% of clients enrolled in the program for 6 months or more will demonstrate improved well-being, as evidenced by a reduction in symptoms related to depression, measured by the PHQ-9 scale improvement definition, assessed in semi-annual consumer evaluations.

- **Individualized Performance Objective:** In FY 15/16, at least 40% of clients enrolled in the program for 12 months or more will build capacity to cope with challenges they encounter, as measured by the increase of at least 1 PCI (Standardized Performance Change Index) point on clinician ratings on the ANSA in Life Domain Functioning or

Strengths domains OR as measured by the decrease of at least 1PCI on Behavioral Health Needs or Risk Behaviors domains; assessed semi-annually.

MHSA Goal: Participant Satisfaction:

- **Individualized Performance Objective:** In FY 14/15, at least 60% of clients enrolled in the program for 6 months or more will report high levels of satisfaction and engagement with services as measured by average scores of 3.5 or greater on the Service Satisfaction Scale, and 5 or greater on the Working Alliance Inventory, assessed in semi-annual consumer evaluations.

8. Continuous Quality Improvement (CQI)

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:

Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:

FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr. McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit process which is conducted as follows:

Monthly:

* There is a Quality Assurance meeting with all program directors across the agency to review "Chart Health" metrics and productivity in each program. This meeting is also a forum to discuss policy changes and issues as they relate to the interface of CIRCE and AVATAR.
* Program directors are required to audit charts at least yearly, when charts are opened, closed, or reviewed for annual TxPOC and PURQC. This audit includes a review of all chart components for quality, Medi-Cal compliance, as well as timeliness of signatures and dates. The attached internal audit sheet is used for this purpose. Any findings are discussed in supervision with line staff and a corrective plan is made for any issues.
* All program directors meet to audit a mental health program utilizing the attached internal audit sheets. One or two charts are audited thoroughly by the group in order to generate questions about changes in policy or other nuances about our evolving QA process.

Quarterly:

All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing:
All staff working for CBHS Contracts is required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services

All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services

FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.

FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients cases are opened, at the time of their re-assessments (at least annually), and when clients cases are closed.

FSP and ICM Programs also use the MORS rating scale and DCR data to evaluate clients' progress and track outcomes of our services. Staff enters data for clients monthly into DCR and/or Avatar. We receive bi-monthly reports from the DCR team about hospitalizations, arrests, housing, etc., as they relate to our clients. We are able to identify needs across Programs that are not being met. The MORS data is used as a way to identify clients that may be getting ready for graduation or step down from the program, as well as to identify those clients that are decompensating or failing to move forward in their recovery.

9. Required Language

N/A

1. Identifiers

Program Name: Full Circle Family Program (FCFP) Outpatient (OP)
Program Address: 1500 Franklin Street
City, State, Zip Code: San Francisco, CA 94109
Telephone: (415) 474-7310 **FAX:** (415) 673-2488
Website Address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Person Completing this Narrative: Min Tan, Program Director
Telephone: (415) 474-7310 ext 457
Email Address: mtan@felton.org

Program Code: 382201

2. Nature of Document

☐ New ■ **Renewal** X ☐ Modification

3. Goal Statement

The overall goal of the Full Circle Family Program (FCFP) is to assist minors experiencing challenges (including but not limited to: child neglect and abuse situations, acting out at school and/or at home, depression, low self-esteem, trauma exposure, etc.) through outpatient mental health services (including individual, group and family therapy, diagnostic evaluation, consultation, case management, and medication evaluation/management) and assistance in accessing supportive services to help maintain them within the community.

4. Target Population

The target population includes children and adolescents up to 21 years old (and their families) whose mental health problems meet medical necessity criteria for specialty mental health services, who are San Francisco residents residing, for the most part, in Tenderloin, Western Addition, or South of Market, Mission, Bayview-Hunters Point and Visitation Valley neighborhoods, and who do not carry private insurance (clients have Medi-Cal, ERMHS, Healthy Kids, or no insurance).

5. Modality(ies)/Interventions

Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive Service activities may include are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Plan Development: "Plan Development" means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

INDIRECT SERVICES:
In addition to the above direct services, the program conducts staff training and community outreach (promotion) activities as indirect services.

6. Methodology

A. Outreach, recruitment, promotion, and advertisement.
Outreach is conducted through networking (e.g., regular Provider meetings) and site visits to various schools, community based organizations. Recruitment is also conducted internally, within FSASF's Children, Youth and Family Services Division, for those participants who will be pregnant and parenting and/or adjudicated during this new contract year. Additionally, staff routinely utilizes health fairs and other such events for outreach, recruitment, and promotion and advertisement purposes.

B. Admission, enrollment and/or intake criteria and process.
Eligibility for FCFP program's admission, enrollment and/or intake criteria is predicated on whether the potential participant is age 4-21 (and at the time of entering program younger

than 18 or ERMHS cases within SFUSD), an SF resident, and meets medical necessity for specialty mental health services. The intake process is initiated when a parent, youth, family friend, or agency worker calls FCFP for a brief phone screening to determine eligibility. Only clients who have private insurance as their primary payer source are not eligible; these applicants are referred back to their health provider for services. For clients whose Medi-Cal coverage is secondary, they are also referred back to their primary health insurance provider. An intake/assessment session is scheduled within 24-48 hours to assess client presenting problems, needs, resources, priorities, and so forth, to determine disposition.

C. Service delivery model.

FCFP provides individual, group and family therapy, including play therapy, and sand tray therapy. Some FCFP staff is trained in Functional Family Therapy, and a focus on Family Systems assessment and interventions predominates. Case management and medication support services are provided as well (e.g. targeted case management program, ERMHS Unit, Human Services Agency).

Regular hours of operation are nine to five, Monday through Friday; services are provided at main clinic site (1010 Gough Street), and at local schools; home visits are conducted as needed. Services are additionally provided on-site and in the community, as warranted, outside of these hours, generally between 8 am and 9 pm.

Typical service protocol includes weekly family-based therapy including individual therapy, parent meetings, collateral contacts and interventions, and medication appointments as appropriate. Length of stay is dependent on client needs and progress towards meeting the plan of care goals.

FCFP also provide psychiatric evaluation and medication services to needed clients. The referrals are coming from two sources. One is our own client base. For needed client, assigned clinician fills out a psychiatric referral form and helps coordinate the appointment with our child psychiatrist. The other is medication-only clients from CYF SOC. FCFP accept such referrals and requires that such client has an assigned therapist from other programs. Once such referral is made and the above requirement is satisfied, FCFP makes every effort to make an appointment with that client in a week.

FCFP clinicians routinely consult with child psychiatrist to triage the case on the needs of psychiatric evaluation and medication services. That effort should result in appropriate amount of medication service referrals. FCFP also routinely advertise our medication-only services to CYF SOC, so the medication support units can be accrued productively from that referral stream as well.

FCFP clinicians make every effort to meet our clients and families wherever they are in order to engage them into services. Those options include schools, homes, and community centers. Our clinicians also use evidence-based practices to structure the initial 2 to 3 sessions, so specific engagement and motivation strategies can be implemented through individual and family sessions. Those practices include change-focus oriented reframing and relabeling and change-meaning oriented strength-based relational statements and theme discussion before recommending behavior-change strategies.

D. Discharge Planning and exit criteria and process.

Discharge criteria include client/family attainment of plan of care goals, mutual agreement to discontinue services, or lack of participation which precludes progress. The Child Adolescent Needs and Strengths (CANS) assessment is utilized as a measurement tool to examine and inform treatment decisions. Clinicians discuss discharge with the family as well as with the FCFP clinical supervisor as part of the treatment plan. If the case status is to change (i.e., step-down, transfer, referral, or closure) the clinician consults with the program director. The FCFP Provider enters an appropriate code for "Reason for Discharge" in the BIS Insyst database when a client case is closed in the BIS Insyst. The FCFP Program Utilization Review Quality Committee (PURQC) reviews all cases after the initial 42 days after opening and annually thereafter, and status updates including continuance of services.

E. Program staffing.

- Children, Youth & Family Division Director – provides overall administrative oversight and leadership of program operations and development
- Program Director – responsible for oversight of the program, including evaluation of staff's clinical duties and other administrative duties
- Supervisor - provides clinical supervision
- Family Clinician – provides case management and family therapy
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- Office manager/Intake Outreach Coordinator – provides billing and administrative support
- Administrative Assistant – provides part-time additional administrative support
- Nurse Practitioner – provides medication support

F. Indirect Services.

Indirect services for this program include outreach and ongoing staff training. Outreach is conducted according to methods described in this document Section 6A. Outreach activities are not billable in the way that other client-level services are, but they are an important element in program design as they help to ensure that needed services reach the highest-risk, most vulnerable, un-served, and underserved populations. FSA also conducts regular staff training in evidence-based practices, strengths-based approaches, cultural competency, and other skill sets that help ensure that services are delivered according to the state of the art. This staff development and training is provided by the Felton Institute and is essential to maintaining high quality service and promoting positive client outcomes. Hours required for both outreach and training are written into job descriptions and part of a full-time employee's expected 1056 hours of work per year.

7. Objectives and Measurements

A. Standardized Objectives

All objectives, and descriptions of how objectives are measured, are contained in the CBHS document entitled Performance Objectives FY 15-16.

8. Continuous Quality Improvement (CQI)

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

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A. Achievement of contract performance objectives and productivity:

Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

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completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

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B. Quality of documentation, including a description of the frequency and scope of internal chart audits:

FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

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FSASF has designed a 3-Tiered QA audit. Full Circle Family Program adopts this agency wide audit process and includes specific steps that are unique to our child/youth and family client population.

a. Basic Audit form- The FCFP, a children's program uses a form called the CHART REVIEW CHECKLIST that makes sure that all the necessary components are in the hard chart. It is the same form that is used for our Staff Peer Review. (see attachment) In addition, the FCFP uses the Medi-Cal CHART REVIEW-NON-HOSPITAL SERVICES checklist.

b. Qualitative Audit form – The FCFP does not have a qualitative audit form other than the Program Director/Clinical Supervisor review of all the initial/reassessment, CAN assessments, and PLANS OF CARE (POC) through AVATAR. The review utilizes the AVATAR CANS ASSESSMENT and TREATMENT PLAN guidelines including the Progress Notes. The guidelines are as follows:

- Quantitative: Initial Assessment/Poc - within 60 calendar days of episode opening.
  Subsequent Re-Assessment/PoC – anniversary date of episode opening.
- Qualitative: Document severity of symptoms/impairments;
  DSM IV-R notation, all five Axis; Clients
  Strength; progress notes use PIRP format.

The procedure for review of the charts is as follows:

New charts: All initial CANs/POC are qualitatively reviewed by the Program Director / Clinical Supervisor signed even if all staff is waivered.

Weekly: Staff is aware of the timelines and submits charts for PURQC on a weekly basis, if applicable. A Request for PURQC form is filled out and submitted.(attached)

Monthly: Staff Peer Review occurs using the CHART REVIEW CHECKLIST/MEDI-CAL form. For FY 14/15, FCFP staff will be participating in a qualitative review of the charts as well as quantitative.

Quarterly: All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing: All staff working for CBHS Contracts is required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services

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D. Satisfaction with services

FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and

make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.

FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FCFP has been actively participating in the work group discussion around proper clinical flow and equal access for clients in CYF SOC. Our program director and admin staff participated in every work group meeting and made tangible contribution to the proposed clinical flow model presented to the provider meeting. FCFP is experimenting with brief treatment model that can treat significant portion of our clients within three months with options for booster sessions later.

9. Required Language:

N/A

1. **Identifiers:**
   Program Name: Full Circle Family Program (FCFP) EPSDT
   Program Address: 1500 Franklin Street
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310 FAX: (415) 673-2488
   Website Address: www.felton.org

   Contractor Address: 1500 Franklin Street
   City, State, ZIP: San Francisco, CA 94109
   Person Completing this Narrative: Min Tan, Program Director
   Telephone: (415) 474-7310 ext 457
   Email Address: mtan@felton.org

   Program Code: 382203

2. **Nature of Document**
   ☐ New **Renewal** X ☐ Modification

3. **Goal Statement**
   The Full Circle Family Program (FCFP) EPSDT seeks to make outpatient mental health services more accessible to San Francisco residents by targeting EPSDT eligible residents who are not currently served by the San Francisco community mental health system.

4. **Target Population**
   San Francisco residents under the age of 21 who are eligible to receive the full scope of Medi-Cal service and meet medical necessity criteria for specialty mental health services, but who are not currently enrolled as clients in San Francisco County's outpatient mental health system, are eligible for EPSDT (full-scope Medi-Cal) services. Full Circle Family Program focuses on serving target populations of greatest need, including foster care children, dually diagnosed, LGBTQQ identified, children and adolescents who have serious emotional problems but not currently at risk for out-of-home placement, homeless children/youth, and other underserved populations.

5. **Modality(ies)/Interventions**
   Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery ensures beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

   Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive Service activities may include are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Plan Development: "Plan Development" means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

INDIRECT SERVICES:
In addition to the above direct services, the program conducts staff training and community outreach (promotion) activities as indirect services.

Total Unit of Service (UOS) Description:
4.5 FTE * 37.5 hrs/wk * 45 wks * 33% = 2449 UOS

6. Methodology

A. Outreach, recruitment, promotion, and advertisement.

Outreach is conducted through networking (e.g., regular Provider meetings) and site visits to various schools, community based organizations. Recruitment is also conducted internally, within FSASF's Children, Youth and Family Services Division, for those participants who will be pregnant and parenting and/or adjudicated during this new contract year. Additionally, staff routinely utilize health fairs and other such events for outreach, recruitment, and promotion and advertisement purposes.

B. Admission, enrollment and/or intake criteria and process.

Eligibility for FCFP EPSDT program's admission, enrollment and/or intake criteria is predicated on whether the potential participant is age 4-21, an SF resident, and meets medical necessity for specialty mental health services. This contract serves only children with full-scope Medi-Cal. The intake process is initiated when a parent, youth, family friend, or agency worker calls FCFP for a brief phone screening to determine eligibility. Clients who are not eligible for EPSDT are either served under FCFP OP or, if they hold private insurance as their primary coverage, they are referred back to their health provider for services. An intake session is scheduled within 24-48 hours to assess client presenting problems, needs, resources, priorities, and so forth, to determine disposition.

C. Service delivery model and how each service is delivered.

FCFP provides individual, group and family therapy, including play therapy, and sand tray therapy. Some FCFP staff are trained in Functional Family Therapy, and a focus on Family Systems assessment and interventions predominates. Case management and medication support services are provided as well (e.g. targeted case management program, AB3632 Unit, Human Services Agency).

Regular hours of operation are nine to five, Monday through Friday; services are provided at main clinic site (1010 Gough Street), and at local schools; home visits are conducted as needed. Services are additionally provided on-site and in the community, as warranted, outside of these hours, generally between 8 am and 9 pm.

Typical service protocol includes weekly family-based therapy including child therapy, regular parent meetings, collateral contacts and interventions, and medication appointments as appropriate. Length of stay is dependent on client needs and progress towards meeting the plan of care goals.

D. Discharge Planning and exit criteria and process.

Discharge criteria include client/family attainment of plan of care goals, mutual agreement to discontinue services, or lack of participation which precludes progress. The Child Adolescent Needs and Strengths (CANS) assessment is utilized as a measurement tool to examine and inform treatment decisions. Clinicians discuss discharge with the family as well as with the FCFP clinical supervisor as part of the treatment plan. If the case status is to change (i.e., step-down, transfer, referral, or closure) the clinician consults with the program director. The FCFP Provider enters an appropriate code for "Reason for Discharge" in the BIS Insyst database when a client case is closed in the BIS Insyst. The FCFP Program Utilization Review Quality Committee (PURQC) reviews all cases at one year anniversary dates for status updates including continuance of services.

E. Program staffing.

- Children, Youth & Family Division Director – provides overall administrative oversight and leadership of program operations and development
- Program Director – responsible for oversight of the program, including evaluation of staff's clinical duties and other administrative duties
- Family Clinician – provides case management and family therapy
- Family Clinician – provides case management and family therapy
- Family Clinician – provides case management and family therapy
- Family Clinician - provides case management and family therapy

- Office manager/Intake Outreach Coordinator – provides billing and administrative support
- Administrative Assistant – provides part-time additional administrative support
- Nurse Practitioner – provides medication support

F. Indirect Services.

Indirect services for this program include outreach and ongoing staff training. Outreach is conducted according to methods described in this document Section 6A. Outreach activities are not billable in the way that other client-level services are, but they are an important element in program design as they help to ensure that needed services reach the highest-risk, most vulnerable, un-served, and underserved populations. FSA also conducts regular staff training in evidence-based practices, strengths-based approaches, cultural competency, and other skill sets that help ensure that services are delivered according to the state of the art. This staff development and training is provided by the Felton Institute and is essential to maintaining high quality service and promoting positive client outcomes. Hours required for both outreach and training are written into job descriptions and part of a full-time employee's expected 1056 hours of work per year.

7. Objectives and Measurements

A. Standardized Objectives

All objectives, and descriptions of how objectives are measured, are contained in the CBHS document entitled Performance Objectives FY 15-16.

8. Continuous Quality Improvement (CQI)

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and

training.

A. Achievement of contract performance objectives and productivity:
Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:
FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

Each month (on the 3rd Tuesday), Dr McCrone meets with Treedeen Tether Compliance Officer, Adrienne Abad Administrative Manager, and all FSASF Administrative staff, to assure that uploads from CIRCE to AVATAR of billing for service entries are correct, and to develop standards for the sometimes complex and multiple procedures which assure continuous calibration and reconciliation of the Electronic Health Records of CIRCE and AVATAR.

FSASF has designed a 3-Tiered QA audit. Full Circle Family Program adopts this agency wide audit process and includes specific steps that are unique to our child/youth and family client

population.

a. Basic Audit form- The FCFP, a children's program uses a form called the CHART REVIEW CHECKLIST that makes sure that all the necessary components are in the hard chart. It is the same form that is used for our Staff Peer Review. (see attachment) In addition, the FCFP uses the Medi-Cal CHART REVIEW-NON-HOSPITAL SERVICES checklist.

b. Qualitative Audit form – The FCFP does not have a qualitative audit form other than the Program Director/Clinical Supervisor review of all the initial/reassessment, CAN assessments, and PLANS OF CARE (POC) through AVATAR. The review utilizes the AVATAR CANS ASSESSMENT and TREATMENT PLAN guidelines including the Progress Notes. The guidelines are as follows:

- Quantitative: Initial Assessment/Poc - within 60 calendar days of episode opening.
  Subsequent Re-Assessment/PoC – anniversary date of episode opening.
- Qualitative: Document severity of symptoms/impairments;
  DSM IV-R notation, all five Axis; Clients
  Strength; progress notes use PIRP format.

The procedure for review of the charts is as follows:

New charts: All initial CANs/POC are qualitatively reviewed by the Program Director / Clinical Supervisor signed even if all staff is waivered.

Weekly: Staff is aware of the timelines and submits charts for PURQC on a weekly basis, if applicable. A Request for PURQC form is filled out and submitted.

Monthly: Staff Peer Review occurs using the CHART REVIEW CHECKLIST/MEDI-CAL form. For 2013, FCFP staff will be participating in a qualitative review of the charts as well as quantitative.

Quarterly: All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing: All staff working for CBHS Contracts are required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services

All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender

Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services

FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.

FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FCFP has been actively participating in the work group discussion around proper clinical flow and equal access for clients in CYF SOC. Our program director and admin staff participated in every work group meeting and made tangible contribution to the proposed clinical flow model presented to the provider meeting. FCFP is experimenting with brief treatment model that can treat significant portion of our clients within three months with options for booster sessions later.

9. Required Language

N/A

1. Identifiers

Program Name: Severe Emotional Disturbance(SED)/Success, Opportunity, Achievement and Resilience Academy (SOAR) Mental Health Partnership
Program Address: 1500 Franklin Street, San Francisco, CA 94109
City, State, Zip Code: San Francisco, CA 94109
Telephone: (415) 474-7310 **FAX:** (415) 673-2488
Website Address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Person Completing this Narrative: Min Tan, Program Director
Telephone: (415) 474-7310 ext 457
Email Address: mtan@felton.org

Program Code: 3822SED

2. Nature of Document

☐ New **Renewal** X ☐ Modification

3. Goal Statement

The Full Circle Family Program (FCFP) provides quality mental health services in several (San Francisco Unified School District) SED or SLI classrooms to assist the students in those classrooms to meet their educational goals and provides direct services and consultation to the classroom teacher, the school principal, and to the school as a whole aimed at improving student performance.

4. Target Population

SED, PDD, LH or SLI children enrolled in the identified classrooms.

5. Modalities/Interventions

Targeted Case Management: means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Mental Health Services: means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive Service activities may include are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

- Plan Development: "Plan Development" means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.
- "Rehabilitation" means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, meal preparation skills, and support resources; and/or medication education.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services: means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis intervention: is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

INDIRECT SERVICES: In addition to the above direct services, the program conducts staff training and community outreach (promotion) activities as indirect services.

6. Methodology

A. Outreach: Partnership classrooms are selected by SFUSD and CBHS. Partnerships complete a yearly memorandum of understanding outlining responsibilities of each Party.

Schools must meet the following criteria (SFUSD is responsible for consultation readiness):

a. The Principal is committed to accept a mental health component in the school
b. The teachers accept consultation from the mental health clinicians.
c. The teachers attend required interagency training or planning activities
d. There is space within the school that is appropriate and available on a regular basis for pull-out counseling services.

B. Admission Criteria: Students in identified classrooms are assessed for need for services, financial and ERMHS status.

C. Service Delivery Model:

a. Mental health services to SED children in the classroom.

FCFP provides the following scope of services:

b. Pull-out individual therapy services
c. Group activities
d. Consultation to teaching staff and the school principal
e. Attendance at IEP meeting when appropriate.
f. Outreach and services to parents and families.
g. Partnerships are 6-8 hours per week during school hours.

D. Exit Criteria: Students exit program when IEP team agrees goals have been accomplished or student graduates or leaves classroom. Clinician works with team regarding discharge planning and follow-up services.

E. Program Staffing:

- Children, Youth & Family Division Director – provides overall administrative oversight and leadership of program operations and development
- Program Director – responsible for oversight of the program, including evaluation of staff's clinical duties and other administrative duties
- Supervisor - provides clinical supervision
- Family Clinician – provides case management and therapy
- Office manager/Intake Outreach Coordinator – provides billing and administrative support

F. Indirect services are provided to students in the identified classroom or as indicated by the school for children not eligible for direct services.

7. Objectives and Measurements

B. Standardized Objectives

All objectives, and descriptions of how objectives are measured, are contained in the CBHS document entitled Performance Objectives FY 15-16.

8. Continuous Quality Improvement (CQI)

CQI activities follow the procedures established agency-wide at FSASF. The CQI overall coordinator for FSASF is Edward McCrone, PhD, Licensed Psychologist, and Quality Assurance Director, who can be reached at emccrone@felton.org , 415-474-7310 x479. Family Service Agency Programs adhere to all CBHS CQI recommendations and comply with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, Client Satisfaction evaluation, and Timely Completion of Outcome Date, including ANSA, CANS, and MORS.

In close cooperation with the QA Director and Compliance Officer, continuous quality improvement mechanisms for all Programs at FSASF first involve the FSA Division Directors, who oversee all aspects of Programs within Divisions. FSASF's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews twice monthly (2nd Tuesday and 4th Thursday) utilization of services as projected in the contracts. The Division Directors, along with this committee, are responsible for establishing and maintaining overall contractual guidelines for CBHS Mental Health Contract Programs. The FSASF Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior

Management Team is composed of CEO, COO, CFO, Controller, HR Director, IT Director, QA Director of FSASF as well as the Division Directors of FSASF responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information through weekly Program meetings and email, orientations, and training.

A. Achievement of contract performance objectives and productivity:
Program staff joins FSASF meetings at the beginning of the Fiscal Year to review all Performance Objectives that relate to 13 CBHS Contracted Client Service Programs. Performance Objectives are revisited, including plan to achieve them and where achievement is recorded (e.g., AVATAR, CIRCE, DCR, other). Some objectives are monitored as often as weekly in program meetings, and most are monitored monthly in regular meetings (Operations and QA, PURQC, QA/IT, and Roundtable Management meetings). At the end of the Fiscal Year, FSASF will prepare reports on progress on any Performance Objectives not directly measured by AVATAR, DCR, or other directly accessible data source to CBHS.

Program staff meets monthly, on the first Tuesday of every month, for a FSA Operations Meeting with Ed McCrone, Marvin Davis, CFO, and Treedeen Tether, Compliance Officer to review program progress relative to CBHS contract deliverables and performance objectives. Operations staff are provided Spreadsheets to review overall Contract Performance and specific program staff's progress in hitting targets (e.g., productivity, units delivered, caseload, UDC); to monitor procedural and documentation standards (e.g., reviewing HIPAA with clients annually and renewing HIPAA documentation; monitoring that assessments and treatment plans of care are completed within required parameters; monitoring that progress notes are completed within 24 hours of services being rendered); and monitoring progress on performance objectives throughout the year (monthly status given to staff per program on spreadsheets).

In another meeting, FSASF QA Director meets monthly for QA/IT Meeting (4th Thursday) with FSASF Compliance Officer, IT, Clinical and Administrative staff to review progress on Performance Objectives, to identify impediments toward progress, and to remediate and solve any problems staff encounters in the documentation of services, meeting or exceeding deadlines, and achieving all Performance Objectives.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits:
FSA continues to utilize its own in house data system, called 'CIRCE' which stands for Cloud-based Integrated Reporting and Charting Environment. CIRCE gives up to the minute program dashboards on productivity, lapse of time between service rendered and service documented, and PURQC minutes utilized. It also alerts program directors and line staff to upcoming due dates for assessments, plans of care, yearly HIPAA rights review and documentation, and PURQC. Programs also have a monthly meeting to PURQC clients on their anniversary dates with new Tx POC, Reassessment, and CANS or ANSA.

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FSASF has designed a 3-Tiered QA audit. Full Circle Family Program adopts this agency wide audit process and includes specific steps that are unique to our child/youth and family client population.

a. Basic Audit form- The FCFP, a children's program uses a form called the CHART REVIEW CHECKLIST that makes sure that all the necessary components are in the hard chart. It is the same form that is used for our Staff Peer Review. (see attachment) In addition, the FCFP uses the Medi-Cal CHART REVIEW-NON-HOSPITAL SERVICES checklist.

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  DSM IV-R notation, all five Axis; Clients
  Strength; progress notes use PIRP format.

The procedure for review of the charts is as follows:

New charts: All initial CANs/POC are qualitatively reviewed by the Program Director / Clinical Supervisor signed even if all staff is waivered.

Weekly: Staff is aware of the timelines and submits charts for PURQC on a weekly basis, if applicable. A Request for PURQC form is filled out and submitted.

Monthly: Staff Peer Review occurs using the CHART REVIEW CHECKLIST/MEDI-CAL form. For 2013, FCFP staff will be participating in a qualitative review of the charts as well as quantitative.

Quarterly: All program directors facilitate a quarterly peer review audit of a random selection of charts in which line staff applies attached audit forms to review each other's charts. Time is spent reviewing the findings at the end of the peer review.

Yearly/Ongoing: All staff working for CBHS Contracts are required to attend CBHS or FSASF Documentation Training. Within Programs, staff meets weekly with Program Directors to address continuous practice enhancement information conveyed via email or CBHS bulletins or from meetings with CBHS (e.g., Monthly Providers Meetings, FSP and DCR Meetings, PURQC Meetings). Staff training is conducted approximately quarterly within Divisions or Programs; such "booster" trainings review practice habits, address more common subtleties of practices that arise from Program Director Audits and PURQCs, and assure that practice habits do not drift from Documentation Standards. All new staff is intensively trained in Mental Health Documentation Standards and Practices by QA Director, Program Directors, and Program staff; and they are sent to any available CBHS formal training as soon as possible after their hire dates.

C. Cultural competency of staff and services

All staff working on CBHS-contracted programs are required yearly to attend at least two trainings geared toward increasing their cultural competency (e.g., recent trainings have focused

on unique backgrounds of a wide range of client profiles, including Deaf and Hard-of-Hearing, African American, Native American, TAY, Street worker, Senior, LGBTQ Youth, Transgender Adults, and SMI client groups, among many others). FSASF also has been participating in the multi-year CBHS Community Advisory Board Project and submitting formal Reports yearly in September.

FSASF stresses the importance of welcoming clients of all backgrounds, and FSASF has a long history of serving marginalized client groups who may not have been able to find services elsewhere. FSASF also actively recruits staff to represent the diversity of clients FSASF Programs serve, including targeting balance in racial, ethnic, gender, sexual orientation, languages, age and experience, and including professional and peer staff in its ranks.

D. Satisfaction with services
FSASF Programs participate in twice-yearly CBHS Client Satisfaction / Mental Health Consumer Perception Surveys. FSASF staff makes a concerted effort to encourage clients to participate and make their opinions known, and staff works to get help for clients who need it to complete surveys (e.g., reading or writing from peers). Clients are encouraged at all times to discuss concerns or ideas for improvement with their therapist/case manager, program manager, division director, or FSASF executive management. Several times per year, clients are offered group events and transitional gatherings during which they are informally surveyed for how well they feel their programs are meeting their needs. At least yearly, therapists review this formally with clients as part of their developing a new Treatment Plan of Care. Survey results and client suggestions are reviewed at Agency, Division, Program, and individual case levels, and practices are adjusted when possible to meet the hopes and expectations of clients.

E. Timely completion and use of outcome data, including CANS and/or ANSA.
FSASF works with canstraining.com, SFDPH/CBHS and Office of Quality Management (OQM) to train staff within 30 days of hire and to re-certify annually in the administration of CANS and/or ANSA for all clients. Ed McCrone is the ANSA liaison and Min Tan MFT, Program Director for Full Circle Family Program, is the CANS liaison. Liaisons attend monthly (usually phone) meetings and contribute to the County-wide discussions of how to make these assessments more pertinent to the work we do (e.g., monitoring overall whether clients are achieving life improvements, impairment reductions, and overall strength building; looking at circumstances when they do not to determine if there are ways our service delivery could be improved to make even greater impact).

Assessments are done when clients are opened, at the time of their re-assessments (at least annually), and when clients are closed.

FCFP has been actively participating in the work group discussion around proper clinical flow and equal access for clients in CYF SOC. Our program director and admin staff participated in every work group meeting and made tangible contribution to the proposed clinical flow model presented to the provider meeting. FCFP is experimenting with brief treatment model that can treat significant portion of our clients within three months with options for booster sessions later.

9. Required Language
N/A

1. Identifiers

Program Name:
Program Address: 315 Franklin Street
City, State, Zip Code: San Francisco, CA 94108
Telephone: (415)-474-7310 **FAX:** (415)-931-0972
Website Address: www.felton.org

Contractor Address: 1500 Franklin Street
City, State, ZIP: San Francisco, CA 94109
Person Completing this Narrative: Marvin Davis, Chief Financial Officer
Telephone: (415) 474-7310 ext 418
Email Address: mdavis@felton.org

Program Code: Fiscal Intermediary

2. Nature of Document

☐ New **Renewal** **X** ☐ Modification

3. Goal Statement

To assist SFDPH-MCAH-CHVP with fiscal and administrative services related to the sub-contractual agreement with Nurse Family Partnership.

4. Target Population

As an administrative function, there is no target population.

5. Modality(ies)/Interventions

As an administrative function, there are no modalities/interventions.

6. Methodology

As an administrative function, all appropriate policies of both Family Service Agency of SF and SFDPH apply.

7. Objectives and Measurements

N/A - Fiscal Intermediary

8. Continuous Quality Assurance and Improvement

N/A - Fiscal Intermediary

9. Required Language

N/A - Fiscal Intermediary

Appendix B
Calculation of Charges

1. Method of Payment

A. Invoices furnished by CONTRACTOR under this Agreement must be in a form acceptable to the Contract Administrator and the CONTROLLER and must include the Contract Progress Payment Authorization number or Contract Purchase Number. All amounts paid by CITY to CONTRACTOR shall be subject to audit by CITY. The CITY shall make monthly payments as described below. Such payments shall not exceed those amounts stated in and shall be in accordance with the provisions of Section 5, COMPENSATION, of this Agreement.

Compensation for all SERVICES provided by CONTRACTOR shall be paid in the following manner. For the purposes of this Section, "General Fund" shall mean all those funds which are not Work Order or Grant funds. "General Fund Appendices" shall mean all those appendices which include General Fund monies.

(1) Fee For Service (Monthly Reimbursement by Certified Units at Budgeted Unit Rates)

CONTRACTOR shall submit monthly invoices in the format attached, Appendix F, and in a form acceptable to the Contract Administrator, by the fifteenth (15th) calendar day of each month, based upon the number of units of service that were delivered in the preceding month. All deliverables associated with the SERVICES defined in Appendix A times the unit rate as shown in the appendices cited in this paragraph shall be reported on the invoice(s) each month. All charges incurred under this Agreement shall be due and payable only after SERVICES have been rendered and in no case in advance of such SERVICES.

(2) Cost Reimbursement (Monthly Reimbursement for Actual Expenditures within Budget):

CONTRACTOR shall submit monthly invoices in the format attached, Appendix F, and in a form acceptable to the Contract Administrator, by the fifteenth (15th) calendar day of each month for reimbursement of the actual costs for SERVICES of the preceding month. All costs associated with the SERVICES shall be reported on the invoice each month. All costs incurred under this Agreement shall be due and payable only after SERVICES have been rendered and in no case in advance of such SERVICES.

B. Final Closing Invoice

(1) Fee For Service Reimbursement:

A final closing invoice, clearly marked "FINAL," shall be submitted no later than forty-five (45) calendar days following the closing date of each fiscal year of the Agreement, and shall include only those SERVICES rendered during the referenced period of performance. If SERVICES are not invoiced during this period, all unexpended funding set aside for this Agreement will revert to CITY. CITY'S final reimbursement to the CONTRACTOR at the close of the Agreement period shall be adjusted to conform to actual units certified multiplied by the unit rates identified in Appendix B attached hereto, and shall not exceed the total amount authorized and certified for this Agreement.

(2) Cost Reimbursement:

A final closing invoice, clearly marked "FINAL," shall be submitted no later than forty-five (45) calendar days following the closing date of each fiscal year of the Agreement, and shall include only those costs incurred during the referenced period of performance. If costs are not invoiced during this period, all unexpended funding set aside for this Agreement will revert to CITY.

C. Payment shall be made by the CITY to CONTRACTOR at the address specified in the section entitled "Notices to Parties."

D. Upon **the effective date** of this Agreement, contingent upon prior approval by the CITY'S Department of Public Health **of an invoice or claim submitted by Contractor, and** of each year's revised Appendix A (Description of Services) and each year's revised Appendix B (Program Budget and Cost Reporting Data Collection Form), and within each fiscal year, the CITY agrees to make an initial payment to CONTRACTOR not to exceed

twenty-five per cent (25%) of the General Fund and MHSA Fund of the CONTRACTOR'S allocation for the applicable fiscal year.

CONTRACTOR agrees that within that fiscal year, this initial payment shall be recovered by the CITY through a reduction to monthly payments to CONTRACTOR during the period of October 1 through March 31 of the applicable fiscal year, unless and until CONTRACTOR chooses to return to the CITY all or part of the initial payment for that fiscal year. The amount of the initial payment recovered each month shall be calculated by dividing the total initial payment for the fiscal year by the total number of months for recovery. Any termination of this Agreement, whether for cause or for convenience, will result in the total outstanding amount of the initial payment for that fiscal year being due and payable to the CITY within thirty (30) calendar days following written notice of termination from the CITY.

2. Program Budgets and Final Invoice

A. Program Budgets are listed below and are attached hereto.

Budget Summary CRDC B1 – B13	
Appendix B-1	Geriatrics West – Community After Care Medication Geriatric Support
Appendix B-2	Geriatric Services at Gough
Appendix B-3	Older Adult Full Service Partnership at Gough (ICM&FP)
Appendix B-4	Older Adult Peer-Based Wellness and Recovery – Curry Senior Drop-In Center
Appendix B-5	Adult Full Service Partnership (FSP)/CARE/ACM
Appendix B-6	Transitional –Age Youth (TAY) Full Service Partnership (FSP)
Appendix B-7	Provider Outpatient Psychiatric Services/Administrative Service Organization
Appendix B-8	Prevention and Recovery in Early Intervention (PREP) Project
Appendix B-9	Full Circle Family Program (FCFP)
AppendixB-10	Full Circle Family Program /Early Periodic Screening, Diagnosis and Treatment
Appendix B-11	SED Mental Health Partnership
Appendix B-12	Early Childhood Mental Health
Appendix B-13	Fiscal Intermediary for SFDPH-Maternal Child and Adolescent Health (MCAH) - California Homes Visiting Program (CHVP)

B. Compensation

Compensation shall be made in monthly payments on or before the 30th day after the DIRECTOR, in his or her sole discretion, has approved the invoice submitted by CONTRACTOR. The breakdown of costs and sources of revenue associated with this Agreement appears in Appendix B, Cost Reporting/Data Collection (CR/DC) and Program Budget, attached hereto and incorporated by reference as though fully set forth herein. The maximum dollar obligation of the CITY under the terms of this Agreement shall not exceed **Sixty Million Four Hundred Sixty Thousand Forty-Nine Dollars ($60,460,049)** for the period of **July 1, 2010 through December 31, 2017.**

CONTRACTOR understands that, of this maximum dollar ob ligation, **$2,034,095** is included as a contingency amount and is neither to be used in Appendix B, Budget, or available to CONTRACTOR without a modification to this Agreement executed in the same manner as this Agreement or a revision to Appendix B, Budget, which has been approved by the Director of Health. CONTRACTOR further understands that no payment of any portion of this contingency amount will be made unless and until such modification or budget revision has been fully approved and executed in accordance with applicable CITY and Department of Public Health laws, regulations and policies/procedures and certification as to the availability of funds by the Controller. CONTRACTOR agrees to fully comply with these laws, regulations, and policies/procedures.

(1) For each fiscal year of the term of this Agreement, CONTRACTOR shall submit for approval of the CITY's Department of Public Health a revised Appendix A, Description of Services, and a revised Appendix B, Program Budget and Cost Reporting Data Collection form, based on the CITY's allocation of funding for SERVICES for the appropriate fiscal year. CONTRACTOR shall create these Appendices in compliance with the instructions of the Department of Public Health. These Appendices shall apply only to the fiscal year for which they were created. These Appendices shall become part of this Agreement only upon approval by the CITY.

(2) CONTRACTOR understands that, of the maximum dollar obligation stated above, the total amount to be used in Appendix B, Budget and available to CONTRACTOR for the entire term of the contract is as follows, not withstanding that for each fiscal year, the amount to be used in Appendix B, Budget and available to CONTRACTOR for that fiscal year shall conform with the Appendix A, Description of Services, and a Appendix B, Program Budget and Cost Reporting Data Collection form, as approved by the CITY's Department of Public Health based on the CITY's allocation of funding for SERVICES for that fiscal year.

July 1, 2010 through December 31, 2010	**$3,412,014 (BPHM07000084)**
July 1, 2010 through June 30, 2011	**$4,114,657**
July 1, 2011 through June 30, 2012	**$7,052,900**
July 1, 2012 through June 30, 2013	**$7,272,194**
July 1, 2013 through June 30, 2014	**$7,285,177**
July 1, 2014 through June 30, 2015	**$8,225,481**
July 1, 2015 through June 30, 2016	**$8,225,481**
July 1, 2016 through June 30, 2017	**$8,600,352**
July 1, 2017 through December 31, 2017	**$4,237,698**
Sub.Total of July 1, 2010 through December 31, 2017	**$58,425,954**
Contingency Available	**$2,034,095**
Total of July 1, 2010 through December 31, 2017	**$60,460,049**

(3) CONTRACTOR understands that the CITY may need to adjust sources of revenue and agrees that these needed adjustments will become part of this Agreement by written modification to CONTRACTOR. In event that such reimbursement is terminated or reduced, this Agreement shall be terminated or proportionately reduced accordingly. In no event will CONTRACTOR be entitled to compensation in excess of these amounts for these periods without there first being a modification of the Agreement or a revision to Appendix B, Budget, as provided for in this section of this Agreement.

(4) CONTRACTOR further understands that, **$3,412,014** of the period from July 1, 2010 through December 31, 2010 in the Contract Number BPHM07000084 is included with this Agreement. Upon execution of this Agreement, all the terms under this Agreement will supersede the Contract Number BPHM07000084 for the Fiscal Year 2010-11.

C. CONTRACTOR agrees to comply with its Budget as shown in Appendix **B** in the provision of SERVICES. Changes to the budget that do not increase or reduce the maximum dollar obligation of the CITY are subject to the provisions of the Department of Public Health Policy/Procedure Regarding Contract Budget Changes. CONTRACTOR agrees to comply fully with that policy/procedure.

D. No costs or charges shall be incurred under this Agreement nor shall any payments become due to CONTRACTOR until reports, SERVICES, or both, required under this Agreement are received from CONTRACTOR and approved by the DIRECTOR as being in accordance with this Agreement. CITY may withhold payment to CONTRACTOR in any instance in which CONTRACTOR has failed or refused to satisfy any material obligation provided for under this Agreement.

E. In no event shall the CITY be liable for interest or late charges for any late payments.

F. CONTRACTOR understands and agrees that should the CITY'S maximum dollar obligation under this Agreement include State or Federal Medi-Cal revenues, CONTRACTOR shall expend such revenues in the provision of SERVICES to Medi-Cal eligible clients in accordance with CITY, State, and Federal Medi-Cal regulations. Should CONTRACTOR fail to expend budgeted Medi-Cal revenues herein, the CITY'S maximum dollar obligation to CONTRACTOR shall be proportionally reduced in the amount of such unexpended revenues. In no event shall State/Federal Medi-Cal revenues be used for clients who do not qualify for Medi-Cal reimbursement.

CBHS BUDGET DOCUMENTS

DPH 1: Department of Public Health Contract Budget Summary

DHCS Legal Entity Number (MH):	00337	Prepared By/Phone #: M Gaston / M Davis 415-474-7310				Fiscal Year:	2015-16
DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco				Document Date: 7/1/2015	Page:	1 of 3
Contract CMS # (CDTA use only):	6974						
Contract Appendix Number:	B-1	B-2	B-3	B-3a	B-4	B-5	
Appendix A/Provider Name:	Geriatrics Services West	Geriatric Services OADSC	Geriatric Services at Franklin	Geriatric Intensive Case Mgmt at Franklin	Older Adult FSP at Turk (MHSA)	Senior Drop-In Center at Curry Senior Center	
Provider Number	8990	8990	3822	3822	38JW	3822	
Program Code(s)	89903	89903MH	38223MH	382213	38JWFSP	3822SD	**PAGE TOTAL**
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	
FUNDING USES							
Salaries & Employee Benefits:	710,264	131,370	521,250	285,015	653,862	121,667	**2,423,428**
Operating Expenses:	139,350	68,856	128,819	42,120	158,877	59,456	**597,478**
Capital Expenses:							-
Subtotal Direct Expenses:	**849,614**	**200,226**	**650,069**	**327,135**	**812,739**	**181,123**	**3,020,906**
Indirect Expenses:	124,893	29,433	95,560	48,089	119,472	26,625	**444,072**
Indirect %:	**14.70%**	**14.70%**	**14.70%**	**14.70%**	**14.70%**	**14.70%**	**14.70%**
TOTAL FUNDING USES	**974,507**	**229,659**	**745,629**	**375,224**	**932,211**	**207,748**	**3,464,978**
					Employee Fringe Benefits %:		**29.99**
BHS MENTAL HEALTH FUNDING SOURCES							
MH FED - SDMC Regular FFP (50%)	370,164	67,929	200,198	173,678	152,077		964,046
MH STATE - MHSA (CSS)					759,359		759,359
MH STATE - MHSA (PEI)						194,825	194,825
MH STATE - SAMHSA SOC Grant							-
MH 3RD PARTY - Medicare	13,331	728	13,652	3,396	963		32,070
MH STATE - 2011 PSR Managed Care							-
MH STATE - 1991 MH Realignment	284,096	80,017	247,909	116,553	11,698		740,273
MH COUNTY - General Fund	299,051	80,202	251,344	80,833	8,114	6,157	725,701
MH COUNTY - General Fund - CODB (Children)							-
MH COUNTY - General Fund - CODB (ADULT)	7,865	783	32,526	764		6,766	48,704
MH STATE - 2011 PSR EPSDT							-
MH STATE - Family Mosaic Capitated Medi-Cal							-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES	**974,507**	**229,659**	**745,629**	**375,224**	**932,211**	**207,748**	**3,464,978**
BHS SUBSTANCE ABUSE FUNDING SOURCES							
							-
							-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES							
							-
Maternal Child Health / Calfornia Homes Visiting Program - Title V							-
							-
TOTAL OTHER DPH FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES	**974,507**	**229,659**	**745,629**	**375,224**	**932,211**	**207,748**	**3,464,978**
NON-DPH FUNDING SOURCES							
TOTAL NON-DPH FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)	**974,507**	**229,659**	**745,629**	**375,224**	**932,211**	**207,748**	**3,464,978**

CBHS BUDGET DOCUMENTS

DPH 1: Department of Public Health Contract Budget Summary

DHCS Legal Entity Number (MH):	00337		Prepared By/Phone #: M Gaston / M Davis 415-474-7310			Fiscal Year:	2015-16
DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco		Document Date: 7/1/2015			Page:	2 of 3
Contract CMS # (CDTA use only):	6974						
Contract Appendix Number:	B-6	B-6a	B-7	B-8	B-9	B-9a	
Appendix A/Provider Name:	ACM (Non-MHSA)	ADULT FSP (MHSA)	TAY FSP (MHSA)	POPS ASO	PREP - CR	PREP - FFS	
Provider Number	3822	3822	3822	3822	8990	8990	
Program Code(s)	3822OP	3822A3	3822T3	FI	8990EP	8990EP	**PAGE TOTAL**
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	
FUNDING USES							
Salaries & Employee Benefits:	488,315	626,396	386,903	174,687	477,478	405,689	**2,559,468**
Operating Expenses:	137,736	137,638	118,536	2,761	210,050	118,647	**725,368**
Capital Expenses:							-
Subtotal Direct Expenses:	**626,051**	**764,034**	**505,439**	**177,448**	**687,528**	**524,336**	**3,284,836**
Indirect Expenses:	92,029	112,313	74,300	26,084	94,925	77,076	**476,727**
Indirect %:	**14.70%**	**14.70%**	**14.70%**	**14.70%**	**13.81%**	**14.70%**	**14.51%**
TOTAL FUNDING USES	**718,080**	**876,347**	**579,739**	**203,532**	**782,453**	**601,412**	**3,761,563**
					Employee Fringe Benefits %:		29.99
BHS MENTAL HEALTH FUNDING SOURCES							
MH FED - SDMC Regular FFP (50%)	318,968	336,870	196,458			145,586	997,882
MH STATE - MHSA (CSS)		539,477	383,281		707,290	455,826	2,085,874
MH STATE - MHSA (PEI)							-
MH STATE - SAMHSA SOC Grant					75,163		75,163
MH 3RD PARTY - Medicare							-
MH STATE - 2011 PSR Managed Care				166,094			166,094
MH STATE - 1991 MH Realignment	142,225						142,225
MH COUNTY - General Fund	254,747			37,366			292,113
MH COUNTY - General Fund - CODB (Children)							-
MH COUNTY - General Fund - CODB (ADULT)	2,140			72			2,212
MH STATE - 2011 PSR EPSDT							-
MH STATE - Family Mosaic Capitated Medi-Cal							-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES	**718,080**	**876,347**	**579,739**	**203,532**	**782,453**	**601,412**	**3,761,563**
BHS SUBSTANCE ABUSE FUNDING SOURCES							
							-
							-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES							
							-
Maternal Child Health / Calfornia Homes Visiting Program - Title V							-
							-
TOTAL OTHER DPH FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES	**718,080**	**876,347**	**579,739**	**203,532**	**782,453**	**601,412**	**3,761,563**
NON-DPH FUNDING SOURCES							
TOTAL NON-DPH FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)	**718,080**	**876,347**	**579,739**	**203,532**	**782,453**	**601,412**	**3,761,563**

CBHS BUDGET DOCUMENTS

DPH 1: Department of Public Health Contract Budget Summary

DHCS Legal Entity Number (MH):	00337		Prepared By/Phone #: M Gaston / M Davis 415-474-7310			Fiscal Year:	2015-16
DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco			Document Date: 7/1/2015		Page:	3 of 3
Contract CMS # (CDTA use only):	6974						
Contract Appendix Number:	B-10	B-11	B-12	B-13			
Appendix A/Provider Name:	Full Circle OP	Full Circle EPSDT	SED / SOAR MH Partnership	MCAH-CHVP			
Provider Number	3822	3822	3822	3822			
Program Code(s)	3822O1	3822O3	3822SED	FI		**PAGE TOTAL**	**GRAND TOTAL**
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16			
FUNDING USES							
Salaries & Employee Benefits:	188,741	255,845	86,558	-		531,144	5,514,040
Operating Expenses:	103,239	111,094	27,793	97,646		339,772	1,662,618
Capital Expenses:						-	-
Subtotal Direct Expenses:	**291,980**	**366,939**	**114,351**	**97,646**	-	**870,916**	7,176,657
Indirect Expenses:	42,922	53,939	16,809	14,354	-	**128,024**	1,048,823
Indirect %:	**14.70%**	**14.70%**	**14.70%**	**14.70%**		**14.7%**	**14.6%**
TOTAL FUNDING USES	**334,902**	**420,878**	**131,160**	**112,000**	-	**998,940**	8,225,481
					Employee Fringe Benefits %:		**29.99**
BHS MENTAL HEALTH FUNDING SOURCES							
MH FED - SDMC Regular FFP (50%)	107,778	206,610				314,388	2,276,316
MH STATE - MHSA (CSS)						-	2,845,233
MH STATE - MHSA (PEI)						-	194,825
MH STATE - SAMHSA SOC Grant						-	75,163
MH 3RD PARTY - Medicare						-	32,070
MH STATE - 2011 PSR Managed Care						-	166,094
MH STATE - 1991 MH Realignment	98,579		32,455			131,034	1,013,532
MH COUNTY - General Fund	103,476	23,223	98,705			225,404	1,243,218
MH COUNTY - General Fund - CODB (Children)	8,016	5,091				13,107	13,107
MH COUNTY - General Fund - CODB (ADULT)						-	50,916
MH STATE - 2011 PSR EPSDT	9,300	185,954				195,254	195,254
MH STATE - Family Mosaic Capitated Medi-Cal	7,753					7,753	7,753
TOTAL BHS MENTAL HEALTH FUNDING SOURCES	**334,902**	**420,878**	**131,160**	-	-	886,940	8,113,481
BHS SUBSTANCE ABUSE FUNDING SOURCES							
						-	-
						-	-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES							
						-	-
Maternal Child Health / Calfornia Homes Visiting Program - Title V				112,000		112,000	112,000
						-	-
TOTAL OTHER DPH FUNDING SOURCES	-	-	-	**112,000**	-	112,000	112,000
TOTAL DPH FUNDING SOURCES	**334,902**	**420,878**	**131,160**	**112,000**	-	**998,940**	**8,225,481**
NON-DPH FUNDING SOURCES							
TOTAL NON-DPH FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)	**334,902**	**420,878**	**131,160**	**112,000**	-	**998,940**	**8,225,481**

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco						Appendix/Page #:	B-1
Provider Name:	Geriatrics Outpatient Services West						Document Date:	7/1/2015
Provider Number:	8990						Fiscal Year:	2015-16
Program Name:	**Geriatrics Services West**							
Program Code (formerly Reporting Unit):	89903	89903	89903	89903	89903			
Mode/SFC (MH) or Modality (SA)	15/01-09	15/10-57, 59	15/60-69	15/70-79	45/20-29			
Service Description:	OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-Cmmty Client Svcs			TOTAL
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16			
FUNDING USES								
Salaries & Employee Benefits:	93,878	395,049	173,598	12,564	35,175			**710,264**
Operating Expenses:	18,418	77,507	34,059	2,465	6,901			**139,350**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:	**112,296**	**472,556**	**207,657**	**15,029**	**42,076**	-		**849,614**
Indirect Expenses:	16,507	69,466	30,526	2,209	6,185			**124,893**
TOTAL FUNDING USES:	**128,803**	**542,022**	**238,183**	**17,238**	**48,261**	-		**974,507**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	50,815	216,847	95,595	6,907			370,164
MH 3RD PARTY - Medicare	HMHMCC730515	1,830	7,809	3,443	249			13,331
MH STATE - 1991 MH Realignment	HMHMCC730515	35,774	152,665	67,301	4,863	23,493		284,096
MH COUNTY - General Fund - CODB (Adult)	HMHMCC730515	2,726	4,000	1,000	100	39		7,865
MH COUNTY - General Fund	HMHMCC730515	37,658	160,701	70,844	5,119	24,729		299,051
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**128,803**	**542,022**	**238,183**	**17,238**	**48,261**	-	974,507
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**128,803**	**542,022**	**238,183**	**17,238**	**48,261**	-	**974,507**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		128,803	542,022	238,183	17,238	48,261	-	974,507
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):	FFS	FFS	FFS	FFS	FFS			
DPH Units of Service:	59,356	192,890	45,893	4,124	470	-		
Unit Type:	Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	0		
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)	2.17	2.81	5.19	4.18	102.60			
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):	2.17	2.81	5.19	4.18	102.60	0.00		
Published Rate (Medi-Cal Providers Only):	2.52	3.26	6.01	4.83	118.46			**Total UDC:**
Unduplicated Clients (UDC):	44	143	34	3				224

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-2
Provider Name:		Older Adult Day Support Center / Community Integration					Document Date:	7/1/2015
Provider Number:		8990					Fiscal Year:	2015-16
Program Name:		Geriatric Services - Older Adult Day Support - Community Integration (OADSC)						
Program Code (formerly Reporting Unit):		89903MH	89903MH	89903MH	89903MH	89903MH		
Mode/SFC (MH) or Modality (SA)		15/01-09	15/10-57, 59	15/60-69	15/70-79	45/20-29		
Service Description:		OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-Cmmty Client Svcs		TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16		
FUNDING USES								
Salaries & Employee Benefits:		20,605	98,845	5,344	119	6,457		**131,370**
Operating Expenses:		10,800	51,809	2,801	63	3,383		**68,856**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**31,405**	**150,654**	**8,145**	**182**	**9,840**	-	**200,226**
Indirect Expenses:		4,617	22,146	1,197	27	1,446		**29,433**
TOTAL FUNDING USES:		**36,022**	**172,800**	**9,342**	**209**	**11,286**	-	**229,659**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	11,246	53,702	2,916	65			67,929
MH 3RD PARTY - Medicare	HMHMCC730515	121	572	30	5			728
MH STATE - 1991 MH Realignment	HMHMCC730515	12,313	58,805	3,194	69	5,636		80,017
MH COUNTY - General Fund - CODB (Adult)	HMHMCC730515		783					783
MH COUNTY - General Fund	HMHMCC730515	12,342	58,938	3,202	70	5,650		80,202
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**36,022**	**172,800**	**9,342**	**209**	**11,286**	-	229,659
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**36,022**	**172,800**	**9,342**	**209**	**11,286**	-	**229,659**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		36,022	172,800	9,342	209	11,286	-	229,659
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		FFS	FFS	FFS	FFS	FFS		
DPH Units of Service:		16,600	61,495	1,800	50	110	-	
Unit Type:		Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		2.17	2.81	5.19	4.18	102.60		
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		2.17	2.81	5.19	4.18	102.60	0.00	
Published Rate (Medi-Cal Providers Only):		2.52	3.26	6.01	4.83	118.46		**Total UDC:**
Unduplicated Clients (UDC):		8	31	1	1			40

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-3
Provider Name:		Family Service Agency Opt. Srvs of SF					Document Date:	7/1/2015
Provider Number:		3822					Fiscal Year:	2015-16
Program Name:		**Geriatric Services at Franklin**						
Program Code (formerly Reporting Unit):		38223MH	38223MH	38223MH	38223MH	38223MH		
Mode/SFC (MH) or Modality (SA)		15/01-09	15/10-57, 59	15/60-69	15/70-79	45/20-29		
Service Description:		OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-Cmmty Client Svcs		TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16		
FUNDING USES								
Salaries & Employee Benefits:		92,184	208,715	183,604	12,246	24,501		**521,250**
Operating Expenses:		22,782	51,581	45,375	3,027	6,054		**128,819**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**114,966**	**260,296**	**228,979**	**15,273**	**30,555**	-	**650,069**
Indirect Expenses:		16,900	38,264	33,660	2,245	4,491		**95,560**
TOTAL FUNDING USES:		**131,866**	**298,560**	**262,639**	**17,518**	**35,046**	-	**745,629**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	37,152	84,116	73,995	4,935			200,198
MH 3RD PARTY - Medicare	HMHMCC730515	2,533	5,736	5,046	337			13,652
MH STATE - 1991 MH Realignment	HMHMCC730515	43,036	97,438	85,715	5,717	16,003		247,909
MH COUNTY - General Fund - CODB (Adult)	HMHMCC730515	6,006	13,598	11,962	798	162		32,526
MH COUNTY - General Fund	HMHMCC730515	43,139	97,672	85,921	5,731	18,881		251,344
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**131,866**	**298,560**	**262,639**	**17,518**	**35,046**	-	745,629
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**131,866**	**298,560**	**262,639**	**17,518**	**35,046**	-	**745,629**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		131,866	298,560	262,639	17,518	35,046	-	745,629
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		FFS	FFS	FFS	FFS	FFS		
DPH Units of Service:		60,768	106,249	50,605	4,191	342	-	
Unit Type:		Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		2.17	2.81	5.19	4.18	102.60	1.00	
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		2.17	2.81	5.19	4.18	102.60	0.00	
Published Rate (Medi-Cal Providers Only):		2.52	3.26	6.01	4.83	118.46		**Total UDC:**
Unduplicated Clients (UDC):		43	76	36	3			158

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-3a
Provider Name:		Family Service Agency Opt. Srvs of SF					Document Date:	7/1/2015
Provider Number:		3822					Fiscal Year:	2015-16
Program Name:		**Geriatric Intensive Case Management at Franklin (Non-MHSA)**						
Program Code (formerly Reporting Unit):		382213	382213	382213	382213			
Mode/SFC (MH) or Modality (SA)		15/01-09	15/10-57, 59	15/60-69	15/70-79			
Service Description:		OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention			TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16			
FUNDING USES								
Salaries & Employee Benefits:		75,976	82,771	110,360	15,908			**285,015**
Operating Expenses:		11,228	12,232	16,309	2,351			**42,120**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**87,204**	**95,003**	**126,669**	**18,259**	-	-	**327,135**
Indirect Expenses:		12,819	13,966	18,620	2,684			**48,089**
TOTAL FUNDING USES:		**100,023**	**108,969**	**145,289**	**20,943**	-	-	**375,224**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	46,297	50,438	67,249	9,694			173,678
MH 3RD PARTY - Medicare	HMHMCC730515	905	986	1,315	190			3,396
MH STATE - 1991 MH Realignment	HMHMCC730515	31,070	33,848	45,130	6,505			116,553
MH COUNTY - General Fund - CODB (Adult)	HMHMCC730515	203	222	296	43			764
MH COUNTY - General Fund	HMHMCC730515	21,548	23,475	31,299	4,511			80,833
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**100,023**	**108,969**	**145,289**	**20,943**	-	-	375,224
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**100,023**	**108,969**	**145,289**	**20,943**	-	-	**375,224**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		100,023	108,969	145,289	20,943	-	-	375,224
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		FFS	FFS	FFS	FFS			
DPH Units of Service:		46,094	38,779	27,994	5,010	-	-	
Unit Type:		Staff Minute	Staff Minute	Staff Minute	Staff Minute	0	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		2.17	2.81	5.19	4.18			
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		2.17	2.81	5.19	4.18	0.00	0.00	
Published Rate (Medi-Cal Providers Only):		2.52	3.26	6.01	4.83			**Total UDC:**
Unduplicated Clients (UDC):		19	16	11	2			48

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-4
Provider Name:		Family Service Agency Opt. Srvs of SF					Document Date:	7/1/2015
Provider Number:		38JW					Fiscal Year:	2015-16
Program Name:		Older Adult Full Service Partnership at Turk (MHSA)						
Program Code (formerly Reporting Unit):		38JWFSP	38JWFSP	38JWFSP	38JWFSP	38JWFSP	38JWFSP	
Mode/SFC (MH) or Modality (SA)		15/01-09	15/10-57, 59	15/60-69	15/70-79	45/20-29	60/72	
Service Description:		OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-Cmmty Client Svcs	SS-Client Flexible Support Exp	TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	
FUNDING USES								
Salaries & Employee Benefits:		210,289	216,505	77,297	67,802	59,760	22,209	**653,862**
Operating Expenses:		38,372	39,506	14,105	12,372	10,906	43,616	**158,877**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**248,661**	**256,011**	**91,402**	**80,174**	**70,666**	**65,825**	**812,739**
Indirect Expenses:		36,553	37,634	13,436	11,786	10,388	9,675	**119,472**
TOTAL FUNDING USES:		**285,214**	**293,645**	**104,838**	**91,960**	**81,054**	**75,500**	**932,211**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	55,920	57,572	20,555	18,030			152,077
MH 3RD PARTY - Medicare	HMHMCC730515	354	365	130	114			963
MH STATE - MHSA (CSS)	HMHMPROP63/PMHS63-1506	222,602	229,185	81,823	71,774	78,475	75,500	759,359
MH STATE - 1991 MH Realignment	HMHMCC730515	3,742	3,851	1,376	1,206	1,523		11,698
MH COUNTY - General Fund	HMHMCC730515	2,596	2,672	954	836	1,056		8,114
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**285,214**	**293,645**	**104,838**	**91,960**	**81,054**	**75,500**	932,211
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**285,214**	**293,645**	**104,838**	**91,960**	**81,054**	**75,500**	**932,211**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		285,214	293,645	104,838	91,960	81,054	75,500	932,211
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		FFS	FFS	FFS	FFS	FFS	CR	
DPH Units of Service:		131,435	104,500	20,200	22,000	790	75,500	
Unit Type:		Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	Staff Hour or Client Day, depending on contract.	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		2.17	2.81	5.19	4.18	102.60	1.00	
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		2.17	2.81	5.19	4.18	102.60	1.00	
Published Rate (Medi-Cal Providers Only):		2.52	3.26	6.01	4.83	118.46		**Total UDC:**
Unduplicated Clients (UDC):		29	23	4	5			61

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-5
Provider Name:		Family Service Agency Opt. Srvs of SF					Document Date:	7/1/2015
Provider Number:		3822					Fiscal Year:	2015-16
Program Name:		**Senior Drop-In Center at Curry Senior Center**						
Program Code (formerly Reporting Unit):		3822SD						
Mode/SFC (MH) or Modality (SA)		60/78						
Service Description:		SS-Other Non-MediCal Client Support Exp						TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16						
FUNDING USES								
Salaries & Employee Benefits:		121,667						**121,667**
Operating Expenses:		59,456						**59,456**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**181,123**	-	-	-	-	-	**181,123**
Indirect Expenses:		26,625						**26,625**
TOTAL FUNDING USES:		**207,748**	-	-	-	-	-	**207,748**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
							-	-
MH STATE - MHSA (PEI)	HMHMPROP63 / PMHS63-1510	194,825						194,825
MH COUNTY - General Fund	HMHMCC730515	6,157						6,157
MH COUNTY - General Fund - CODB (Adult)	HMHMCC730515	6,766						6,766
								-
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**207,748**	-	-	-	-	-	207,748
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**207,748**	-	-	-	-	-	**207,748**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		207,748	-	-	-	-	-	207,748
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		CR						
DPH Units of Service:		207,748	-	-	-	-	-	
Unit Type:		Staff Hour or Client Day, depending on contract.	0	0	0	0	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		1.00						
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		1.00	0.00	0.00	0.00	0.00	0.00	
Published Rate (Medi-Cal Providers Only):		N/A						**Total UDC:**
Unduplicated Clients (UDC):		150						150

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-6
Provider Name:		Family Service Agency Opt. Srvs of SF					Document Date:	7/1/2015
Provider Number:		3822					Fiscal Year:	2015-16
Program Name:		Adult Care Management (ACM) (Non-MHSA)						
Program Code (formerly Reporting Unit):		3822OP	3822OP	3822OP	3822OP	3822OP	3822OP	
Mode/SFC (MH) or Modality (SA)		15/01-09	15/10-57, 59	15/60-69	15/70-79	45/20-29	60/72	
Service Description:		OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-Cmmty Client Svcs	SS-Client Flexible Support Exp	TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	
FUNDING USES								
Salaries & Employee Benefits:		186,953	118,625	146,887	6,981	23,669	5,200	**488,315**
Operating Expenses:		47,264	29,989	37,134	1,765	5,984	15,600	**137,736**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**234,217**	**148,614**	**184,021**	**8,746**	**29,653**	**20,800**	**626,051**
Indirect Expenses:		34,429	21,846	27,051	1,286	4,359	3,058	**92,029**
TOTAL FUNDING USES:		**268,646**	**170,460**	**211,072**	**10,032**	**34,012**	**23,858**	**718,080**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	129,454	82,141	102,539	4,834			318,968
MH STATE - 1991 MH Realignment	HMHMCC730515	49,869	31,642	39,500	1,862	12,186	7,166	142,225
MH COUNTY - General Fund	HMHMCC730515	89,323	56,677	69,033	3,336	21,826	14,552	254,747
MH COUNTY - General Fund - CODB (Adult)	HMHMCC730515						2,140	2,140
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**268,646**	**170,460**	**211,072**	**10,032**	**34,012**	**23,858**	718,080
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**268,646**	**170,460**	**211,072**	**10,032**	**34,012**	**23,858**	**718,080**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		268,646	170,460	211,072	10,032	34,012	23,858	718,080
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		FFS	FFS	FFS	FFS	FFS	CR	
DPH Units of Service:		123,800	60,662	40,669	2,400	332	23,858	
Unit Type:		Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	Staff Hour or Client Day, depending on contract.	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		2.17	2.81	5.19	4.18	102.60	1.00	
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		2.17	2.81	5.19	4.18	102.60	1.00	
Published Rate (Medi-Cal Providers Only):		2.52	3.26	6.01	4.83	118.46		**Total UDC:**
Unduplicated Clients (UDC):		45	22	15	8			82

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco						Appendix/Page #:	B-6a
Provider Name:	Family Service Agency Opt. Srvs of SF						Document Date:	7/1/2015
Provider Number:	3822						Fiscal Year:	2015-16
Program Name:	**Adult Full Service Partnership (MHSA)**							
Program Code (formerly Reporting Unit):	3822A3	3822A3	3822A3	3822A3	3822A3	3822A3		
Mode/SFC (MH) or Modality (SA)	15/01-09	15/10-57, 59	15/60-69	15/70-79	45/20-29	60/72		
Service Description:	OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-Cmmty Client Svcs	SS-Client Flexible Support Exp	**TOTAL**	
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16		
FUNDING USES:								
Salaries & Employee Benefits:	147,643	262,646	128,548	11,729	62,571	13,259	**626,396**	
Operating Expenses:	24,378	43,367	21,225	1,937	10,331	36,400	**137,638**	
Capital Expenses (greater than $5,000):							-	
Subtotal Direct Expenses:	**172,021**	**306,013**	**149,773**	**13,666**	**72,902**	**49,659**	**764,034**	
Indirect Expenses:	25,287	44,984	22,016	2,009	10,717	7,300	**112,313**	
TOTAL FUNDING USES:	**197,308**	**350,997**	**171,789**	**15,675**	**83,619**	**56,959**	**876,347**	
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
							-	
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	89,314	161,370	78,980	7,206			336,870
MH STATE - MHSA (CSS)	HMHMPROP63/PMHS63-1505	107,994	189,627	92,809	8,469	83,619	56,959	539,477
								-
								-
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**197,308**	**350,997**	**171,789**	**15,675**	**83,619**	**56,959**	876,347
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**197,308**	**350,997**	**171,789**	**15,675**	**83,619**	**56,959**	**876,347**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		197,308	350,997	171,789	15,675	83,619	56,959	876,347
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):	FFS	FFS	FFS	FFS	FFS	CR		
DPH Units of Service:	90,925	124,910	33,100	3,750	815	56,959		
Unit Type:	Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	Staff Hour or Client Day, depending on contract.		
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)	2.17	2.81	5.19	4.18	102.60	1.00		
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):	2.17	2.81	5.19	4.18	102.60	1.00		
Published Rate (Medi-Cal Providers Only):	2.52	3.26	6.01	4.83	118.46		**Total UDC:**	
Unduplicated Clients (UDC):	29	40	10	4			80	

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco						Appendix/Page #:	B-7
Provider Name:	Family Service Agency Opt. Srvs of SF						Document Date:	7/1/2015
Provider Number:	3822						Fiscal Year:	2015-16
Program Name:	Transitional Age Youth (TAY) Full Service Partnership							
Program Code (formerly Reporting Unit):	3822T3	3822T3	3822T3	3822T3	3822T3	3822T3		
Mode/SFC (MH) or Modality (SA)	15/01-09	15/10-57, 59	15/60-69	15/70-79	45/20-29	60/72		
Service Description:	OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-Cmmty Client Svcs	SS-Client Flexible Support Exp	TOTAL	
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16		
FUNDING USES								
Salaries & Employee Benefits:	109,842	162,923	58,486	3,817	38,836	12,999	**386,903**	
Operating Expenses:	24,247	35,964	12,910	842	8,573	36,000	**118,536**	
Capital Expenses (greater than $5,000):							-	
Subtotal Direct Expenses:	**134,089**	**198,887**	**71,396**	**4,659**	**47,409**	**48,999**	**505,439**	
Indirect Expenses:	19,711	29,236	10,495	685	6,969	7,203	**74,299**	
TOTAL FUNDING USES:	**153,800**	**228,123**	**81,891**	**5,344**	**54,378**	**56,202**	**579,738**	
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	64,403	95,526	34,291	2,238			196,458
MH STATE - MHSA (CSS)	HMHMPROP63/PMHS83-1504	89,397	132,598	47,600	3,106	54,378	56,202	383,281
								-
								-
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**153,800**	**228,124**	**81,891**	**5,344**	**54,378**	**56,202**	579,739
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**					**37,695**	**48,999**	86,694
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**153,800**	**228,124**	**81,891**	**5,344**	**54,378**	**56,202**	**579,739**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		153,800	228,124	81,891	5,344	54,378	56,202	579,739
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)				-				
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):	FFS	FFS	FFS	FFS	FFS	CR		
DPH Units of Service:	70,876	81,183	15,779	1,278	530	56,202		
Unit Type:	Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	Staff Hour or Client Day, depending on contract.		
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)	2.17	2.81	5.19	4.18	102.60	1.00		
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):	2.17	2.81	5.19	4.18	102.60	1.00		
Published Rate (Medi-Cal Providers Only):	2.52	3.26	6.01	4.83	118.46	1.00	**Total UDC:**	
Unduplicated Clients (UDC):	39	45	27	7			56	

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-8
Provider Name:		Family Service Agency Opt. Srvs of SF					Document Date:	7/1/2015
Provider Number:		3822					Fiscal Year:	2015-16
Program Name:		POPS / ASO						
Program Code (formerly Reporting Unit):		Fiscal Intermediary						
Mode/SFC (MH) or Modality (SA)		00-20						
Service Description:		Administration Support (i.e. check Writing, hired staff to work for Admin)						TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16						
FUNDING USES								
Salaries & Employee Benefits:		174,687						**174,687**
Operating Expenses:		2,761						**2,761**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**177,448**	-	-	-	-	-	**177,448**
Indirect Expenses:		26,084						**26,084**
TOTAL FUNDING USES:		**203,532**	-	-	-	-	-	**203,532**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
MH STATE - 2011 PSR Managed Care	HMHMOPMGDCAR/PHMGDC15	166,094						166,094
MH COUNTY - General Fund	HMHMCC730515	37,366						37,366
MH COUNTY - General Fund - CODB (Adult)	HMHMCC730515	72						72
								-
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**203,532**	-	-	-	-	-	203,532
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**203,532**	-	-	-	-	-	**203,532**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		203,532	-	-	-	-	-	203,532
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		CR						
DPH Units of Service:		203,532	-	-	-	-	-	
Unit Type:		Not Applicable	0	0	0	0	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		1.00						
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		1.00	0.00	0.00	0.00	0.00	0.00	
Published Rate (Medi-Cal Providers Only):		N/A						**Total UDC:**
Unduplicated Clients (UDC):		N/A						N/A

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-9
Provider Name:		Geriatrics Services West					Document Date:	7/1/2015
Provider Number:		8990					Fiscal Year:	2015-16
Program Name:		Prevention & Recovery in Early Psychosis (PREP) - Cost Reimbursement						
Program Code (formerly Reporting Unit):			8990EP	8990EP				
Mode/SFC (MH) or Modality (SA)			60/78	60/78				
Service Description:			SS-Other Non-MediCal Client Support Exp	SS-Other Non-MediCal Client Support Exp				TOTAL
FUNDING TERM:			7/01/15 _ 6/30/16	7/01/15 _ 6/30/16				
FUNDING USES								
Salaries & Employee Benefits:			406,593	70,885				**477,478**
Operating Expenses:			210,050					**210,050**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		-	**616,643**	**70,885**	-	-	-	**687,528**
Indirect Expenses:			90,647	4,278				**94,925**
TOTAL FUNDING USES:		-	**707,290**	**75,163**	-	-	-	**782,453**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
MH STATE - MHSA (CSS)	HMHMPROP63/PMHS63-1504		707,290					707,290
MH STATE - SAMHSA SOC Grant	HMHMRCGRANTS / HMM007-1501			75,163				75,163
								-
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		-	**707,290**	**75,163**	-	-	-	782,453
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		-	**707,290**	**75,163**	-	-	-	**782,453**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		-	707,290	75,163	-	-	-	782,453
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):			CR	CR				
DPH Units of Service:		-	707,290	75,163	-	-	-	
Unit Type:		0	Staff Hour or Client Day, depending on contract.	Staff Hour or Client Day, depending on contract.	0	0	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)			1.00	1.00				
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		0.00	1.00	1.00	0.00	0.00	0.00	
Published Rate (Medi-Cal Providers Only):			N/A	N/A				**Total UDC:**
Unduplicated Clients (UDC):			N/A	N/A				N/A

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco					Appendix/Page #:	B-9a
Provider Name:		Geriatrics Services West					Document Date:	7/1/2015
Provider Number:		8990					Fiscal Year:	2015-16
Program Name:		**Prevention & Recovery in Early Psychosis (PREP) - Fee For Service**						
Program Code (formerly Reporting Unit):		8990EP	8990EP	8990EP	8990EP	8990EP		
Mode/SFC (MH) or Modality (SA)		15/01-09	15/10-57, 59	15/60-69	15/70-79	45/10-19		
Service Description:		OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-MH Promotion		**TOTAL**
FUNDING TERM:		7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16		
FUNDING USES								
Salaries & Employee Benefits:		23,645	263,287	93,472	5,076	20,209		**405,689**
Operating Expenses:		6,915	77,000	27,337	1,484	5,911		**118,647**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:		**30,560**	**340,287**	**120,809**	**6,560**	**26,120**	-	**524,336**
Indirect Expenses:		4,492	50,022	17,759	964	3,839		**77,076**
TOTAL FUNDING USES:		**35,052**	**390,309**	**138,568**	**7,524**	**29,959**	-	**601,412**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
MH FED - SDMC Regular FFP (50%)	HMHMCC730515	8,930	99,437	35,302	1,917			145,586
MH STATE - MHSA (CSS)	HMHMPROP63/PMHS83-1504	26,122	290,872	103,266	5,607	29,959		455,826
								-
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**35,052**	**390,309**	**138,568**	**7,524**	**29,959**	-	601,412
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
		-	-	-	-			-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**35,052**	**390,309**	**138,568**	**7,524**	**29,959**	-	**601,412**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		35,052	390,309	138,568	7,524	29,959	-	601,412
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):		FFS	FFS	FFS	FFS	FFS		
DPH Units of Service:		16,153	138,900	26,699	1,800	292	-	
Unit Type:		Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		2.17	2.81	5.19	4.18	102.60		
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		2.17	2.81	5.19	4.18	102.60	0.00	
Published Rate (Medi-Cal Providers Only):		2.52	3.26	6.01	4.83	118.46		**Total UDC:**
Unduplicated Clients (UDC):		10	50	18	5			55

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco						Appendix/Page #:	B-10
Provider Name:	Family Service Agency Opt. Srvs of SF						Document Date:	7/1/2015
Provider Number:	3822						Fiscal Year:	2015-16
Program Name:	Full Circle Family Program - OP							
Program Code (formerly Reporting Unit):	382201	382201	382201	382201	382201			
Mode/SFC (MH) or Modality (SA)	15/01-09	15/10-57, 59	15/60-69	15/70-79	45/10-19			
Service Description:	OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention	OS-MH Promotion			TOTAL
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16			
FUNDING USES								
Salaries & Employee Benefits:	8,969	111,184	33,549	1,279	33,760			**188,741**
Operating Expenses:	4,792	61,803	17,924	683	18,037			**103,239**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:	**13,761**	**172,987**	**51,473**	**1,962**	**51,797**		-	**291,980**
Indirect Expenses:	2,023	25,429	7,567	288	7,615			**42,922**
TOTAL FUNDING USES:	**15,784**	**198,416**	**59,040**	**2,250**	**59,412**		-	**334,902**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
MH FED - SDMC Regular FFP (50%)	HMHMCP751594	2,480	82,598	22,140	560			107,778
MH STATE - 1991 MH Realignment	HMHMCP751594	2,479	50,620	22,140	560	22,780		98,579
MH STATE - 2011 PSR EPSDT	HMHMCP751594		9,300					9,300
MH COUNTY - General Fund	HMHMCP751594	5,562	45,392	14,760	1,130	36,632		103,476
MH COUNTY - General Fund - CODB (Children)	HMHMCP751594	5,263	2,753					8,016
MH STATE - Family Mosaic Capitated Medi-Cal	HMHMCP8828CH		7,753					7,753
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**15,784**	**198,416**	**59,040**	**2,250**	**59,412**	-	334,902
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**15,784**	**198,416**	**59,040**	**2,250**	**59,412**	-	**334,902**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		15,784	198,416	59,040	2,250	59,412	-	334,902
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):	FFS	FFS	FFS	FFS	FFS			
DPH Units of Service:	7,274	70,611	11,376	538	579	-		
Unit Type:	Staff Minute	Staff Minute	Staff Minute	Staff Minute	Staff Hour	0		
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)	*2.17*	*2.81*	*5.19*	*4.18*	*102.60*			
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):	2.17	2.81	5.19	4.18	102.60	0.00		
Published Rate (Medi-Cal Providers Only):	2.52	3.26	6.01	4.83	118.46			**Total UDC:**
Unduplicated Clients (UDC):	7	30	12	3				30

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco						Appendix/Page #:	B-11
Provider Name:	Family Service Agency Opt. Srvs of SF						Document Date:	7/1/2015
Provider Number:	3822						Fiscal Year:	2015-16
Program Name:	Full Circle Family Program - EPSDT							
Program Code (formerly Reporting Unit):	382203	382203	382203	382203				
Mode/SFC (MH) or Modality (SA)	15/01-09	15/10-57, 59	15/60-69	15/70-79				
Service Description:	OP-Case Mgt Brokerage	OP-MH Svcs	OP-Medication Support	OP-Crisis Intervention				TOTAL
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16				
FUNDING USES								**0**
Salaries & Employee Benefits:	25,214	219,065	10,859	707				**255,845**
Operating Expenses:	10,948	95,124	4,715	307				**111,094**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:	**36,162**	**314,189**	**15,574**	**1,014**	-	-		**366,939**
Indirect Expenses:	5,316	46,186	2,288	149				**53,939**
TOTAL FUNDING USES:	**41,478**	**360,375**	**17,862**	**1,163**	-	-		**420,878**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
MH FED - SDMC Regular FFP (50%)	HMHMCP751594	20,361	176,909	8,769	571			206,610
MH STATE - 1991 MH Realignment	HMHMCP751594							-
MH STATE - 2011 PSR EPSDT	HMHMCP751594	18,326	159,222	7,892	514			185,954
MH COUNTY - General Fund	HMHMCP751594	2,289	19,885	985	64			23,223
MH COUNTY - General Fund - CODB (Children)	HMHMCP751594	502	4,359	216	14			5,091
MH STATE - Family Mosaic Capitated Medi-Cal	HMHMCP8828CH							-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**41,478**	**360,375**	**17,862**	**1,163**	-	-	420,878
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**41,478**	**360,375**	**17,862**	**1,163**	-	-	**420,878**
NON-DPH FUNDING SOURCES								-
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		41,478	360,375	17,862	1,163	-	-	420,878
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):	FFS	FFS	FFS	FFS				
DPH Units of Service:	19,114	128,247	3,442	278	-	-		
Unit Type:	Staff Minute	Staff Minute	Staff Minute	Staff Minute	0	0		
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)	2.17	2.81	5.19	4.18				
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):	2.17	2.81	5.19	4.18	0.00	0.00		
Published Rate (Medi-Cal Providers Only):	2.52	3.26	6.01	4.83				**Total UDC:**
Unduplicated Clients (UDC):	15	30	4	2				30

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):	Family Service Agency of San Francisco						Appendix/Page #:	B-12
Provider Name:	Family Service Agency Opt. Srvs of SF						Document Date:	7/1/2015
Provider Number:	3822						Fiscal Year:	2015-16
Program Name:	SED / SOAR Mental Health Partnership (Cost Reimbursement)							
Program Code (formerly Reporting Unit):	3822SED	3822SED	3822SED					
Mode/SFC (MH) or Modality (SA)	15/01-09	15/10-57, 59	45/10-19					
Service Description:	OP-Case Mgt Brokerage	OP-MH Svcs	OS-MH Promotion					TOTAL
FUNDING TERM:	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16	7/01/15 _ 6/30/16					
FUNDING USES								
Salaries & Employee Benefits:	1,154	56,551	28,853					**86,558**
Operating Expenses:	371	18,158	9,264					**27,793**
Capital Expenses (greater than $5,000):								-
Subtotal Direct Expenses:	**1,525**	**74,709**	**38,117**	-	-	-		**114,351**
Indirect Expenses:	224	10,982	5,603	-	-	-		**16,809**
TOTAL FUNDING USES:	**1,749**	**85,691**	**43,720**	-	-	-		**131,160**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
MH STATE - 1991 MH Realignment	HMHMCP751594	433	21,204	10,818				32,455
MH COUNTY - General Fund	HMHMCP751594	1,316	64,487	32,902				98,705
								-
								-
								-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**1,749**	**85,691**	**43,720**	-	-	-	131,160
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**							-
								-
								-
								-
TOTAL OTHER DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL DPH FUNDING SOURCES		**1,749**	**85,691**	**43,720**	-	-	-	**131,160**
NON-DPH FUNDING SOURCES								
								-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		1,749	85,691	43,720	-	-	-	131,160
BHS UNITS OF SERVICE AND UNIT COST								
Number of Beds Purchased (if applicable)								
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)								
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program								
Cost Reimbursement (CR) or Fee-For-Service (FFS):	FFS	FFS	FFS					
DPH Units of Service:	806	30,495	426	-	-	-		
Unit Type:	Staff Minute	Staff Minute	Staff Hour					
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)	2.17	2.81	102.60					
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):	2.17	2.81	102.60					
Published Rate (Medi-Cal Providers Only):	2.52	3.26	118.46					**Total UDC:**
Unduplicated Clients (UDC):	9	9	30					9

CBHS BUDGET DOCUMENTS

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Name (MH)/Contractor Name (SA):		Family Service Agency of San Francisco				Appendix/Page #:	B-13
Provider Name:		Family Service Agency Opt. Srvs of SF				Document Date:	7/1/2015
Provider Number:		3822				Fiscal Year:	2015-16
Program Name:		**Maternal, Child & Adolescent Health / California Homes Visiting Program**					
Program Code (formerly Reporting Unit):		Fiscal Intermeiary					
Mode/SFC (MH) or Modality (SA)		00-20					
Service Description:		Administration Support (i.e. check Writing, hired staff to work for Admin)					TOTAL
FUNDING TERM:		7/01/15 _ 6/30/16					
FUNDING USES							
Salaries & Employee Benefits:		-					-
Operating Expenses:		97,646					**97,646**
Capital Expenses (greater than $5,000):							-
Subtotal Direct Expenses:		**97,646**	-	-	-	-	**97,646**
Indirect Expenses:		14,354					**14,354**
TOTAL FUNDING USES:		**112,000**	-	-	-	-	**112,000**
BHS MENTAL HEALTH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**						-
							-
							-
							-
							-
							-
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		-	-	-	-	-	-
BHS SUBSTANCE ABUSE FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**						-
							-
							-
TOTAL BHS SUBSTANCE ABUSE FUNDING SOURCES		-	-	-	-	-	-
OTHER DPH FUNDING SOURCES	**Index Code/Project Detail/CFDA#:**						-
Maternal Child Health / California Homes Visiting Program - Title V	HCHPMMCHADGR HCMC02	112,000					112,000
							-
TOTAL OTHER DPH FUNDING SOURCES		**112,000**	-	-	-	-	112,000
TOTAL DPH FUNDING SOURCES		**112,000**	-	-	-	-	**112,000**
NON-DPH FUNDING SOURCES							-
							-
TOTAL NON-DPH FUNDING SOURCES		-	-	-	-	-	-
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		112,000	-	-	-	-	112,000
BHS UNITS OF SERVICE AND UNIT COST							
Number of Beds Purchased (if applicable)							
Substance Abuse Only - Non-Res 33 - ODF # of Group Sessions (classes)							
Substance Abuse Only - Licensed Capacity for Medi-Cal Provider with Narcotic Tx Program							
Cost Reimbursement (CR) or Fee-For-Service (FFS):		CR					
DPH Units of Service:		112,000	-	-	-	-	
Unit Type:		Not Applicable	0	0	0	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		1.00					
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES):		1.00	0.00	0.00	0.00	0.00	
Published Rate (Medi-Cal Providers Only):		N/A					**Total UDC:**
Unduplicated Clients (UDC):		N/A					N/A

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 89903
Program Name: Geriatrics Services West
Document Date: 7/1/15

Appendix/Page #: B-1

	TOTAL		General Fund		Funding Source 1 (include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 2 (include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Clinical Case Manager	4.96	243,370	4.96	243,370								
Nurse Practitioner	0.30	35,700	0.30	35,700								
Psychiatric Nurse Practitioner	0.32	42,022	0.32	42,022								
Director Clinical Supervision	0.19	14,693	0.19	14,693								
Psychiatrist	0.18	42,232	0.18	42,232								
Intake Manager	0.28	14,840	0.28	14,840								
QA & Program Monitor	0.45	23,680	0.45	23,680								
Program Administrator	0.54	18,005	0.54	18,005								
Office Manager	1.00	37,968	1.00	37,968								
Program Director	0.80	43,632	0.80	43,632								
Division Director	0.29	26,257	0.29	26,257								
On Call Stipend	0.00	4,000		4,000								
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
Totals:	9.31	546,399	9.31	$546,399	0.00	$0	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	163,865	29.99%	$ 163,865	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 710,264		$ 710,264		$ -		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 89903MH
Program Name: Geriatric Services - Older Adult Day Support - Community Integration (OADSC)
Document Date: 7/1/15

Appendix/Page #: B-2

	TOTAL		General Fund		Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Clinical Case Manager	0.67	$ 30,000	0.67	30,000								
Director Clinical Supervision	0.05	$ 2,099	0.05	2,099								
Senior Division Medical Director / Psychiatrist	0.06	$ 13,824	0.06	13,824								
Peer Case Aides & Community Specialists	0.27	$ 10,125	0.27	10,125								
Administrative Assistant/Activity Coornidator	0.60	$ 23,410	0.60	23,410								
Program Administration & QA	0.04	$ 2,120	0.04	2,120								
Program Director	0.17	$ 12,139	0.17	12,139								
Division Director	0.08	$ 7,345	0.08	7,345								
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
Totals:	1.94	$ 101,062	1.94	$101,062	0.00	$0	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 30,308	29.99%	$ 30,308	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 131,370		$ 131,370		$ -		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 38223MH
Program Name: Geriatric Services at Franklin
Document Date: 7/1/15

Appendix/Page #: B-3

	TOTAL		General Fund		Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term: 7/01/15 to 6/30/16		Term: 7/01/15 to 6/30/16		Term:		Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Clinical Case Managers	3.88	$ 188,008	3.880	$ 188,008								
Psychiatric Nurse Practitioner	0.58	$ 75,898	0.58	$ 75,898								
Director Clinical Supervision	0.11	$ 8,396	0.11	$ 8,396								
Senior Division Medical Director / Psychiatrist	0.13	$ 29,808	0.13	$ 29,808								
Peer Case Aides & Community Specialists	0.38	$ 13,630	0.38	$ 13,630								
Administrative Assistant	0.54	$ 21,748	0.54	$ 21,748								
Program Administration & QA	0.11	$ 5,600	0.11	$ 5,600								
Program Director	0.68	$ 39,827	0.68	$ 39,827								
Division Director	0.14	$ 12,477	0.14	$ 12,477								
On Call Stipend	0.00	$ 5,600		$ 5,600								
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
Totals:	6.54	$ 400,992	6.54	$400,992	0.00	$0	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 120,258	29.99%	$ 120,258	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 521,250		$ 521,250		$ -		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 382213
Program Name: Geriatric Intensive Case Management at Franklin
Document Date: 7/1/15

Appendix/Page #: B-3a

	TOTAL		General Fund		General Fund CR - Mode 60 Services		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Clinical Case Managers	2.07	$ 93,073	2.07	$ 93,073								
Psychiatric Nurse Practitioner	0.33	$ 42,327	0.33	$ 42,327								
Director Clinical Supervision	0.11	$ 8,396	0.11	$ 8,396								
Senior Division Medical Director / Psychiatrist	0.01	$ 2,340	0.01	$ 2,340								
Peer Case Aides & Community Specialists	0.17	$ 6,255	0.17	$ 6,255								
Intake Manager	0.24	$ 12,720	0.24	$ 12,720								
Program Administration & QA	0.09	$ 4,770	0.09	$ 4,770								
Program Manager	0.40	$ 22,600	0.40	$ 22,600								
Program Director	0.21	$ 15,210	0.21	$ 15,210								
Division Director	0.13	$ 11,568	0.13	$ 11,568								
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
Totals:	3.75	219,259	3.75	$219,259	0.00	$0	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 65,756	29.99%	$ 65,756	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 285,015		$ 285,015		$ -		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 38JWFSP
Program Name: Older Adult FSP at Turk
Document Date: 7/1/15

Appendix/Page #: B-4

	TOTAL		General Fund		MHSA-CSS HMHMPROP63 PMHS63-1506 Fee For Service		MHSA-CSS HMHMPROP63 PMHS63-1506 CR - Mode 60/72 Services		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Clinical Case Manager	4.46	206,178	0.86	39,858	3.45	159,433	0.149	6,887				
Psychiatric Nurse Practitioner	0.50	65,764	0.10	12,714	0.39	50,854	0.017	2,196				
Director Clinical Supervision	0.08	6,297	0.02	1,217	0.06	4,870	0.003	210				
Senior Division Medical Director / Psychiatrist	0.06	14,040	0.01	2,714	0.05	10,572	0.003	754				
Peer Case Aides & Community Specialists	3.08	116,031	0.60	22,431	2.38	89,725	0.103	3,875				
Administrative Assistant	0.46	18,526	0.09	3,581	0.36	14,326	0.015	619				
Program Administration & QA	0.12	6,590	0.02	1,274	0.10	5,096	0.004	220				
Program Manager	0.84	44,255	0.16	8,555	0.65	34,222	0.028	1,478				
Program Director	0.10	7,141	0.02	1,380	0.08	5,522	0.003	239				
Division Director	0.20	18,187	0.04	3,516	0.15	14,064	0.007	607				
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
Totals:	9.90	503,009	1.91	$97,242	7.65	$388,682	0.33	$17,085	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 150,853	29.99%	$ 29,163	29.99%	$ 116,566	29.99%	$ 5,124	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 653,862		$ 126,405		$ 505,248		$ 22,209		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 3822SD
Program Name: Senior Drop-In Center at Curry Senior Center
Document Date: 7/1/15

Appendix/Page #: B-5

	TOTAL		General Fund		MHSA-CSS HMHMPROP63 PMHS63-1406		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	Term: 1/15 to 6/30		7/01/14 to 6/30/15	Term:	7/01/14 to 6/30/15	Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Peer Case Aides	1.66	$ 54,518			1.66	54,518						
Community Specialist	0.21	$ 7,283			0.21	7,283						
Admin Manager	0.01	$ 530			0.01	530						
Program Director	0.43	$ 30,348			0.43	30,348						
Division Director	0.01	$ 918			0.01	918						
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
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	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
Totals:	2.31	$ 93,597	0.00	$0	2.31	$93,597	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 28,070	#DIV/0!	$ -	29.99%	$ 28,070	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 121,667		$ -		$ 121,667		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 3822OP
Program Name: Adult Care Management (ACM)
Document Date: 7/1/15

Appendix/Page #: B-6

	TOTAL		General Fund Fee for Service		General Fund CR - Mode 60/72 Services		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	Term:	1/15 to 6/30	7/01/14 to 6/30/15	Term:	7/01/14 to 6/30/15	Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Clinical Case Managers	5.99	212,853	5.92	210,538	0.065	2,315						
Registered Nurse	0.18	8,591	0.18	8,498	0.002	93						
Psychiatric Nurse Practitioner	0.35	32,196	0.35	31,846	0.004	350						
Psychiatrist	0.20	54,691	0.20	54,096	0.002	595						
Outreach Worker	0.19	6,238	0.19	6,171	0.002	68						
ASL Interpreter / Office Assistant	0.37	14,800	0.37	14,639	0.004	161						
Office Manager	0.08	4,298	0.08	4,251	0.001	47						
Program Director	0.47	28,193	0.46	27,886	0.005	307						
Division Director	0.06	5,949	0.06	5,884	0.001	65						
On-Call Stipend	0.00	7,846	0.00	7,846								
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
Totals:	7.89	375,656	7.80	$371,656	0.09	$4,000	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	112,660	29.99%	$ 111,460	30.00%	$ 1,200	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 488,315		$ 483,115		$ 5,200		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 3822A3
Program Name: Adult FSP
Document Date: 7/1/15

Appendix/Page #: B-6a

	TOTAL		General Fund Fee for Service		MHSA-CSS HMHMPROP63 PMHS63-1505 Fee For Service		MHSA-CSS HMHMPROP63 PMHS63-1505 CR - Mode 60/72 Services		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:	
Position Title	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**
Clinical Case Managers	2.75	172,162	1.03	64,272	1.66	104,117	0.0602	3,774				
Registered Nurse	0.65	30,914	0.24	11,541	0.39	18,696	0.0143	678				
Psychiatric Nurse Practitioner	0.45	41,580	0.17	15,522	0.27	25,146	0.0099	912				
Psychiatrist	0.45	123,082	0.17	45,949	0.27	74,435	0.0099	2,698				
Outreach Worker	0.56	21,500	0.21	8,026	0.34	13,002	0.0122	471				
ASL Interpreter / Office Assistant	0.03	1,230	0.01	459	0.02	744	0.0007	27				
Office Manager	0.02	1,152	0.01	430	0.01	697	0.0005	25				
Program Director	0.60	33,200	0.22	12,394	0.36	20,078	0.0131	728				
Division Director	0.40	40,537	0.15	15,134	0.24	24,515	0.0088	888				
On-Call Stipend	0.00	16,523	0.00	6,351	0.00	10,172						
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
	0.00	-										
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	0.00	-										
Totals:	5.91	481,880	2.21	$180,080	3.58	$291,601	0.13	$10,200	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	144,516	29.99%	$ 54,006	29.99%	$ 87,451	29.99%	$ 3,059	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		**$ 626,396**		**$ 234,085**		**$ 379,052**		**$ 13,259**		**$ -**		**$ -**

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 3822T3
Program Name: Transitional Age Youth (TAY) FSP
Document Date: 7/1/15

Appendix/Page #: B-7

	TOTAL		General Fund		MHSA-CSS HMHMPROP63 PMHS63-1504 Fee For Service		MHSA-CSS HMHMPROP63 PMHS63-1504 CR - Mode 60/72 Srvs		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term: 7/01/15 to 6/30/16		Term: 7/01/15 to 6/30/16		Term: 7/01/15 to 6/30/16		Term: 7/01/15 to 6/30/16		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Clinical Case Manager	3.40	$ 150,162	1.12	49,176	2.18	95,941	0.114	5,045				
Registered Nurse	0.27	$ 25,198	0.09	8,252	0.17	16,099	0.009	847				
Nurse Practioner	0.20	$ 18,270	0.07	5,983	0.13	11,673	0.007	614				
Psychiatrist	0.20	$ 53,423	0.06	17,495	0.13	34,133	0.007	1,795				
Outreach Worker	0.25	$ 9,673	0.08	3,168	0.16	6,180	0.008	325				
ASL Interpreter / Office Assistant	0.05	$ 3,151	0.02	1,032	0.03	2,013	0.002	106				
Office Manager	0.15	$ 6,000	0.05	1,965	0.10	3,834	0.005	202				
Program Director	0.40	$ 22,153	0.13	7,255	0.25	14,154	0.013	744				
Division Director	0.10	$ 9,611	0.03	3,147	0.06	6,141	0.003	323				
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
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	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
Totals:	5.01	$ 297,641	1.64	$97,474	3.20	$190,167	0.17	$10,000	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 89,262	29.99%	$ 29,232	29.99%	$ 57,031	29.99%	$ 2,999	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 386,903		$ 126,706		$ 247,198		$ 12,999		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: Fiscal Intermediary
Program Name: POPS / ASO
Document Date: 7/1/15

Appendix/Page #: B-8

	TOTAL		General Fund		Managed Care HMHMOPMGDCAR/ PHMGDC15		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	Term:					Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Intake and Referral Coordinator	1.00	$ 43,166	0.18	7,966	0.82	35,200						
Credential Coordinator	2.00	$ 84,979	0.37	15,682	1.63	69,297						
Program Manager	0.10	$ 6,240	0.02	1,152	0.08	5,088						
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
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	0.00	$ -										
	0.00	$ -										
Totals:	3.10	$ 134,385	0.57	$24,800	2.52	$109,585	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 40,302	29.99%	$ 7,437	29.99%	$ 32,865	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 174,687		$ 32,237		$ 142,450		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 8990EP
Program Name: PREP - Cost Reimbursement
Document Date: 7/1/15

Appendix/Page #: B-9

	TOTAL		General Fund		MHSA-CSS HMHMPROP63 PMHS63-1504		SAMHSA SOC #93.958 HMHMRCGRANTS HMM007-1501		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Director of Research	0.01	$ 756			0.01	756						
Research Assistant	0.47	$ 19,616			0.47	19,616						
Training Coordinator	0.01	$ 620			0.01	620						
Staff Therapist	1.77	$ 95,299			1.77	95,299						
Bi-Lingual Staff Therapist	0.19	$ 9,794			0.19	9,794						
Clinical Case Manager	0.28	$ 13,819			0.28	13,819						
Psychiatric Nurse Practitioner	0.47	$ 57,425			0.47	57,425						
Clinical Supervisor	0.47	$ 29,850			0.47	29,850						
Vocational Case Manager	1.00	$ 54,527					1.00	54,527				
Care Advocate	0.49	$ 19,000			0.49	19,000						
Program Manager	0.47	$ 29,376			0.47	29,376						
Office Manager	0.47	$ 17,329			0.47	17,329						
Associate Director	0.10	$ 10,476			0.10	10,476						
Division Director	0.10	$ 9,428			0.10	9,428						
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
Totals:	6.32	$ 367,315	0.00	$0	5.32	$312,788	1.00	$54,527	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 110,163	#DIV/0!	$ -	29.99%	$ 93,805	30.00%	$ 16,358	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 477,478		$ -		$ 406,593		$ 70,885		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 8990EP
Program Name: PREP - Fee-For-Service
Document Date: 7/1/15

Appendix/Page #: B-9a

	TOTAL		General Fund		MHSA-CSS HMHMPROP63 PMHS63-1504		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Director of Research	0.01	$ 840	0.00	263	0.005	577						
Research Assistant	0.53	$ 21,784	0.16	6,816	0.362	14,968						
Training Coordinator	0.01	$ 336	0.00	105	0.004	231						
aff Therapist	1.18	$ 63,803	0.37	19,962	0.814	43,841						
-Lingual Staff Therapist	0.21	$ 10,876	0.07	3,403	0.144	7,473						
Clinical Case Manager	0.31	$ 15,348	0.10	4,802	0.211	10,546						
Psychiatric Nurse Practitioner	0.53	$ 63,775	0.16	19,953	0.362	43,822						
Clinical Supervisor	0.53	$ 33,150	0.16	10,372	0.362	22,778						
Vocational & Educational Specialist	0.33	$ 12,219	0.10	3,824	0.227	8,395						
Care Advocate	0.51	$ 19,995	0.160	6,256	0.352	13,739						
Program Manager	0.53	$ 32,624	0.16	10,207	0.362	22,417						
Office Manager	0.53	$ 19,246	0.16	6,022	0.362	13,224						
Associate Director	0.10	$ 9,524	0.03	2,980	0.065	6,544						
Division Director	0.10	$ 8,572	0.03	2,682	0.065	5,890						
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
Totals:	5.38	$ 312,092	1.68	$97,645	3.69	$214,447	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 93,597	29.99%	$ 29,284	29.99%	$ 64,313	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		**$ 405,689**		**$ 126,929**		**$ 278,760**		**$ -**		**$ -**		**$ -**

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 3822O1
Program Name: Full Circle OP
Document Date: 7/1/15

Appendix/Page #: B-10

	TOTAL		General Fund (HMHMCP751594)		Family Mosaic Cap Medi-Cal (HMHMCP8828CH)		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Family Clinicians	1.07	$ 46,604	1.03	44,935	0.0382	1,669						
Bi-lingual Family Clinicians	0.80	$ 36,756	0.77	35,440	0.0286	1,316						
Psychiatrist	0.01	$ 1,516	0.01	1,462	0.0004	54						
Clinical Supervisor	0.06	$ 5,241	0.05	5,053	0.0020	188						
Administrative Assistant	0.12	$ 5,151	0.12	4,967	0.0044	184						
Intake Outreach Coordinator	0.40	$ 21,014	0.39	20,261	0.0143	753						
Program Director	0.41	$ 26,815	0.40	25,855	0.0148	960						
Division Director	0.02	$ 2,100	0.02	2,025	0.0007	75						
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
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Totals:	2.89	$ 145,197	2.79	$139,998	0.10	$5,199	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 43,544	29.99%	$ 41,985	29.99%	$ 1,559	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 188,741		$ 181,983		$ 6,758		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 382203
Program Name: Full Circle - EPSDT
Document Date: 7/1/15

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	TOTAL		General Fund (HMHMCP751594)		Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term: 7/01/15 to 6/30/16		Term: 7/01/15 to 6/30/16		Term:		Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Family Clinicians	1.46	$ 64,031	1.464	64,031								
Bi-lingual Family Clinicians	1.20	$ 55,159	1.200	55,159								
Psychiatrist	0.03	$ 8,675	0.032	8,675								
Clinical Supervisor	0.08	$ 5,240	0.081	5,240								
Administrative Assistant	0.30	$ 8,566	0.30	8,566								
Intake Outreach Coordinator	0.40	$ 21,013	0.40	21,013								
Program Director	0.49	$ 31,685	0.487	31,685								
Division Director	0.02	$ 2,450	0.024	2,450								
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
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	0.00	$ -										
Totals:	3.99	$ 196,819	3.99	$196,819	0.00	$0	0.00	$0	0.00	$0	0.00	$0
Employee Fringe Benefits:	29.99%	$ 59,026	29.99%	$ 59,026	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 255,845		$ 255,845		$ -		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: 3822SED
Program Name: SED / SOAR Partnership
Document Date: 7/1/15

Appendix/Page #: B-12

	TOTAL		General Fund (HMHMCP751594)		Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Family Clinician	1.00	$ 45,000	1.00	45,000								
Intake Outreach Coordinator	0.20	$ 10,508	0.20	10,508								
Program Director	0.10	$ 6,500	0.10	6,500								
Division Director	0.05	$ 4,580	0.05	4,580								
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
	0.00	$ -										
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	0.00	$ -										
Totals:	1.35	$ 66,588	1.35	$ 66,588	0.00	$ -	0.00	$ -	0.00	$ -	0.00	$ -
Employee Fringe Benefits:	29.99%	$ 19,970	29.99%	$ 19,970	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ 86,558		$ 86,558		$ -		$ -		$ -		$ -

CBHS BUDGET DOCUMENTS

DPH 3: Salaries & Benefits Detail

Program Code: Fiscal Intermediary
Program Name: SFDPH MCAH / California Homes Visiting Program - Fiscal Intermediary
Document Date: 7/1/15

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	TOTAL		General Fund (Include all Funding Sources with this Index Code)		Federal Title V Block Grant (HCHPMMCHADGR HCMC02)		Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)		Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	
	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:	7/01/15 to 6/30/16	Term:		Term:		Term:	
Position Title	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries	FTE	Salaries
Totals:	0.00	$ -	0.00	$ -	0.00	$ -	0.00	$ -	0.00	$ -	0.00	$ -
Employee Fringe Benefits:	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -
TOTAL SALARIES & BENEFITS		$ -		$ -		$ -		$ -		$ -		$ -

DPH 4: Operating Expenses Detail

Program Code: 89903
Program Name: Geriatrics Services West
Document Date: 7/1/15

Appendix/Page #: B-1

Expenditure Category	TOTAL	General Fund	Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 94,300	$ 94,300				
Communications (landline, mobile, fax, internet)	$ 10,552	$ 10,552				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 1,180	$ 1,180				
Photocopying	$ -					
Printing	$ 100	$ 100				
Program Supplies	$ 900	$ 900				
Computer hardware/software	$ 150	$ 150				
General Operating:						
Training/Staff Development	$ 500	$ 500				
Insurance	$ 9,060	$ 9,060				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 12,888	$ 12,888				
Staff Travel:						
Local Travel	$ 6,500	$ 6,500				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
CONSULTANT/SUBCONTRACTOR (Provide Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -					
Other:						
Program Related: Water ($600), Coffee ($240), Snacks/Food ($360)	$ 1,200	$ 1,200				
Organizational Dues	$ 500	$ 500				
Subscriptions / Publications	$ 600	$ 600				
Client Related: Food ($240), Transportation ($300), Clothing ($180), Housing ($200)	$ 920	$ 920				
TOTAL OPERATING EXPENSE	**$ 139,350**	**$ 139,350**	**$ -**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 89903MH
Program Name: Geriatric Services - Older Adult Day Support - Community Integration (OADSC)
Document Date: 7/1/15
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Expenditure Category	TOTAL	General Fund	Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 30,881	$ 30,881				
Communications (landline, mobile, fax, internet)	$ 2,748	$ 2,748				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 600	$ 600				
Photocopying	$ -					
Printing	$ 348	$ 348				
Program Supplies	$ -					
Computer hardware/software	$ 294	$ 294				
General Operating:						
Training/Staff Development	$ 600	$ 600				
Insurance	$ 2,040	$ 2,040				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 2,474	$ 2,474				
Staff Travel:						
Local Travel	$ 3,100	$ 3,100				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
CONSULTANT - John McDonald, Peer Case Aide $20.00/hr x 52 hrs/month x 10 months	$ 10,400	$ 10,400				
CONSULTANT - Linda Fong, Peer Case Aide $24.17/hr x 24 hrs/month x 9 months	$ 5,221	$ 5,221				
Other:						
Program Related: Water ($600), Coffee ($240), Snacks/Food ($360), Misc. Supplies - Art & Crafts ($600)	$ 1,800	$ 1,800				
Organizational Dues	$ 250	$ 250				
Subscriptions / Publications	$ 300	$ 300				
Client Related: Food ($240), Transportation ($300), Clothing ($180), Housing ($200)	$ 3,600	$ 3,600				
Volunteer Stipends	$ 4,200	$ 4,200				
TOTAL OPERATING EXPENSE	**$ 68,856**	**$ 68,856**	**$ -**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 38223MH
Program Name: Geriatric Services at Franklin
Document Date: 7/1/15

Appendix/Page #: B-3

Expenditure Category	TOTAL	General Fund	Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 72,872	$ 72,872				
Communications (landline, mobile, fax, internet)	$ 6,000	$ 6,000				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 1,873	$ 1,873				
Photocopying	$ -					
Printing	$ 914	$ 914				
Program Supplies	$ 900	$ 900				
Computer hardware/software	$ 456	$ 456				
General Operating:						
Training/Staff Development	$ 1,254	$ 1,254				
Insurance	$ 12,832	$ 12,832				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 13,418	$ 13,418				
Staff Travel:						
Local Travel	$ 13,600	$ 13,600				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
CONSULTANT/SUBCONTRACTOR (Provide Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -					
Other:						
Program Related: Water ($360), Coffee ($240), Snacks/Food ($780).	$ 1,380	$ 1,380				
Organizational Dues	$ 500	$ 500				
Subscriptions / Publications	$ 900	$ 900				
Client Related: Food ($600), Transportation ($420), Clothing ($360), Housing ($540)	$ 1,920	$ 1,920				
TOTAL OPERATING EXPENSE	**$ 128,819**	**$ 128,819**	**$ -**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 382213 / 3822G3
Program Name: Geriatric Intensive Case Management at Franklin
Document Date: 7/1/15

Appendix/Page #: B-3a

Expenditure Category	TOTAL	General Fund	Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 30,000	$ 30,000				
Communications (landline, mobile, fax, internet)	$ 2,300	$ 2,300				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 1,267	$ 1,267				
Photocopying	$ -					
Printing	$ -					
Program Supplies	$ -					
Computer hardware/software	$ 100	$ 100				
General Operating:						
Training/Staff Development	$ 400	$ 400				
Insurance	$ 857	$ 857				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 1,700	$ 1,700				
Staff Travel:						
Local Travel	$ 3,000	$ 3,000				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
CONSULTANT/SUBCONTRACTOR (Provide Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -					
Other:						
Program Related: Water ($264), Coffee ($180), Snacks/Food ($300).	$ 744	$ 744				
Organizational Dues	$ 250	$ 250				
Subscriptions / Publications	$ 150	$ 150				
Client Related: Food ($240), Transportation ($264), Clothing ($168), Housing ($180)	$ 852	$ 852				
Staff Recognition	$ 500	$ 500				
TOTAL OPERATING EXPENSE	**$ 42,120**	**$ 42,120**	**$ -**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 38JWMH
Program Name: Older Adult FSP at Turk
Document Date: 7/1/15

Appendix/Page #: B-4

Expenditure Category	TOTAL	General Fund	MHSA-CSS HMHMPROP63 PMHS63-1506 Fee For Service	MHSA-CSS HMHMPROP63 PMHS63-1506 CR Mode 60/72 Services	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:
Occupancy:						
Rent & Utilities	$ 47,640	$ 10,630	$ 37,010			
Communications (landline, mobile, fax, internet)	$ 30,115	$ 6,720	$ 23,395			
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 2,334	$ 357	$ 1,977			
Photocopying	$ -					
Printing	$ 35	$ 11	$ 24			
Program Supplies	$ 396	$ 132	$ 264			
Computer hardware/software	$ 1,445	$ 37	$ 1,408			
General Operating:						
Training/Staff Development	$ 2,958	$ 558	$ 2,400			
Insurance	$ 1,838	$ 276	$ 1,562			
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 960	$ 170	$ 790			
Staff Travel:						
Local Travel	$ 10,200	$ 1,740	$ 8,460			
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
Nurse Practitioner ($75/hrs x 40 /hrs over 5.0 months)	$ 15,000	$ 3,347	$ 11,653			
Other:						
Program Related: Water ($480), Coffee ($240), Snacks/Food ($420).	$ 1,140	$ 198	$ 942			
Organizational Dues	$ 250	$ 17	$ 233			
Subscriptions / Publications	$ 450	$ 45	$ 405			
Client Flexible Support Expenses - Food & Groceries	$ 26,130			$ 26,130		
Client Flexible Support Expenses - Housing	$ 4,355			$ 4,355		
Client Flexible Support Expenses - Transportation	$ 10,887			$ 10,887		
Client Flexible Support Expenses - Clothing including shoes	$ 2,244			$ 2,244		
Staff Recognition	$ 500	$ 56	$ 444			
TOTAL OPERATING EXPENSE	**$ 158,877**	**$ 24,294**	**$ 90,967**	**$ 43,616**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 3822SD
Program Name: Senior Drop-In Center at Curry Senior Center
Document Date: 7/1/15

Appendix/Page #: B-5

Expenditure Category	TOTAL	General Fund	MHSA-CSS HMHMPROP63 PMHS63-1506	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ -					
Communications (landline, mobile, fax, internet)	$ 636		$ 636			
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 214		$ 214			
Photocopying	$ -					
Printing	$ 100		$ 100			
Program Supplies	$ -					
Computer hardware/software	$ 100		$ 100			
General Operating:						
Training/Staff Development	$ 600		$ 600			
Insurance	$ 720		$ 720			
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 450		$ 450			
Staff Travel:						
Local Travel	$ 1,440		$ 1,440			
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
Subcontractor - Curry Senior Center - (Facility / space & staff support @ $3,950/month)	$ 47,400		$ 47,400			
Other:						
Program Related: Snacks/Food ($600), Misc. Supplies - Art & Crafts ($396).	$ 996		$ 996			
Organizational Dues	$ 150		$ 150			
Subscriptions / Publications	$ 50		$ 50			
Volunteer Stipends	$ 6,600		$ 6,600			
TOTAL OPERATING EXPENSE	$ 59,456	$ -	$ 59,456	$ -	$ -	$ -

DPH 4: Operating Expenses Detail

Program Code: 3822OP
Program Name: Adult Care Management
Document Date: 7/1/15

Appendix/Page #: B-6

Expenditure Category	TOTAL	General Fund	General Fund CR - Mode 60/72 Srvs	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 52,722	$ 52,722				
Communications (landline, mobile, fax, internet)	$ 15,000	$ 15,000				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 2,384	$ 2,384				
Photocopying	$ -					
Printing	$ -					
Program Supplies	$ -					
Computer hardware/software	$ 500	$ 500				
General Operating:						
Training/Staff Development	$ 144	$ 144				
Insurance	$ 7,600	$ 7,600				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 8,500	$ 8,500				
Staff Travel:						
Local Travel	$ 12,500	$ 12,500				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
Extra Clerical Support - provided by Office Team $27.00 /hr X 44.0 / hr/month X 12 /months	$ 14,256	14,256.00				
Other:						
Program Related: Water ($360), Coffee ($240), Snacks/Food ($480).	$ 1,080	$ 1,080				
Organizational Dues	$ 625	$ 625				
Subscriptions / Publications	$ 525	$ 525				
Volunteer Stipends	$ 5,800	$ 5,800				
Client Flexible Support Expenses - Food & Groceries	$ 10,140		$ 10,140			
Client Flexible Support Expenses - Housing	$ 468		$ 468			
Client Flexible Support Expenses - Transportation	$ 3,900		$ 3,900			
Client Flexible Support Expenses - Clothing including shoes	$ 1,092		$ 1,092			
Staff Recognition	$ 500	$ 500				
TOTAL OPERATING EXPENSE	**$ 137,736**	**$ 122,136**	**$ 15,600**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 3822A3
Program Name: Adult FSP
Document Date: 7/1/15

Appendix/Page #: B-6a

Expenditure Category	TOTAL	General Fund	MHSA-CSS HMHMPROP63 PMHS63-1505 Fee For Service	MHSA-CSS HMHMPROP63 PMHS63-1505 CR - Mode 60/72 Srvs	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:
Occupancy:						
Rent & Utilities	$ 47,200	$ 27,792	$ 19,408			
Communications (landline, mobile, fax, internet)	$ 14,400	$ 8,479	$ 5,921			
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 2,734	$ 1,603	$ 1,131			
Photocopying	$ -					
Printing	$ 200	$ 118	$ 82			
Program Supplies	$ -					
Computer hardware/software	$ 500	$ 294	$ 206			
General Operating:						
Training/Staff Development	$ 120	$ 71	$ 49			
Insurance	$ 4,800	$ 2,826	$ 1,974			
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 5,200	$ 3,062	$ 2,138			
Staff Travel:						
Local Travel	$ 7,960	$ 4,706	$ 3,254			
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
Extra Clerical Support - provided by Office Team $27.00 /hr X 34.0 / hr/month X 12 /months	$ 11,016	$ 6,493	$ 4,523			
Other:						
Program Related: Water ($360), Coffee ($240), Snacks/Food ($468).	$ 1,068	$ 642	$ 426			
Organizational Dues	$ 500	$ 275	$ 225			
Subscriptions / Publications	$ 300	$ 165	$ 135			
Volunteer Stipends	$ 4,740	$ 2,791	$ 1,949			
Client Flexible Support Expenses - Food & Groceries	$ 23,660			$ 23,660		
Client Flexible Support Expenses - Housing	$ 1,092			$ 1,092		
Client Flexible Support Expenses - Transportation	$ 9,100			$ 9,100		
Client Flexible Support Expenses - Clothing including shoes	$ 2,548			$ 2,548		
Staff Recognition	$ 500	$ 294	$ 206			
TOTAL OPERATING EXPENSE	**$ 137,638**	**$ 59,611**	**$ 41,627**	**$ 36,400**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 3822T3
Program Name: Transitional Age Youth (TAY) FSP
Document Date: 7/1/15

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Expenditure Category	TOTAL	General Fund	MHSA-CSS HMHMPROP63 PMHS63-1504 Fee For Service	MHSA-CSS HMHMPROP63 PMHS63-1504 CR - Mode 60/72 Srvs	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term: 7/01/15 - 6/30/16	Term:	Term:
Occupancy:						
Rent & Utilities	$ 38,744	$ 20,924	$ 17,820			
Communications (landline, mobile, fax, internet)	$ 9,100	$ 4,915	$ 4,185			
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 2,497	$ 1,302	$ 1,195			
Photocopying	$ -					
Printing	$ 664	$ 359	$ 305			
Program Supplies	$ -					
Computer hardware/software	$ 1,410	$ 761	$ 649			
General Operating:						
Training/Staff Development	$ 1,844	$ 996	$ 848			
Insurance	$ 2,000	$ 1,080	$ 920			
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 5,500	$ 2,970	$ 2,530			
Staff Travel:						
Local Travel	$ 8,000	$ 4,321	$ 3,679			
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
Extra Clerical Support - provided by Office Team $27.00 /hr X 25.0 / hr/month X 12 /months	$ 8,100	$ 4,537	$ 3,563			
Other:						
Program Related: Water ($300), Coffee ($192), Snacks/Food ($420).	$ 912	$ 587	$ 325			
Organizational Dues	$ 625	$ 162	$ 463			
Subscriptions / Publications	$ 300	$ 126	$ 174			
Volunteer Stipends	$ 2,340	$ 1,264	$ 1,076			
Client Flexible Support Expenses - Food & Groceries	$ 23,000			$ 23,000		
Client Flexible Support Expenses - Housing	$ 1,480			$ 1,480		
Client Flexible Support Expenses - Transportation	$ 9,000			$ 9,000		
Client Flexible Support Expenses - Clothing including shoes	$ 2,520			$ 2,520		
Staff Recognition	$ 500	$ 270	$ 230			
TOTAL OPERATING EXPENSE	**$ 118,536**	**$ 44,574**	**$ 37,962**	**$ 36,000**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: Fiscal Intermediary - FI
Program Name: POPS / ASO
Document Date: 7/1/15

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Expenditure Category	TOTAL	General Fund	Managed Care HMHMOPMGDCAR/ PHMGDC15	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ -					
Communications (landline, mobile, fax, internet)	$ -					
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ -					
Photocopying	$ -					
Printing	$ -					
Program Supplies	$ 840		$ 840			
Computer hardware/software	$ -					
General Operating:						
Training/Staff Development	$ -					
Insurance	$ 1,921	$ 404	$ 1,517			
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ -					
Staff Travel:						
Local Travel	$ -					
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
CONSULTANT/SUBCONTRACTOR (Provide Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -					
Other:						
TOTAL OPERATING EXPENSE	$ 2,761	$ 404	$ 2,357	$ -	$ -	$ -

DPH 4: Operating Expenses Detail

Program Code: 8990EP
Program Name: PREP - Cost Reimbursement
Document Date: 7/1/15

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Expenditure Category	TOTAL	General Fund	MHSA-CSS HMHMPROP63 PMHS63-1504	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 36,600		$ 36,600			
Communications (landline, mobile, fax, internet)	$ 6,300		$ 6,300			
Building Repair/Maintenance	$ 2,250		$ 2,250			
Materials & Supplies:						
Office Supplies & Postage	$ 1,810		$ 1,810			
Photocopying	$ -		$ -			
Printing	$ 1,350		$ 1,350			
Program Supplies	$ -		$ -			
Computer hardware/software	$ 895		$ 895			
General Operating:						
Training/Staff Development	$ 1,350		$ 1,350			
Insurance	$ 1,760		$ 1,760			
Professional License	$ -		$ -			
Permits	$ -		$ -			
Equipment Lease & Maintenance	$ 2,520		$ 2,520			
Staff Travel:						
Local Travel	$ 3,600		$ 3,600			
Out-of-Town Travel	$ -		$ -			
Field Expenses	$ -		$ -			
Consultant/Subcontractor:						
University of California, San Francisco - Subcontract	$ 119,412		$ 119,412			
Sojourner Truth Foster Family Agency - Subcontract	$ 19,638		$ 19,638			
Extra Clerical Support - provided by Office Team $27.00 /hr X 20 / hr/month X 12 /months	$ 5,840		$ 5,840			
Other:						
Program Related: Water ($420), Coffee ($360), Snacks/Food ($600).	$ 1,260		$ 1,260			
Subscriptions / Publications	$ 1,285		$ 1,285			
Meeting Costs	$ 1,800		$ 1,800			
Client Related: Food ($600), Transportation ($480), Clothing ($540), Housing ($240)	$ 1,680		$ 1,680			
Staff Recognition	$ 700		$ 700			
TOTAL OPERATING EXPENSE	**$ 210,050**	**$ -**	**$ 210,050**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 8990EP
Program Name: PREP - Fee-For-Service
Document Date: 7/1/15

Appendix/Page #: B-9a

Expenditure Category	TOTAL	General Fund	MHSA-CSS HMHMPROP63 PMHS63-1504	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 39,516		$ 39,516			
Communications (landline, mobile, fax, internet)	$ 8,080		$ 8,080			
Building Repair/Maintenance	$ 3,500		$ 3,500			
Materials & Supplies:						
Office Supplies & Postage	$ 2,200		$ 2,200			
Photocopying	$ -		$ -			
Printing	$ 2,540		$ 2,540			
Program Supplies	$ -		$ -			
Computer hardware/software	$ 3,127		$ 3,127			
General Operating:						
Training/Staff Development	$ 4,100		$ 4,100			
Insurance	$ 4,800		$ 4,800			
Professional Fees - Staff Recruitment	$ 2,500		$ 2,500			
Permits	$ -		$ -			
Equipment Lease & Maintenance	$ 5,000		$ 5,000			
Staff Travel:						
Local Travel	$ 12,000		$ 12,000			
Out-of-Town Travel	$ -		$ -			
Field Expenses	$ -		$ -			
Consultant/Subcontractor:						
Clinical Director (Michael Minzenberg - $115 hrly rate x 20.25 hrs/month x 12 mos	$ 27,945		$ 27,945			
			$ -			
Other:						
Program Related: Water ($420), Coffee ($360), Snacks/Food ($444).	$ 1,224		$ 1,224			
Subscriptions / Publications	$ 675		$ 675			
Client Related: Food ($480), Transportation ($360), Clothing ($360), Housing ($240)	$ 1,440		$ 1,440			
TOTAL OPERATING EXPENSE	**$ 118,647**	**$ -**	**$ 118,647**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 3822O1
Program Name: Full Circle OP
Document Date: 7/1/15

Appendix/Page #: B-10

Expenditure Category	TOTAL	General Fund (HMHMCP751594)	Family Mosaic Cap Medi-Cal (HMHMCP8828CH)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 45,067	$ 45,067				
Communications (landline, mobile, fax, internet)	$ 7,295	$ 7,295				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 1,612	$ 1,612				
Photocopying	$ -					
Printing	$ 230	$ 230				
Program Supplies	$ 264	$ 264				
Computer hardware/software	$ 500	$ 500				
General Operating:						
Training/Staff Development	$ 2,508	$ 2,508				
Insurance	$ 2,300	$ 2,300				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 5,620	$ 5,620				
Staff Travel:						
Local Travel	$ 6,547	$ 6,547				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
Sojourner Truth Foster Family Agency - Subcontract	$ 30,000	$ 30,000				
Other:						
Program Related: Water ($240), Coffee ($144), Snacks/Food ($300), Misc. Supplies - Games, Toys, Crafts ($312).	$ 996	$ 996				
Subscriptions / Publications	$ 300	$ 300				
TOTAL OPERATING EXPENSE	$ 103,239	$ 103,239	$ -	$ -	$ -	$ -

DPH 4: Operating Expenses Detail

Program Code: 382203
Program Name: Full Circle EPSDT
Document Date: 7/1/15

Appendix/Page #: B-11

Expenditure Category	TOTAL	General Fund (HMHMCP751594)	Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term:	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 56,035	$ 56,035				
Communications (landline, mobile, fax, internet)	$ 3,950	$ 3,950				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 600	$ 600				
Photocopying	$ -					
Printing	$ 300	$ 300				
Program Supplies	$ 869	$ 869				
Computer hardware/software	$ 1,000	$ 1,000				
General Operating:						
Training/Staff Development	$ 2,100	$ 2,100				
Insurance	$ 2,680	$ 2,680				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 5,490	$ 5,490				
Staff Travel:						
Local Travel	$ 3,810	$ 3,810				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
Sojourner Truth Foster Family Agency - Subcontract	$ 30,392	$ 30,392				
Clinical Director (8 weeks x 10Hrs X $40/hr)	$ 3,200	$ 3,200				
Other:						
Program Related: Water ($120), Coffee ($72), Snacks/Food ($192), Misc. Supplies - Games, Toys, Crafts ($144).	$ 528	$ 528				
Subscriptions / Publications	$ 140	$ 140				
TOTAL OPERATING EXPENSE	**$ 111,094**	**$ 111,094**	**$ -**	**$ -**	**$ -**	**$ -**

DPH 4: Operating Expenses Detail

Program Code: 3822SED
Program Name: SED / SOAR Partnership
Document Date: 7/1/15

Appendix/Page #: B-12

Expenditure Category	TOTAL	General Fund (HMHMCP751594)	Funding Source 1 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term:	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ 19,476	$ 19,476				
Communications (landline, mobile, fax, internet)	$ 1,660	$ 1,660				
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ 442	$ 442				
Photocopying	$ -					
Printing	$ -					
Program Supplies	$ -					
Computer hardware/software	$ -					
General Operating:						
Training/Staff Development	$ -					
Insurance	$ 1,950	$ 1,950				
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ 2,400	$ 2,400				
Staff Travel:						
Local Travel	$ 1,745	$ 1,745				
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
CONSULTANT/SUBCONTRACTOR (Provide Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -					
Other:						
Program Related: Misc. School Supplies ($120).	$ 120	$ 120				
TOTAL OPERATING EXPENSE	$ 27,793	$ 27,793	$ -	$ -	$ -	$ -

DPH 4: Operating Expenses Detail

Program Code: Fiscal Intermediary
Program Name: SFDPH MCAH / California Homes Visiting Program - Fiscal Intermediary
Document Date: 7/1/15
Appendix/Page #: B-13

Expenditure Category	TOTAL	General Fund (Include all Funding Sources with this Index Code)	Federal Title V Block Grant (HCHPMMCHADGR HCMC02)	Funding Source 2 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 3 (Include Funding Source Name and Index Code/Project Detail/CFDA#)	Funding Source 4 (Include Funding Source Name and Index Code/Project Detail/CFDA#)
	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term: 7/01/15 - 06/30/16	Term:	Term:	Term:
Occupancy:						
Rent & Utilities	$ -					
Communications (landline, mobile, fax, internet)	$ -					
Building Repair/Maintenance	$ -					
Materials & Supplies:						
Office Supplies & Postage	$ -					
Photocopying	$ -					
Printing	$ -					
Program Supplies	$ -					
Computer hardware/software	$ -					
General Operating:						
Training/Staff Development	$ -					
Insurance	$ -					
Professional License	$ -					
Permits	$ -					
Equipment Lease & Maintenance	$ -					
Staff Travel:						
Local Travel	$ -					
Out-of-Town Travel	$ -					
Field Expenses	$ -					
Consultant/Subcontractor:						
SFDPH Maternal, Child & Adolescent Health / California Homes Visiting Program - FSA as fiscal intermediary	$ 97,646		$ 97,646			
CONSULTANT/SUBCONTRACTOR (Provide Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -					
Other:						
TOTAL OPERATING EXPENSE	**$ 97,646**	**$ -**	**$ 97,646**	**$ -**	**$ -**	**$ -**

FY 14-15 BHS APPENDIX B
BUDGET DOCUMENTS

DPH 7: Contract-Wide Indirect Detail

Contractor Name/Program Name:	Family Service Agency of San Francisco
Document Date:	7/1/2015
Fiscal Year:	2015-16

1. SALARIES & BENEFITS

Position Title	FTE	Salaries
Chief Executive Officer	0.327	$ 72,398
Chief Operating Officer	0.374	$ 66,585
Director of Human Resources	0.374	$ 42,668
Chief Financial Officer	0.421	$ 50,930
Information Technology Director	0.421	$ 31,953
Controller	0.336	$ 27,672
Board Liason, Admin Asst. CEO	0.327	$ 14,854
QA Monitor/Admin Coordinator	0.421	$ 22,513
Human Resources Recruiter	0.374	$ 22,635
Human Resources Coordinator	0.421	$ 20,407
Payroll Manager	0.512	$ 30,423
Senior Accountant	0.374	$ 19,618
AP Manager	0.512	$ 30,580
Accounting Clerk	0.319	$ 11,261
Information Technology Supervisor	0.330	$ 20,804
Information Technology Specialist	0.327	$ 12,775
Facilities Manager	0.234	$ 11,424
Front Desk & Safety Supervisor	0.327	$ 11,709
SUBTOTAL SALARIES		$ 521,209
EMPLOYEE FRINGE BENEFITS	29.99%	$ 156,311
TOTAL SALARIES & BENEFITS		$ 677,520

2. OPERATING COSTS

Expense line item:	Amount
Occupancy (Space, Utilities, Security, Maint, Repairs, Garbage, Cleaning)	$ 108,376
Materials & Supplies	$ 34,912
Equipment (Rental & Maintenance)	$ 12,172
Admin & Management Fees (Payroll & Benefit Processing)	$ 39,069
Audit Fees	$ 27,892
Travel	$ 20,469
Professional Services (Legal & Consultants)	$ 92,397
Communications (landline, mobile, fax & internet)	$ 30,440
Insurance	$ 4,181
Training & Staff Development	$ 1,395
TOTAL OPERATING COSTS	$ 371,303
TOTAL INDIRECT COSTS (Salaries & Benefits + Operating Costs)	$ 1,048,823

Appendix D
Additional Terms

1. PROTECTED HEALTH INFORMATION AND BAA

The parties acknowledge that CITY is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information.

The parties acknowledge that CONTRACTOR is one of the following:

X☐ CONTRACTOR will render services under this contract that include possession or knowledge of identifiable Protected Health Information (PHI), such as health status, health care history, or payment for health care history obtained from CITY. Specifically, CONTRACTOR will:

- Create PHI
- Receive PHI
- Maintain PHI
- Transmit PHI and/or
- Access PHI

The Business Associate Agreement (BAA) in Appendix E is required. Please note that BAA requires attachments to be completed.

☐ CONTRACTOR will not have knowledge of, create, receive, maintain, transmit, or have access to any Protected Health Information (PHI), such as health status, health care history, or payment for health care history obtained from CITY.

The Business Associate Agreement is not required.

2. THIRD PARTY BENEFICIARIES

No third parties are intended by the parties hereto to be third party beneficiaries under this Agreement, and no action to enforce the terms of this Agreement may be brought against either party by any person who is not a party hereto.

17921 and 45 C.F.R. Section 164.402], as well as California Civil Code Sections 1798.29 and 1798.82.

b. **Breach Notification Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.
c. **Business Associate** is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information received from a covered entity, and shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.
d. **Covered Entity** means a health plan, a health care clearinghouse, or a health care provider who transmits any information in electronic form in connection with a transaction covered under HIPAA Regulations, and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.
e. **Data Aggregation** means the combining of Protected Information by the BA with the Protected Information received by the BA in its capacity as a BA of another CE, to permit data analyses that relate to the health care operations of the respective covered entities, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.
f. **Designated Record Set** means a group of records maintained by or for a CE, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.
g. **Electronic Protected Health Information** means Protected Health Information that is maintained in or transmitted by electronic media and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103. For the purposes of this Agreement, Electronic PHI includes all computerized data, as defined in California Civil Code Sections 1798.29 and 1798.82.
h. **Electronic Health Record** means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given to such term under the HITECT Act, including, but not limited to, 42 U.S.C. Section 17921.
i. **Health Care Operations** means any of the following activities: i) conducting quality assessment and improvement activities; ii) reviewing the competence or qualifications of health care professionals; iii) underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits; iv) conducting or arranging for medical review, legal services, and auditing functions; v) business planning development; vi) business management and general administrative activities of the entity. This shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.
j. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.
k. **Protected Health Information or PHI** means any information, including electronic PHI, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Sections 160.103

and 164.501. For the purposes of this Agreement, PHI includes all medical information and health insurance information as defined in California Civil Code Sections 56.05 and 1798.82.

l. **Protected Information** shall mean PHI provided by CE to BA or created, maintained, received or transmitted by BA on CE's behalf.

m. **Security Incident** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. **Unsecured PHI** means PHI that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute, and shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. Obligations of Business Associate.

a. **Permitted Uses.** BA may use, access, and/or disclose PHI only for the purpose of performing BA's obligations for or on behalf of the City and as permitted or required under the Contract [MOU] and Agreement, or as required by law. Further, BA shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE [45 C.F.R. Sections 164.502, 164.504(e)(2). and 164.504(e)(4)(i)].

b. **Permitted Disclosures.** BA shall disclose Protected Information only for the purpose of performing BA's obligations for or on behalf of the City and as permitted or required under the Contract [MOU] and Agreement, or as required by law. BA shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Agreement and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2. k. of the Agreement, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)]. BA may disclose PHI to a BA that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit Protected Information on its behalf, if the BA obtains

satisfactory assurances, in accordance with 45 C.F.R. Section 164.504(e)(1), that the subcontractor will appropriately safeguard the information [45 C.F.R. Section 164.502(e)(1)(ii)].

c. **Prohibited Uses and Disclosures.** BA shall not use or disclose PHI other than as permitted or required by the Contract and Agreement, or as required by law. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates [42 U.S.C. Section 17935(a) and 45 C.F.R. Section 164.522(a)(1)(vi)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2), and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Contract.

d. **Appropriate Safeguards.** BA shall take the appropriate security measures to protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the CE, and shall prevent any use or disclosure of PHI other than as permitted by the Contract or this Agreement, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.306, 164.308, 164.310, 164.312, 164.314 164.316, and 164.504(e)(2)(ii)(B). BA shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316, and 42 U.S.C. Section 17931. BA is responsible for any civil penalties assessed due to an audit or investigation of BA, in accordance with 42 U.S.C. Section 17934(c).

e. **Business Associate's Subcontractors and Agents.** BA shall ensure that any agents and subcontractors that create, receive, maintain or transmit Protected Information on behalf of BA, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph 2.d. above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2) through (e)(5); 45 C.F.R. Section 164.308(b)]. BA shall mitigate the effects of any such violation.

f. **Accounting of Disclosures.** Within ten (10) calendar days of a request by CE for an accounting of disclosures of Protected Information or upon any disclosure of Protected Information for which CE is required to account to an individual, BA and its agents and subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935 (c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents and subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an Electronic Health Record. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and

(iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure [45 C.F.R. 164.528(b)(2)]. If an individual or an individual's representative submits a request for an accounting directly to BA or its agents or subcontractors, BA shall forward the request to CE in writing within five (5) calendar days.

g. **Access to Protected Information.** BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within (5) days of request by CE to enable CE to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. 164.524.

h. **Amendment of Protected Information.** Within ten (10) days of a request by CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA and its agents and subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment or other documentation to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R Section 164.526. If an individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request and of any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

i. **Governmental Access to Records.** BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)]. BA shall provide CE a copy of any Protected Information and other documents and records that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

j. **Minimum Necessary.** BA, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the intended purpose of such use, disclosure, or request. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary" to accomplish the intended purpose in accordance with HIPAA and HIPAA Regulations.

k. **Data Ownership.** BA acknowledges that BA has no ownership rights with respect to the Protected Information.

l. **Notification of Breach. BA shall notify CE within 5 calendar days of any breach of Protected Information;** any use or disclosure of Protected Information not permitted by the Agreement; any Security Incident (except as otherwise provided below) related to Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by BA or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been,

or is reasonably believed by the BA to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. BA shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 42 U.S.C. Section 17932; 45 C.F.R. 164.410; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)]

m. **Breach Pattern or Practice by Business Associate's Subcontractors and Agents.** Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(iii), if the BA knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this Agreement, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the contractual arrangement with its subcontractor or agent, if feasible. **BA shall provide written notice to CE of any pattern of activity or practice of a subcontractor or agent that BA believes constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this Agreement within five (5) calendar days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.**

3. **Termination.**

a. **Material Breach.** A breach by BA of any provision of this Agreement, as determined by CE, shall constitute a material breach of the CONTRACT and this Agreement and shall provide grounds for immediate termination of the CONTRACT and this Agreement, any provision in the CONTRACT to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii)].

b. **Judicial or Administrative Proceedings.** CE may terminate the CONTRACT and this Agreement, effective immediately, if (i) BA is named as defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. **Effect of Termination.** Upon termination of the CONTRACT and this Agreement for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of Section 2 of this Agreement to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

d. **Civil and Criminal Penalties.** BA understands and agrees that it is subject to civil or criminal penalties applicable to BA for unauthorized use, access or disclosure or Protected Information in accordance with the HIPAA Regulations and the HITECH Act including, but not limited to, 42 U.S.C. 17934 (c).

e. **Disclaimer.** CE makes no warranty or representation that compliance by BA with this Agreement, HIPAA, the HITECH Act, or the HIPAA Regulations or corresponding California law provisions will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

4. **Amendment to Comply with Law.**

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the CONTRACT or this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable state or federal laws. CE may terminate the Contract upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the CONTRACT or this Agreement when requested by CE pursuant to this section or (ii) BA does not enter into an amendment to the Contract or this Agreement providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

5. **Reimbursement for Fines or Penalties.**

In the event that CE pays a fine to a state or federal regulatory agency, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of PHI by BA or its subcontractors or agents, then BA shall reimburse CE in the amount of such fine or penalties or damages within thirty (30) calendar days.

Attachments (links)

- ***Privacy, Data Security, and Compliance Attestations*** located at https://www.sfdph.org/dph/files/HIPAAdocs/PDSCAttestations.pdf
- ***Data Trading Partner Request to Access SFDPH Systems and Notice of Authorizer*** located at https://www.sfdph.org/dph/files/HIPAAdocs/DTPAuthorization.pdf
- ***User Agreement for Confidentiality, Data Security and Electronic Signature Form*** located at https://www.sfdph.org/dph/files/HIPAAdocs/2015Revisions/ConfSecElecSigAgr.pdf

Appendix E
San Francisco Department of Public Health
Business Associate Agreement

Office of Compliance and Privacy Affairs
San Francisco Department of Public Health
101 Grove Street, Room 330, San Francisco, CA 94102
Office email: compliance.privacy@sfdph.org
Office telephone: 415-554-2787
Confidential Privacy Hotline (Toll-Free): 1-855-729-6040
Confidential Compliance Hotline: 415-642-5790

FAMIL-9 OP ID: OS

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 07/17/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Farallone Pacific Insurance Services, License# 0F84441 859 Diablo Avenue Novato, CA 94947 Daniel J. Costello Phone: 415-493-2500 Fax: 415-493-2505	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED Family Service Agency of San Francisco 1500 Franklin Street San Francisco, CA 94109	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A : Cypress Insurance Company INSURER B : Philadelphia Insurance Co. INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR X Sex Abuse 1M/1M X Prof Liab 1M/2M GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC	X		PHPK1349638	07/01/2015	07/01/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG EEBenefit	$ 1,000,000 $ 1,000,000 $ 50,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $ $1M/$1M
B	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			PHPK1349638	07/01/2015	07/01/2016	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			PHUB502855	07/01/2015	07/01/2016	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		X	FAWC601150	01/01/2015	01/01/2016	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
B	Medical Malpractic			PHPK1349638	07/01/2015	07/01/2016	Med Mal	Incl with Prof Liab

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

City and County of San Francisco, Department of Public Health, its Officers, Agents, and Employees are named as Additional Insureds with respects to Named Insured's operations, per attached form PI-GLD-HS 10/11. Workers Compensation Waiver of Subrogation applies per attached form WC 99 04 02C (Ed. 9-14). SEE NOTEPAD FOR OTHER COVERAGES.

CERTIFICATE HOLDER

City & County of San Francisco
Department of Public Health
Attn: Ada Ling
1380 Howard Street, Room 419b
San Francisco, CA 94103

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Olivia Lykes

CRIME COVERAGE/EMPLOYEE DISHONESTY:
COMPANY: Philadelphia Indemnity Insurance Company
POLICY NUMBER: PHSD1041020
EFFECTIVE: 05/06/15 to 07/01/16
LIMIT: $2,000,000
DEDUCTIBLE: $ 10,000

MEDICAL MALPRACTICE/PROFESSIONAL LIABILITY - NOSE/PRIOR ACTS:
COMPANY: Tokio Marine Specialty Insurance Company
POLICY NUMBER: PPK1351153
EFFECTIVE: 07/01/15 to 07/01/20
LIMIT: $1,000,000 - Each Professional Incident
$3,000,000 - Aggregate
RETROACTIVE DATE: 07/01/86 (policy covers 07/01/86 to 06/30/15)
REPORTING PERIOD: 07/01/15 to 07/01/20

CYBER LIABILITY:
COMPANY: Philadelphia Indemnity Insurance Company
POLICY NUMBER: PHSD1056470
EFFECTIVE: 07/01/15 to 07/01/16
LIMITS:
$1,000,000 - Security Event Costs
$1,000,000 - Network Security and Privacy Liability Coverage
$1,000,000 - Employee Privacy Liability Coverage
$ 500,000 - Special Expenses Aggregate Limit
$ 500,000 - Customer Notification Expenses Sublimit
$ 500,000 - Public Relations Expenses Sublimit
$1,000,000 - Policy Aggregate Limit of Insurance
DEDUCTIBLE: $ 25,000
RETROACTIVE DATE: 07/01/15

VOLUNTEER & DAY CARE ACCIDENT:
COMPANY: Federal Insurance Company/Chubb
POLICY NUMBER: 9907-79-53
EFFECTIVE: 07/01/15 to 07/01/16
LIMITS: $ 50,000 - Accident Medical - Students & Volunteers
$ 10,000 - Accidental Death & Dismemberment - Per Person
$500,000 - AD&D Policy Aggregate - Per Accident
$ 1,000 - Dental
DEDUCTIBLE: $ 25

* * * * * * * * O R I G I N A L * * * * * * * * * *

CITY AND COUNTY OF SAN FRANCISCO PAGE :01

CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

TO: FAMILY SERVICE AGENCY OF SAN FRANCISCO
1010 GOUGH ST
SAN FRANCISCO CA 94109-7697

PO PRINT DATE: 12/20/2010

CONTACT:ROBERT W BENNETT, P
PHONE : 415-474-7310
VENDOR ID: 07426

TERMS: NET
FOB : DEST

BPO # : BPHM11000033 <<
EFF. DATE : 07/01/2010
EXP. DATE : 12/31/2015

ISSUE DATE : 12/23/2010

DELIVER TO: 1380 HOWARD ST 4TH FLOOR
SAN FRANCISCO CA 94103-0000

AUTHORIZED SIGNATURE: _____ DATE : 12/20/2010
PHONE:

ORIGINAL ORDER MUST BE SIGNED TO BE VALID

INVOICE TO: SUBSTANCE ABUSE & FORENSICS (HMI01)
1380 HOWARD ST - RM 444
SAN FRANCISCO CA 94103-0000

TERMS:

THIS CONTRACT PURCHASE ORDER AND THE ACCOMPANYING SIGNED CONTRACT AUTHORIZE YOU TO BEGIN PERFORMING THE CONTRACT AND INVOICING THE CITY. THIS IS SUBJECT TO THE TERMS AND CONDITIONS IN THE CONTRACT. ANY TERMS AND CONDITIONS ON THE REVERSE OF THIS DOCUMENT DO NOT APPLY.

YOU MUST INCLUDE THE CONTRACT PURCHASE ORDER NUMBER ON ALL INVOICES.

CONTINUED, NEXT PAGE

CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
1	7400-20	EA	N	1.00	2,339,932.0000	2,339,932.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

2	7400-20	EA	N	1.00	358,750.0000	358,750.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

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CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
3	7400-20	EA	N	1.00	80,400.0000	80,400.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
4	7400-20	EA	N	1.00	3,876.0000	3,876.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

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CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
5	7400-20 SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)	EA	N	1.00	8,467.0000	8,467.00

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

6	7400-20 SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)	EA	N	1.00	89,153.0000	89,153.00

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

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CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
7	7400-20	EA	N	1.00	2,500.0000	2,500.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
8	7400-20	EA	N	1.00	181,342.0000	181,342.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

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CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO.NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
9	7400-20 SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)	EA	N	1.00	294,818.0000	294,818.00

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
10	7400-20 SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)	EA	N	1.00	417,885.0000	417,885.00

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

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CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
11	7400-20	EA	N	1.00	458,800.0000	458,800.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE
12	7400-20	EA	N	1.00	44,500.0000	44,500.00

SVC,MED/HLTH;CMH (COMMUNITY MENTAL HEALTH)

AGREEMENT WITH FAMILY SERVICE AGENCY OF SF TO PROVIDE MENTAL HEALTH SERVICES.

7/1/10 - 12/31/10	$ 3,412,014	(BPHM07000084)
7/1/10 - 6/30/11	4,114,657	
7/1/11 - 6/30/12	7,428,328	
7/1/12 - 6/30/13	7,329,985	
7/1/13 - 6/30/14	7,329,985	
7/1/14 - 6/30/15	7,329,985	
7/1/15 - 12/31/15	3,664,993	
CONTINGENCY	$ 4,873,193	
TOTAL CONTRACT AMOUNT	$45,483,140	
LESS ENCUMBERED AMOUNT RELEASED FROM BPHM07000084	(3,412,014)	
BLANKET TOTAL	$42,071,126	

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CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

ITEM	COMMODITY ID NAME/SPECS	UOM	TAX	QUANTITY	UNIT PRICE	TOTAL PRICE

TOTAL ITEMS AMOUNT	$4,280,423.00
SALES TAX	$.00
INVOICE AMOUNT	$4,280,423.00

**** END OF ITEM LIST ****

CONTRACT PURCHASE ORDER RELEASE
COMMUNITY MENTAL HEALTH SYSTEM

PO NUMBER: DPHM11000275
PO AMOUNT: $4,280,423.00

SFX	INDEX	SUBOBJ	USERCODE	PROJCT	PRJDTL	GRANT	GRNTDTL	AMOUNT
01	HMHMCC730515	02789						2,339,932.00
02	HMHMCP751594	02789						358,750.00
03	HMHMOPMGDCAR	02789		PHMGDC	11			80,400.00
04	HMHMCP8828CH	02789						3,876.00
05	HMHMCHSRIPWO	02789						8,467.00
06	HMHMCHPFAPWO	02789						89,153.00
07	HCHPMFAMPLGR	02789				HCPM24	1100	2,500.00
08	HMHMPROP63	02789		PMHS63	1104			181,342.00
09	HMHMPROP63	02789		PMHS63	1105			294,818.00
10	HMHMPROP63	02789		PMHS63	1106			417,885.00
11	HMHMPROP63	02789		PMHS63	1110			458,800.00
12	HMHMPROP63	02789		PMHS63	1010			44,500.00
								4,280,423.00

ADPICS/FAMIS - FY 10-11
CITY/COUNTY OF SAN FRANCISCO
CONTRACT PURCHASE ORDER INPUT FORM

Original: X
Modification-Increase:
-Decrease:
Date Change Only:

DOCUMENT NUMBER: DPHM11000275 BPHM11000033

DEPARTMENT: 82 Mental Health & Substance Abuse
DEPARTMENT CONTRACT #: HM-11-6108-MH
DATE: 10/21/10
PAGE: 1 of 1
ORIGINAL CONTRACT NUMBER:
PERIOD COVERED: BEG 7/1/2010 END 6/30/2011

Complete for Contract Order type Agreements and Contracts

AMOUNT OF THIS ENCUMBRANCE: $4,114,657
TOTAL APPROVED CONTRACT: $ 45,483,140
OTHER DEPARTMENT INFORMATION CR NO: CMS 6974
CIVIL SERVICE RESOLUTION NO: 4152-09/10 6/21/10

CONTRACTOR: Family Service Agency of SF
ADDRESS: 1010 Gough Street, San Francisco, CA 94109
VENDOR NO: 07426 SUFFIX: 01
FEIN/SSN No: 94-1156530
Phone #: (415) 474-7310

DELIVER TO: Same

SEND INVOICES IN DUPLICATE (Inter-Office): PH&P Accounting Office, 1380 Howard St., Rm. 447, San Francisco, CA 94103

TERMS OF PAYMENT: Monthly
RETAINAGE REQUIRED, IF YES, AMOUNT OR %: YES/NO: NO

COMMODITY OR SERVICE CODE #: 7400-20 (CMHS)
PROFSERV -- BID

DETAILED DESCRIPTION OF SERVICES AND PRODUCTS

FY10-11 New Contract based on the award letter dated 9/27/10.

Contract Term: 07/01/10-12/31/15	Original Award:	Contingency Approved	Contingency Used	Encumb. Total	Contingency Still Avail.	Blanket Total
10-11 Prev Enc(BPHM07000084)	$ 3,412,014			$ 3,412,014		
→ 10-11 This Encu.	$ 4,114,657			$ 4,114,657		
11-12 To Be Encu.	$ 7,428,328					
12-13 To Be Encu.	$ 7,329,985					
13-14 To Be Encu.	$ 7,329,985					
14-15 To Be Encu.	$ 7,329,985					
15-16 To Be Encu.	$ 3,664,993					
Total contract	$ 40,609,947	$ 4,873,194	$ -	$ 7,526,671	$ 4,873,194	$ 45,483,140

INSURANCE

	REQUIRED	AMOUNT	EXPIRATION DATE	ATTACH
WORKER'S COMP		$1,000,000	1/1/11	X
COMP GEN. LIABILITY		$1,000,000	7/1/11	X
AUTOMOBILE		$1,000,000	7/1/11	X
UMBRELLA		$5,000,000	7/1/11	X
FIDELITY BOND/ COMM BLANKET	(= initial pyt amt)	$2,000,000	11/16/11	X
OTHER INSURANCE:	Prof.	$1,000,000	7/1/11	X

ATTACHMENTS - Please identify by title or description:

SYSTEM USE

PREPARED BY (Print): Ada Ling (Sr. Administrative Analyst)
Phone # 255-3493 Fax # 252-3088
APPROVED BY (Signature) (Print Name)

APPROVALS
BOARD OR COMMISSION
MATERIALS, SUPPLIES, & SERVICES - PURCHASER
REAL PROPERTY LEASES & RENT - DIRECTOR OF PROPERTY
CONTROLLER

Line No.	Document Number: Number	Suffix	Amount		Index Code	Sub-Object	User Code	Project	Project Detail	Grant	Grant Date	ADDENDUM ATTACHED
1			$2,339,932	00	HMHMCC730515	02789	SK 11/17/10					
			$358,750	00	HMHMCP751594	02789						
			($80,401)	00	HMHMOPMGDCAR	02789	SK 11/17/10					
			$160,801	00	HMHMOPMGDCAR	02789		PHMGDC	11			
			$3,876	00	HMHMCP8828CH	02789	SK 11/17/10					
Decrease from DPHM11000105 thru COHM11000214			($36,162)	00	HMHMCHCDHSWO	02789						
			($19,060)	00	HMHMCHCDYFWO	02789						
			$8,467	00	HMHMCHSRIPWO	02789	11/19/10					
			$89,153	00	HMHMCHPFAPWO	02789				HGPM24	1100	KC 11/22/10
			$2,500	00	HCHPMFAMPLGR	02789		~~PMHS63~~	~~1104~~			
			$181,342	00	HMHMPROP63	02789		PMHS63	1105			
			$294,818	00	HMHMPROP63	02789		PMHS63	1106			
			$417,885	00	HMHMPROP63	02789	11/15/10	PMHS63	1110			
			$458,800	00	HMHMPROP63	02789		PMHS63	1010			
			$44,500	00	HMHMPROP63	02789						
			($110,544)	00	HMHSCCRES227	02789	HFL 11/22/10					
	Total:		$4,114,657	00								

Exp Date: 6/30/11

Decrease $55,272 from DPHM11000105 thru COHM11000214

Back of these should be moved one line down. CK

City and County of San Francisco
Office of Contract Administration
Purchasing Division
City Hall, Room 430
1 Dr. Carlton B. Goodlett Place
San Francisco, California 94102-4685

Agreement between the City and County of San Francisco and

Family Service Agency of San Francisco

This Agreement is made this 1st day of July, 2010 in the City and County of San Francisco, State of California, by and between **Family Service Agency of San Francisco** hereinafter referred to as "Contractor," and the City and County of San Francisco, a municipal corporation, hereinafter referred to as "City," acting by and through its Director of the Office of Contract Administration or the Director's designated agent, hereinafter referred to as "Purchasing."

Recitals

WHEREAS, the Department of Public Health, Community Behavioral Health Services, ("Department") wishes to secure community based mental health services; and,

WHEREAS, a Request for Proposal ("RFP") was issued on **July 31, 2009** and City selected Contractor as the highest qualified scorer pursuant to the RFP; and

WHEREAS, Contractor represents and warrants that it is qualified to perform the services required by City as set forth under this Contract; and,

WHEREAS, approval for this Agreement was obtained when the Civil Service Commission approved Contract number PSC 4152-09/10 on June 21, 2010;

Now, THEREFORE, the parties agree as follows:

1. **Certification of Funds; Budget and Fiscal Provisions; Termination in the Event of Non-Appropriation.** This Agreement is subject to the budget and fiscal provisions of the City's Charter. Charges will accrue only after prior written authorization certified by the Controller, and the amount of City's obligation hereunder shall not at any time exceed the amount certified for the purpose and period stated in such advance authorization. This Agreement will terminate without penalty, liability or expense of any kind to City at the end of any fiscal year if funds are not appropriated for the next succeeding fiscal year. If funds are appropriated for a portion of the fiscal year, this Agreement will terminate, without penalty, liability or expense of any kind at the end of the term for which funds are appropriated. City has no obligation to make appropriations for this Agreement in lieu of appropriations for new or other agreements. City budget decisions are subject to the discretion of the Mayor and the Board of Supervisors. Contractor's assumption of risk of possible non-appropriation is part of the consideration for this Agreement.

THIS SECTION CONTROLS AGAINST ANY AND ALL OTHER PROVISIONS OF THIS AGREEMENT.

2. **Term of the Agreement.** Subject to Section 1, the term of this Agreement shall be from **July 1, 2010 to December 31, 2015.**

3. **Effective Date of Agreement.** This Agreement shall become effective when the Controller has certified to the availability of funds and Contractor has been notified in writing.

4. **Services Contractor Agrees to Perform.** The Contractor agrees to perform the services provided for in Appendix A, "Description of Services," attached hereto and incorporated by reference as though fully set forth herein.

5. **Compensation.** Compensation shall be made in monthly payments on or before the 30th day of each month for work, as set forth in Section 4 of this Agreement, that the **Director of the Department of Public Health**], in his or her sole discretion, concludes has been performed as of the **30th** day of the immediately preceding month. In no event shall the amount of this Agreement exceed **Forty Five Million Four Hundred Eighty Three Thousand One Hundred Forty Dollars ($45,483,140).** The breakdown of costs associated with this Agreement appears in Appendix B, "Calculation of Charges," attached hereto and incorporated by reference as though fully set forth herein. No charges shall be incurred under this Agreement nor shall any payments become due to Contractor until reports, services, or both, required under this Agreement are received from Contractor and approved by **Department of Public Health** as being in accordance with this Agreement. City may withhold payment to Contractor in any instance in which Contractor has failed or refused to satisfy any material obligation provided for under this Agreement. In no event shall City be liable for interest or late charges for any late payments.

6. **Guaranteed Maximum Costs.** The City's obligation hereunder shall not at any time exceed the amount certified by the Controller for the purpose and period stated in such certification. Except as may be provided by laws governing emergency procedures, officers and employees of the City are not authorized to request, and the City is not required to reimburse the Contractor for, Commodities or Services beyond the agreed upon contract scope unless the changed scope is authorized by amendment and approved as required by law. Officers and employees of the City are not authorized to offer or promise, nor is the City required to honor, any offered or promised additional funding in excess of the maximum amount of funding for which the contract is certified without certification of the additional amount by the Controller. The Controller is not authorized to make payments on any contract for which funds have not been certified as available in the budget or by supplemental appropriation.

7. **Payment; Invoice Format.** Invoices furnished by Contractor under this Agreement must be in a form acceptable to the Controller, and must include a unique invoice number and must conform to Appendix F. All amounts paid by City to Contractor shall be subject to audit by City. Payment shall be made by City to Contractor at the address specified in the section entitled "Notices to the Parties."

8. **Submitting False Claims; Monetary Penalties.** Pursuant to San Francisco Administrative Code §21.35, any contractor, subcontractor or consultant who submits a false claim shall be liable to the City for the statutory penalties set forth in that section. The text of Section 21.35, along with the entire San Francisco Administrative Code is available on the web at http://www.municode.com/Library/clientCodePage.aspx?clientID=4201. A contractor, subcontractor or consultant will be deemed to have submitted a false claim to the City if the contractor, subcontractor or consultant: (a) knowingly presents or causes to be presented to an officer or employee of the City a false claim or request for payment or approval; (b) knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the City; (c) conspires to defraud the City by getting a false claim allowed or paid by the City; (d) knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the City; or (e) is a beneficiary of an inadvertent submission of a false claim to the City, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the City within a reasonable time after discovery of the false claim.

9. **Disallowance.** If Contractor claims or receives payment from City for a service, reimbursement for which is later disallowed by the State of California or United States Government, Contractor shall promptly refund the disallowed amount to City upon City's request. At its option, City may offset the amount disallowed from any payment due or to become due to Contractor under this Agreement or any other Agreement. By executing this Agreement, Contractor certifies that Contractor is not suspended, debarred or otherwise excluded from participation in federal assistance programs. Contractor acknowledges that this certification of eligibility to receive federal funds is a material terms of the Agreement.

10. **Taxes.** Payment of any taxes, including possessory interest taxes and California sales and use taxes, levied upon or as a result of this Agreement, or the services delivered pursuant hereto, shall be the obligation of Contractor. Contractor recognizes and understands that this Agreement may create a "possessory interest" for property tax purposes. Generally, such a possessory interest is not created unless the Agreement entitles the Contractor to

possession, occupancy, or use of City property for private gain. If such a possessory interest is created, then the following shall apply:

1) Contractor, on behalf of itself and any permitted successors and assigns, recognizes and understands that Contractor, and any permitted successors and assigns, may be subject to real property tax assessments on the possessory interest;

2) Contractor, on behalf of itself and any permitted successors and assigns, recognizes and understands that the creation, extension, renewal, or assignment of this Agreement may result in a "change in ownership" for purposes of real property taxes, and therefore may result in a revaluation of any possessory interest created by this Agreement. Contractor accordingly agrees on behalf of itself and its permitted successors and assigns to report on behalf of the City to the County Assessor the information required by Revenue and Taxation Code section 480.5, as amended from time to time, and any successor provision.

3) Contractor, on behalf of itself and any permitted successors and assigns, recognizes and understands that other events also may cause a change of ownership of the possessory interest and result in the revaluation of the possessory interest. (see, e.g., Rev. & Tax. Code section 64, as amended from time to time). Contractor accordingly agrees on behalf of itself and its permitted successors and assigns to report any change in ownership to the County Assessor, the State Board of Equalization or other public agency as required by law.

4) Contractor further agrees to provide such other information as may be requested by the City to enable the City to comply with any reporting requirements for possessory interests that are imposed by applicable law.

11. Payment Does Not Imply Acceptance of Work. The granting of any payment by City, or the receipt thereof by Contractor, shall in no way lessen the liability of Contractor to replace unsatisfactory work, equipment, or materials, although the unsatisfactory character of such work, equipment or materials may not have been apparent or detected at the time such payment was made. Materials, equipment, components, or workmanship that do not conform to the requirements of this Agreement may be rejected by City and in such case must be replaced by Contractor without delay.

12. Qualified Personnel. Work under this Agreement shall be performed only by competent personnel under the supervision of and in the employment of Contractor. Contractor will comply with City's reasonable requests regarding assignment of personnel, but all personnel, including those assigned at City's request, must be supervised by Contractor. Contractor shall commit adequate resources to complete the project within the project schedule specified in this Agreement.

13. Responsibility for Equipment. City shall not be responsible for any damage to persons or property as a result of the use, misuse or failure of any equipment used by Contractor, or by any of its employees, even though such equipment be furnished, rented or loaned to Contractor by City.

14. Independent Contractor; Payment of Taxes and Other Expenses

a. **Independent Contractor.** Contractor or any agent or employee of Contractor shall be deemed at all times to be an independent contractor and is wholly responsible for the manner in which it performs the services and work requested by City under this Agreement. Contractor or any agent or employee of Contractor shall not have employee status with City, nor be entitled to participate in any plans, arrangements, or distributions by City pertaining to or in connection with any retirement, health or other benefits that City may offer its employees. Contractor or any agent or employee of Contractor is liable for the acts and omissions of itself, its employees and its agents. Contractor shall be responsible for all obligations and payments, whether imposed by federal, state or local law, including, but not limited to, FICA, income tax withholdings, unemployment compensation, insurance, and other similar responsibilities related to Contractor's performing services and work, or any agent or employee of Contractor providing same. Nothing in this Agreement shall be construed as creating an employment or agency relationship between City and Contractor or any agent or employee of Contractor. Any terms in this Agreement referring to direction from City shall be construed as providing for direction as to policy and the result of

Contractor's work only, and not as to the means by which such a result is obtained. City does not retain the right to control the means or the method by which Contractor performs work under this Agreement.

b. **Payment of Taxes and Other Expenses.** Should City, in its discretion, or a relevant taxing authority such as the Internal Revenue Service or the State Employment Development Division, or both, determine that. Contractor is an employee for purposes of collection of any employment taxes, the amounts payable under this Agreement shall be reduced by amounts equal to both the employee and employer portions of the tax due (and offsetting any credits for amounts already paid by Contractor which can be applied against this liability). City shall then forward those amounts to the relevant taxing authority. Should a relevant taxing authority determine a liability for past services performed by Contractor for City, upon notification of such fact by City, Contractor shall promptly remit such amount due or arrange with City to have the amount due withheld from future payments to Contractor under this Agreement (again, offsetting any amounts already paid by Contractor which can be applied as a credit against such liability). A determination of employment status pursuant to the preceding two paragraphs shall be solely for the purposes of the particular tax in question, and for all other purposes of this Agreement, Contractor shall not be considered an employee of City. Notwithstanding the foregoing, should any court, arbitrator, or administrative authority determine that Contractor is an employee for any other purpose, then Contractor agrees to a reduction in City's financial liability so that City's total expenses under this Agreement are not greater than they would have been had the court, arbitrator, or administrative authority determined that Contractor was not an employee.

15. Insurance

a. Without in any way limiting Contractor's liability pursuant to the "Indemnification" section of this Agreement, Contractor must maintain in force, during the full term of the Agreement, insurance in the following amounts and coverages:

1) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness; and

2) Commercial General Liability Insurance with limits not less than $1,000,000 each occurrence Combined Single Limit for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; and

3) Commercial Automobile Liability Insurance with limits not less than $1,000,000 each occurrence Combined Single Limit for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

4) Professional liability insurance, applicable to Contractor's profession, with limits not less than $1,000,000 each claim with respect to negligent acts, errors or omissions in connection with professional services to be provided under this Agreement.

5) Blanket Fidelity Bond (Commercial Blanket Bond) : Limits in the amount of the Initial Payment provided for in the Agreement - $ 1,612,000.

b. Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to provide:

1) Name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

2) That such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this Agreement, and that insurance applies separately to each insured against whom claim is made or suit is brought.

c. Regarding Workers' Compensation, Contractor hereby agrees to waive subrogation which any insurer of Contractor may acquire from Contractor by virtue of the payment of any loss. Contractor agrees to obtain any

endorsement that may be necessary to effect this waiver of subrogation. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Contractor, its employees, agents and subcontractors.

d. All policies shall provide thirty days' advance written notice to the City of reduction or nonrenewal of coverages or cancellation of coverages for any reason. Notices shall be sent to the City address in the "Notices to the Parties" section:

e. Should any of the required insurance be provided under a claims-made form, Contractor shall maintain such coverage continuously throughout the term of this Agreement and, without lapse, for a period of three years beyond the expiration of this Agreement, to the effect that, should occurrences during the contract term give rise to claims made after expiration of the Agreement, such claims shall be covered by such claims-made policies.

f. Should any of the required insurance be provided under a form of coverage that includes a general annual aggregate limit or provides that claims investigation or legal defense costs be included in such general annual aggregate limit, such general annual aggregate limit shall be double the occurrence or claims limits specified above.

g. Should any required insurance lapse during the term of this Agreement, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this Agreement, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this Agreement effective on the date of such lapse of insurance.

h. Before commencing any operations under this Agreement, Contractor shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in form evidencing all coverages set forth above. Failure to maintain insurance shall constitute a material breach of this Agreement.

i. Approval of the insurance by City shall not relieve or decrease the liability of Contractor hereunder.

16. Indemnification

Contractor shall indemnify and save harmless City and its officers, agents and employees from, and, if requested, shall defend them against any and all loss, cost, damage, injury, liability, and claims thereof for injury to or death of a person, including employees of Contractor or loss of or damage to property, arising directly or indirectly from Contractor's performance of this Agreement, including, but not limited to, Contractor's use of facilities or equipment provided by City or others, regardless of the negligence of, and regardless of whether liability without fault is imposed or sought to be imposed on City, except to the extent that such indemnity is void or otherwise unenforceable under applicable law in effect on or validly retroactive to the date of this Agreement, and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City and is not contributed to by any act of, or by any omission to perform some duty imposed by law or agreement on Contractor, its subcontractors or either's agent or employee. The foregoing indemnity shall include, without limitation, reasonable fees of attorneys, consultants and experts and related costs and City's costs of investigating any claims against the City. In addition to Contractor's obligation to indemnify City, Contractor specifically acknowledges and agrees that it has an immediate and independent obligation to defend City from any claim which actually or potentially falls within this indemnification provision, even if the allegations are or may be groundless, false or fraudulent, which obligation arises at the time such claim is tendered to Contractor by City and continues at all times thereafter. Contractor shall indemnify and hold City harmless from all loss and liability, including attorneys' fees, court costs and all other litigation expenses for any infringement of the patent rights, copyright, trade secret or any other proprietary right or trademark, and all other intellectual property claims of any person or persons in consequence of the use by City, or any of its officers or agents, of articles or services to be supplied in the performance of this Agreement.

17. Incidental and Consequential Damages. Contractor shall be responsible for incidental and consequential damages resulting in whole or in part from Contractor's acts or omissions. Nothing in this Agreement shall constitute a waiver or limitation of any rights that City may have under applicable law.

18. Liability of City. CITY'S PAYMENT OBLIGATIONS UNDER THIS AGREEMENT SHALL BE LIMITED TO THE PAYMENT OF THE COMPENSATION PROVIDED FOR IN SECTION 5 OF THIS AGREEMENT. NOTWITHSTANDING ANY OTHER PROVISION OF THIS AGREEMENT, IN NO EVENT SHALL CITY BE LIABLE, REGARDLESS OF WHETHER ANY CLAIM IS BASED ON CONTRACT OR TORT, FOR ANY SPECIAL, CONSEQUENTIAL, INDIRECT OR INCIDENTAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES PERFORMED IN CONNECTION WITH THIS AGREEMENT.

19. Left blank by agreement of the parties. (Liquidated damages)

20. Default; Remedies. Each of the following shall constitute an event of default ("Event of Default") under this Agreement:

(1) Contractor fails or refuses to perform or observe any term, covenant or condition contained in any of the following Sections of this Agreement:

8. Submitting False Claims; Monetary Penalties.
10. Taxes
15. Insurance
24. Proprietary or confidential information of City
30. Assignment
37. Drug-free workplace policy,
53. Compliance with laws
55. Supervision of minors
57. Protection of private information
58. Graffiti removal

And, item 1 of Appendix D attached to this Agreement

2) Contractor fails or refuses to perform or observe any other term, covenant or condition contained in this Agreement, and such default continues for a period of ten days after written notice thereof from City to Contractor.

3) Contractor (a) is generally not paying its debts as they become due, (b) files, or consents by answer or otherwise to the filing against it of, a petition for relief or reorganization or arrangement or any other petition in bankruptcy or for liquidation or to take advantage of any bankruptcy, insolvency or other debtors' relief law of any jurisdiction, (c) makes an assignment for the benefit of its creditors, (d) consents to the appointment of a custodian, receiver, trustee or other officer with similar powers of Contractor or of any substantial part of Contractor's property or (e) takes action for the purpose of any of the foregoing.

4) A court or government authority enters an order (a) appointing a custodian, receiver, trustee or other officer with similar powers with respect to Contractor or with respect to any substantial part of Contractor's property, (b) constituting an order for relief or approving a petition for relief or reorganization or arrangement or any other petition in bankruptcy or for liquidation or to take advantage of any bankruptcy, insolvency or other debtors' relief law of any jurisdiction or (c) ordering the dissolution, winding-up or liquidation of Contractor.

b. On and after any Event of Default, City shall have the right to exercise its legal and equitable remedies, including, without limitation, the right to terminate this Agreement or to seek specific performance of all or any part of this Agreement. In addition, City shall have the right (but no obligation) to cure (or cause to be cured) on behalf of Contractor any Event of Default; Contractor shall pay to City on demand all costs and expenses incurred by City in effecting such cure, with interest thereon from the date of incurrence at the maximum rate then permitted by law. City shall have the right to offset from any amounts due to Contractor under this Agreement or any other agreement between City and Contractor all damages, losses, costs or expenses incurred by City as a result of such Event of Default and any liquidated damages due from Contractor pursuant to the terms of this Agreement or any other agreement.

c. All remedies provided for in this Agreement may be exercised individually or in combination with any other remedy available hereunder or under applicable laws, rules and regulations. The exercise of any remedy shall not preclude or in any way be deemed to waive any other remedy.

21. Termination for Convenience

a. City shall have the option, in its sole discretion, to terminate this Agreement, at any time during the term hereof, for convenience and without cause. City shall exercise this option by giving Contractor written notice of termination. The notice shall specify the date on which termination shall become effective.

b. Upon receipt of the notice, Contractor shall commence and perform, with diligence, all actions necessary on the part of Contractor to effect the termination of this Agreement on the date specified by City and to minimize the liability of Contractor and City to third parties as a result of termination. All such actions shall be subject to the prior approval of City. Such actions shall include, without limitation:

1) Halting the performance of all services and other work under this Agreement on the date(s) and in the manner specified by City.

2) Not placing any further orders or subcontracts for materials, services, equipment or other items.

3) Terminating all existing orders and subcontracts.

4) At City's direction, assigning to City any or all of Contractor's right, title, and interest under the orders and subcontracts terminated. Upon such assignment, City shall have the right, in its sole discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts.

5) Subject to City's approval, settling all outstanding liabilities and all claims arising out of the termination of orders and subcontracts.

6) Completing performance of any services or work that City designates to be completed prior to the date of termination specified by City.

7) Taking such action as may be necessary, or as the City may direct, for the protection and preservation of any property related to this Agreement which is in the possession of Contractor and in which City has or may acquire an interest.

c. Within 30 days after the specified termination date, Contractor shall submit to City an invoice, which shall set forth each of the following as a separate line item:

1) The reasonable cost to Contractor, without profit, for all services and other work City directed Contractor to perform prior to the specified termination date, for which services or work City has not already tendered payment. Reasonable costs may include a reasonable allowance for actual overhead, not to exceed a total of 10% of Contractor's direct costs for services or other work. Any overhead allowance shall be separately itemized. Contractor may also recover the reasonable cost of preparing the invoice.

2) A reasonable allowance for profit on the cost of the services and other work described in the immediately preceding subsection (1), provided that Contractor can establish, to the satisfaction of City, that Contractor would have made a profit had all services and other work under this Agreement been completed, and provided further, that the profit allowed shall in no event exceed 5% of such cost.

3) The reasonable cost to Contractor of handling material or equipment returned to the vendor, delivered to the City or otherwise disposed of as directed by the City.

4) A deduction for the cost of materials to be retained by Contractor, amounts realized from the sale of materials and not otherwise recovered by or credited to City, and any other appropriate credits to City against the cost of the services or other work.

d. In no event shall City be liable for costs incurred by Contractor or any of its subcontractors after the termination date specified by City, except for those costs specifically enumerated and described in the immediately preceding subsection (c). Such non-recoverable costs include, but are not limited to, anticipated profits on this Agreement, post-termination employee salaries, post-termination administrative expenses, post-termination

overhead or unabsorbed overhead, attorneys' fees or other costs relating to the prosecution of a claim or lawsuit, prejudgment interest, or any other expense which is not reasonable or authorized under such subsection (c).

e. In arriving at the amount due to Contractor under this Section, City may deduct: (1) all payments previously made by City for work or other services covered by Contractor's final invoice; (2) any claim which City may have against Contractor in connection with this Agreement; (3) any invoiced costs or expenses excluded pursuant to the immediately preceding subsection (d); and (4) in instances in which, in the opinion of the City, the cost of any service or other work performed under this Agreement is excessively high due to costs incurred to remedy or replace defective or rejected services or other work, the difference between the invoiced amount and City's estimate of the reasonable cost of performing the invoiced services or other work in compliance with the requirements of this Agreement.

f. City's payment obligation under this Section shall survive termination of this Agreement.

22. **Rights and Duties upon Termination or Expiration.** This Section and the following Sections of this Agreement shall survive termination or expiration of this Agreement:

8. Submitting false claims	26. Ownership of Results
9. Disallowance	27. Works for Hire
10. Taxes	28. Audit and Inspection of Records
11. Payment does not imply acceptance of work	48. Modification of Agreement.
13. Responsibility for equipment	49. Administrative Remedy for Agreement Interpretation.
14. Independent Contractor; Payment of Taxes and Other Expenses	50. Agreement Made in California; Venue
15. Insurance	51. Construction
16. Indemnification	52. Entire Agreement
17. Incidental and Consequential Damages	56. Severability
18. Liability of City	57. Protection of private information
24. Proprietary or confidential information of City	And, item 1 of Appendix D attached to this Agreement.

Subject to the immediately preceding sentence, upon termination of this Agreement prior to expiration of the term specified in Section 2, this Agreement shall terminate and be of no further force or effect. Contractor shall transfer title to City, and deliver in the manner, at the times, and to the extent, if any, directed by City, any work in progress, completed work, supplies, equipment, and other materials produced as a part of, or acquired in connection with the performance of this Agreement, and any completed or partially completed work which, if this Agreement had been completed, would have been required to be furnished to City. This subsection shall survive termination of this Agreement.

23. **Conflict of Interest.** Through its execution of this Agreement, Contractor acknowledges that it is familiar with the provision of Section 15.103 of the City's Charter, Article III, Chapter 2 of City's Campaign and Governmental Conduct Code, and Section 87100 et seq. and Section 1090 et seq. of the Government Code of the State of California, and certifies that it does not know of any facts which constitutes a violation of said provisions and agrees that it will immediately notify the City if it becomes aware of any such fact during the term of this Agreement.

24. **Proprietary or Confidential Information of City**

a. Contractor understands and agrees that, in the performance of the work or services under this Agreement or in contemplation thereof, Contractor may have access to private or confidential information which may be owned or controlled by City and that such information may contain proprietary or confidential details, the disclosure of which to third parties may be damaging to City. Contractor agrees that all information disclosed by City to Contractor shall be held in confidence and used only in performance of the Agreement. Contractor shall exercise the same standard of care to protect such information as a reasonably prudent contractor would use to protect its own proprietary data.

b. Contractor shall maintain the usual and customary records for persons receiving Services under this Agreement. Contractor agrees that all private or confidential information concerning persons receiving Services under this Agreement, whether disclosed by the City or by the individuals themselves, shall be held in the strictest confidence, shall be used only in performance of this Agreement, and shall be disclosed to third parties only as authorized by law. Contractor understands and agrees that this duty of care shall extend to confidential information contained or conveyed in any form, including but not limited to documents, files, patient or client records, facsimiles, recordings, telephone calls, telephone answering machines, voice mail or other telephone voice recording systems, computer files, e-mail or other computer network communications, and computer backup files, including disks and hard copies. The City reserves the right to terminate this Agreement for default if Contractor violates the terms of this section.

c. Contractor shall maintain its books and records in accordance with the generally accepted standards for such books and records for five years after the end of the fiscal year in which Services are furnished under this Agreement. Such access shall include making the books, documents and records available for inspection, examination or copying by the City, the California Department of Health Services or the U.S. Department of Health and Human Services and the Attorney General of the United States at all reasonable times at the Contractor's place of business or at such other mutually agreeable location in California. This provision shall also apply to any subcontract under this Agreement and to any contract between a subcontractor and related organizations of the subcontractor, and to their books, documents and records. The City acknowledges its duties and responsibilities regarding such records under such statutes and regulations.

d. The City owns all records of persons receiving Services and all fiscal records funded by this Agreement if Contractor goes out of business. Contractor shall immediately transfer possession of all these records if Contractor goes out of business. If this Agreement is terminated by either party, or expires, records shall be submitted to the City upon request.

e. All of the reports, information, and other materials prepared or assembled by Contractor under this Agreement shall be submitted to the Department of Public Health Contract Administrator and shall not be divulged by Contractor to any other person or entity without the prior written permission of the Contract Administrator listed in Appendix A.

25. Notices to the Parties. Unless otherwise indicated elsewhere in this Agreement, all written communications sent by the parties may be by U.S. mail, e-mail or by fax, and shall be addressed as follows:

To CITY:	Office of Contract Management and Compliance Department of Public Health 1380 Howard Street, Room 442 San Francisco, California 94103	FAX: e-mail:	(415) 252-3088 Ada.ling@sfdph.org
And:	Hilda M. Jones, Program Manager Contract Development & Technical Assistance Department of Public Health 1380 Howard Street, 5/F San Francisco, California 94103	FAX: e-mail:	(415) 255-3567 Hilda.jones@sfdph.org
To CONTRACTOR:	1010 Gough Street San Francisco, CA 94109	FAX: e-mail:	(415)563-2097 bbennett@fsasf.org

Any notice of default must be sent by registered mail.

26. Ownership of Results. Any interest of Contractor or its Subcontractors, in drawings, plans, specifications, blueprints, studies, reports, memoranda, computation sheets, computer files and media or other documents prepared by Contractor or its subcontractors in connection with services to be performed under this Agreement, shall become the property of and will be transmitted to City. However, Contractor may retain and use copies for reference and as documentation of its experience and capabilities.

27. **Works for Hire.** If, in connection with services performed under this Agreement, Contractor or its subcontractors create artwork, copy, posters, billboards, photographs, videotapes, audiotapes, systems designs, software, reports, diagrams, surveys, blueprints, source codes or any other original works of authorship, such works of authorship shall be works for hire as defined under Title 17 of the United States Code, and all copyrights in such works are the property of the City. If it is ever determined that any works created by Contractor or its subcontractors under this Agreement are not works for hire under U.S. law, Contractor hereby assigns all copyrights to such works to the City, and agrees to provide any material and execute any documents necessary to effectuate such assignment. With the approval of the City, Contractor may retain and use copies of such works for reference and as documentation of its experience and capabilities.

28. **Audit and Inspection of Records**

a. Contractor agrees to maintain and make available to the City, during regular business hours, accurate books and accounting records relating to its work under this Agreement. Contractor will permit City to audit, examine and make excerpts and transcripts from such books and records, and to make audits of all invoices, materials, payrolls, records or personnel and other data related to all other matters covered by this Agreement, whether funded in whole or in part under this Agreement. Contractor shall maintain such data and records in an accessible location and condition for a period of not less than five years after final payment under this Agreement or until after final audit has been resolved, whichever is later. The State of California or any federal agency having an interest in the subject matter of this Agreement shall have the same rights conferred upon City by this Section.

b. Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report and the associated management letter(s) shall be transmitted to the Director of Public Health or his /her designee within one hundred eighty (180) calendar days following Contractor's fiscal year end date. If Contractor expends $500,000 or more in Federal funding per year, from any and all Federal awards, said audit shall be conducted in accordance with OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. Said requirements can be found at the following website address: http://www.whitehouse.gov/omb/circulars/a133/a133.html. If Contractor expends less than $500,000 a year in Federal awards, Contractor is exempt from the single audit requirements for that year, but records must be available for review or audit by appropriate officials of the Federal Agency, pass-through entity and General Accounting Office. Contractor agrees to reimburse the City any cost adjustments necessitated by this audit report. Any audit report which addresses all or part of the period covered by this Agreement shall treat the service components identified in the detailed descriptions attached to Appendix A and referred to in the Program Budgets of Appendix B as discrete program entities of the Contractor.

c. The Director of Public Health or his / her designee may approve of a waiver of the aforementioned audit requirement if the contractual Services are of a consulting or personal services nature, these Services are paid for through fee for service terms which limit the City's risk with such contracts, and it is determined that the work associated with the audit would produce undue burdens or costs and would provide minimal benefits. A written request for a waiver must be submitted to the DIRECTOR ninety (90) calendar days before the end of the Agreement term or Contractor's fiscal year, whichever comes first.

d. Any financial adjustments necessitated by this audit report shall be made by Contractor to the City. If Contractor is under contract to the City, the adjustment may be made in the next subsequent billing by Contractor to the City, or may be made by another written schedule determined solely by the City. In the event Contractor is not under contract to the City, written arrangements shall be made for audit adjustments.

29. **Subcontracting.** Contractor is prohibited from subcontracting this Agreement or any part of it unless such subcontracting is first approved by City in writing. Neither party shall, on the basis of this Agreement, contract on behalf of or in the name of the other party. An agreement made in violation of this provision shall confer no rights on any party and shall be null and void.

30. **Assignment.** The services to be performed by Contractor are personal in character and neither this Agreement nor any duties or obligations hereunder may be assigned or delegated by the Contractor unless first approved by City by written instrument executed and approved in the same manner as this Agreement.

31. **Non-Waiver of Rights.** The omission by either party at any time to enforce any default or right reserved to it, or to require performance of any of the terms, covenants, or provisions hereof by the other party at the time designated, shall not be a waiver of any such default or right to which the party is entitled, nor shall it in any way affect the right of the party to enforce such provisions thereafter.

32. **Earned Income Credit (EIC) Forms.** Administrative Code section 120 requires that employers provide their employees with IRS Form W-5 (The Earned Income Credit Advance Payment Certificate) and the IRS EIC Schedule, as set forth below. Employers can locate these forms at the IRS Office, on the Internet, or anywhere that Federal Tax Forms can be found. Contractor shall provide EIC Forms to each Eligible Employee at each of the following times: (i) within thirty days following the date on which this Agreement becomes effective (unless Contractor has already provided such EIC Forms at least once during the calendar year in which such effective date falls); (ii) promptly after any Eligible Employee is hired by Contractor; and (iii) annually between January 1 and January 31 of each calendar year during the term of this Agreement. Failure to comply with any requirement contained in subparagraph (a) of this Section shall constitute a material breach by Contractor of the terms of this Agreement. If, within thirty days after Contractor receives written notice of such a breach, Contractor fails to cure such breach or, if such breach cannot reasonably be cured within such period of thirty days, Contractor fails to commence efforts to cure within such period or thereafter fails to diligently pursue such cure to completion, the City may pursue any rights or remedies available under this Agreement or under applicable law. Any Subcontract entered into by Contractor shall require the subcontractor to comply, as to the subcontractor's Eligible Employees, with each of the terms of this section. Capitalized terms used in this Section and not defined in this Agreement shall have the meanings assigned to such terms in Section 120 of the San Francisco Administrative Code.

33. **Local Business Enterprise Utilization; Liquidated Damages**

a. The LBE Ordinance.

Contractor, shall comply with all the requirements of the Local Business Enterprise and Non-Discrimination in Contracting Ordinance set forth in Chapter 14B of the San Francisco Administrative Code as it now exists or as it may be amended in the future (collectively the "LBE Ordinance"), provided such amendments do not materially increase Contractor's obligations or liabilities, or materially diminish Contractor's rights, under this Agreement. Such provisions of the LBE Ordinance are incorporated by reference and made a part of this Agreement as though fully set forth in this section. Contractor's willful failure to comply with any applicable provisions of the LBE Ordinance is a material breach of Contractor's obligations under this Agreement and shall entitle City, subject to any applicable notice and cure provisions set forth in this Agreement, to exercise any of the remedies provided for under this Agreement, under the LBE Ordinance or otherwise available at law or in equity, which remedies shall be cumulative unless this Agreement expressly provides that any remedy is exclusive. In addition, Contractor shall comply fully with all other applicable local, state and federal laws prohibiting discrimination and requiring equal opportunity in contracting, including subcontracting.

b. Compliance and Enforcement

If Contractor willfully fails to comply with any of the provisions of the LBE Ordinance, the rules and regulations implementing the LBE Ordinance, or the provisions of this Agreement pertaining to LBE participation, Contractor shall be liable for liquidated damages in an amount equal to Contractor's net profit on this Agreement, or 10% of the total amount of this Agreement, or $1,000, whichever is greatest. The Director of the City's Human Rights Commission or any other public official authorized to enforce the LBE Ordinance (separately and collectively, the "Director of HRC") may also impose other sanctions against Contractor authorized in the LBE Ordinance, including declaring the Contractor to be irresponsible and ineligible to contract with the City for a period of up to five years or revocation of the Contractor's LBE certification. The Director of HRC will determine the sanctions to be imposed, including the amount of liquidated damages, after investigation pursuant to Administrative Code §14B.17.

By entering into this Agreement, Contractor acknowledges and agrees that any liquidated damages assessed by the Director of the HRC shall be payable to City upon demand. Contractor further acknowledges and agrees that any liquidated damages assessed may be withheld from any monies due to Contractor on any contract with City.

Contractor agrees to maintain records necessary for monitoring its compliance with the LBE Ordinance for a period of three years following termination or expiration of this Agreement, and shall make such records available for audit and inspection by the Director of HRC or the Controller upon request.

34. **Nondiscrimination; Penalties**

a. **Contractor Shall Not Discriminate.** In the performance of this Agreement, Contractor agrees not to discriminate against any employee, City and County employee working with such contractor or subcontractor, applicant for employment with such contractor or subcontractor, or against any person seeking accommodations, advantages, facilities, privileges, services, or membership in all business, social, or other establishments or organizations, on the basis of the fact or perception of a person's race, color, creed, religion, national origin, ancestry, age, height, weight, sex, sexual orientation, gender identity, domestic partner status, marital status, disability or Acquired Immune Deficiency Syndrome or HIV status (AIDS/HIV status), or association with members of such protected classes, or in retaliation for opposition to discrimination against such classes.

b. **Subcontracts.** Contractor shall incorporate by reference in all subcontracts the provisions of §§12B.2(a), 12B.2(c)-(k), and 12C.3 of the San Francisco Administrative Code (copies of which are available from Purchasing) and shall require all subcontractors to comply with such provisions. Contractor's failure to comply with the obligations in this subsection shall constitute a material breach of this Agreement.

c. **Nondiscrimination in Benefits.** Contractor does not as of the date of this Agreement and will not during the term of this Agreement, in any of its operations in San Francisco, on real property owned by San Francisco, or where work is being performed for the City elsewhere in the United States, discriminate in the provision of bereavement leave, family medical leave, health benefits, membership or membership discounts, moving expenses, pension and retirement benefits or travel benefits, as well as any benefits other than the benefits specified above, between employees with domestic partners and employees with spouses, and/or between the domestic partners and spouses of such employees, where the domestic partnership has been registered with a governmental entity pursuant to state or local law authorizing such registration, subject to the conditions set forth in §12B.2(b) of the San Francisco Administrative Code.

d. **Condition to Contract.** As a condition to this Agreement, Contractor shall execute the "Chapter 12B Declaration: Nondiscrimination in Contracts and Benefits" form (form HRC-12B-101) with supporting documentation and secure the approval of the form by the San Francisco Human Rights Commission.

e. **Incorporation of Administrative Code Provisions by Reference.** The provisions of Chapters 12B and 12C of the San Francisco Administrative Code are incorporated in this Section by reference and made a part of this Agreement as though fully set forth herein. Contractor shall comply fully with and be bound by all of the provisions that apply to this Agreement under such Chapters, including but not limited to the remedies provided in such Chapters. Without limiting the foregoing, Contractor understands that pursuant to §§12B.2(h) and 12C.3(g) of the San Francisco Administrative Code, a penalty of $50 for each person for each calendar day during which such person was discriminated against in violation of the provisions of this Agreement may be assessed against Contractor and/or deducted from any payments due Contractor.

35. **MacBride Principles—Northern Ireland.** Pursuant to San Francisco Administrative Code §12F.5, the City and County of San Francisco urges companies doing business in Northern Ireland to move towards resolving employment inequities, and encourages such companies to abide by the MacBride Principles. The City and County of San Francisco urges San Francisco companies to do business with corporations that abide by the MacBride Principles. By signing below, the person executing this agreement on behalf of Contractor acknowledges and agrees that he or she has read and understood this section.

36. **Tropical Hardwood and Virgin Redwood Ban.** Pursuant to §804(b) of the San Francisco Environment Code, the City and County of San Francisco urges contractors not to import, purchase, obtain, or use for any purpose, any tropical hardwood, tropical hardwood wood product, virgin redwood or virgin redwood wood product.

37. **Drug-Free Workplace Policy.** Contractor acknowledges that pursuant to the Federal Drug-Free Workplace Act of 1989, the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited on City premises. Contractor agrees that any violation of this prohibition by Contractor, its employees, agents or assigns will be deemed a material breach of this Agreement.

38. Resource Conservation. Chapter 5 of the San Francisco Environment Code ("Resource Conservation") is incorporated herein by reference. Failure by Contractor to comply with any of the applicable requirements of Chapter 5 will be deemed a material breach of contract.

39. Compliance with Americans with Disabilities Act. Contractor acknowledges that, pursuant to the Americans with Disabilities Act (ADA), programs, services and other activities provided by a public entity to the public, whether directly or through a contractor, must be accessible to the disabled public. Contractor shall provide the services specified in this Agreement in a manner that complies with the ADA and any and all other applicable federal, state and local disability rights legislation. Contractor agrees not to discriminate against disabled persons in the provision of services, benefits or activities provided under this Agreement and further agrees that any violation of this prohibition on the part of Contractor, its employees, agents or assigns will constitute a material breach of this Agreement.

40. Sunshine Ordinance. In accordance with San Francisco Administrative Code §67.24(e), contracts, contractors' bids, responses to solicitations and all other records of communications between City and persons or firms seeking contracts, shall be open to inspection immediately after a contract has been awarded. Nothing in this provision requires the disclosure of a private person or organization's net worth or other proprietary financial data submitted for qualification for a contract or other benefit until and unless that person or organization is awarded the contract or benefit. Information provided which is covered by this paragraph will be made available to the public upon request.

41. Public Access to Meetings and Records. If the Contractor receives a cumulative total per year of at least $250,000 in City funds or City-administered funds and is a non-profit organization as defined in Chapter 12L of the San Francisco Administrative Code, Contractor shall comply with and be bound by all the applicable provisions of that Chapter. By executing this Agreement, the Contractor agrees to open its meetings and records to the public in the manner set forth in §§12L.4 and 12L.5 of the Administrative Code. Contractor further agrees to make-good faith efforts to promote community membership on its Board of Directors in the manner set forth in §12L.6 of the Administrative Code. The Contractor acknowledges that its material failure to comply with any of the provisions of this paragraph shall constitute a material breach of this Agreement. The Contractor further acknowledges that such material breach of the Agreement shall be grounds for the City to terminate and/or not renew the Agreement, partially or in its entirety.

42. Limitations on Contributions. Through execution of this Agreement, Contractor acknowledges that it is familiar with section 1.126 of the City's Campaign and Governmental Conduct Code, which prohibits any person who contracts with the City for the rendition of personal services, for the furnishing of any material, supplies or equipment, for the sale or lease of any land or building, or for a grant, loan or loan guarantee, from making any campaign contribution to (1) an individual holding a City elective office if the contract must be approved by the individual, a board on which that individual serves, or the board of a state agency on which an appointee of that individual serves, (2) a candidate for the office held by such individual, or (3) a committee controlled by such individual, at any time from the commencement of negotiations for the contract until the later of either the termination of negotiations for such contract or six months after the date the contract is approved. Contractor acknowledges that the foregoing restriction applies only if the contract or a combination or series of contracts approved by the same individual or board in a fiscal year have a total anticipated or actual value of $50,000 or more. Contractor further acknowledges that the prohibition on contributions applies to each prospective party to the contract; each member of Contractor's board of directors; Contractor's chairperson, chief executive officer, chief financial officer and chief operating officer; any person with an ownership interest of more than 20 percent in Contractor; any subcontractor listed in the bid or contract; and any committee that is sponsored or controlled by Contractor. Additionally, Contractor acknowledges that Contractor must inform each of the persons described in the preceding sentence of the prohibitions contained in Section 1.126. Contractor further agrees to provide to City the names of each person, entity or committee described above.

43. Requiring Minimum Compensation for Covered Employees

a. Contractor agrees to comply fully with and be bound by all of the provisions of the Minimum Compensation Ordinance (MCO), as set forth in San Francisco Administrative Code Chapter 12P (Chapter 12P), including the remedies provided, and implementing guidelines and rules. The provisions of Sections 12P.5 and

12P.5.1 of Chapter 12P are incorporated herein by reference and made a part of this Agreement as though fully set forth. The text of the MCO is available on the web at www.sfgov.org/olse/mco. A partial listing of some of Contractor's obligations under the MCO is set forth in this Section. Contractor is required to comply with all the provisions of the MCO, irrespective of the listing of obligations in this Section.

b. The MCO requires Contractor to pay Contractor's employees a minimum hourly gross compensation wage rate and to provide minimum compensated and uncompensated time off. The minimum wage rate may change from year to year and Contractor is obligated to keep informed of the then-current requirements. Any subcontract entered into by Contractor shall require the subcontractor to comply with the requirements of the MCO and shall contain contractual obligations substantially the same as those set forth in this Section. It is Contractor's obligation to ensure that any subcontractors of any tier under this Agreement comply with the requirements of the MCO. If any subcontractor under this Agreement fails to comply, City may pursue any of the remedies set forth in this Section against Contractor.

c. Contractor shall not take adverse action or otherwise discriminate against an employee or other person for the exercise or attempted exercise of rights under the MCO. Such actions, if taken within 90 days of the exercise or attempted exercise of such rights, will be rebuttably presumed to be retaliation prohibited by the MCO.

d. Contractor shall maintain employee and payroll records as required by the MCO. If Contractor fails to do so, it shall be presumed that the Contractor paid no more than the minimum wage required under State law.

e. The City is authorized to inspect Contractor's job sites and conduct interviews with employees and conduct audits of Contractor

f. Contractor's commitment to provide the Minimum Compensation is a material element of the City's consideration for this Agreement. The City in its sole discretion shall determine whether such a breach has occurred. The City and the public will suffer actual damage that will be impractical or extremely difficult to determine if the Contractor fails to comply with these requirements. Contractor agrees that the sums set forth in Section 12P.6.1 of the MCO as liquidated damages are not a penalty, but are reasonable estimates of the loss that the City and the public will incur for Contractor's noncompliance. The procedures governing the assessment of liquidated damages shall be those set forth in Section 12P.6.2 of Chapter 12P.

g. Contractor understands and agrees that if it fails to comply with the requirements of the MCO, the City shall have the right to pursue any rights or remedies available under Chapter 12P (including liquidated damages), under the terms of the contract, and under applicable law. If, within 30 days after receiving written notice of a breach of this Agreement for violating the MCO, Contractor fails to cure such breach or, if such breach cannot reasonably be cured within such period of 30 days, Contractor fails to commence efforts to cure within such period, or thereafter fails diligently to pursue such cure to completion, the City shall have the right to pursue any rights or remedies available under applicable law, including those set forth in Section 12P.6(c) of Chapter 12P. Each of these remedies shall be exercisable individually or in combination with any other rights or remedies available to the City.

h. Contractor represents and warrants that it is not an entity that was set up, or is being used, for the purpose of evading the intent of the MCO.

i. If Contractor is exempt from the MCO when this Agreement is executed because the cumulative amount of agreements with this department for the fiscal year is less than $25,000, but Contractor later enters into an agreement or agreements that cause contractor to exceed that amount in a fiscal year, Contractor shall thereafter be required to comply with the MCO under this Agreement. This obligation arises on the effective date of the agreement that causes the cumulative amount of agreements between the Contractor and this department to exceed $25,000 in the fiscal year.

44. Requiring Health Benefits for Covered Employees. Contractor agrees to comply fully with and be bound by all of the provisions of the Health Care Accountability Ordinance (HCAO), as set forth in San Francisco Administrative Code Chapter 12Q, including the remedies provided, and implementing regulations, as the same may be amended from time to time. The provisions of section 12Q.5.1 of Chapter 12Q are incorporated by reference and made a part of this Agreement as though fully set forth herein. The text of the HCAO is available on the web at

www.sfgov.org/olse. Capitalized terms used in this Section and not defined in this Agreement shall have the meanings assigned to such terms in Chapter 12Q.

a. For each Covered Employee, Contractor shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Contractor chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission..

b. Notwithstanding the above, if the Contractor is a small business as defined in Section 12Q.3(e) of the HCAO, it shall have no obligation to comply with part (a) above.

c. Contractor's failure to comply with the HCAO shall constitute a material breach of this agreement. City shall notify Contractor if such a breach has occurred. If, within 30 days after receiving City's written notice of a breach of this Agreement for violating the HCAO, Contractor fails to cure such breach or, if such breach cannot reasonably be cured within such period of 30 days, Contractor fails to commence efforts to cure within such period, or thereafter fails diligently to pursue such cure to completion, City shall have the right to pursue the remedies set forth in 12Q.5.1 and 12Q.5(f)(1-6). Each of these remedies shall be exercisable individually or in combination with any other rights or remedies available to City.

d. Any Subcontract entered into by Contractor shall require the Subcontractor to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section. Contractor shall notify City's Office of Contract Administration when it enters into such a Subcontract and shall certify to the Office of Contract Administration that it has notified the Subcontractor of the obligations under the HCAO and has imposed the requirements of the HCAO on Subcontractor through the Subcontract. Each Contractor shall be responsible for its Subcontractors' compliance with this Chapter. If a Subcontractor fails to comply, the City may pursue the remedies set forth in this Section against Contractor based on the Subcontractor's failure to comply, provided that City has first provided Contractor with notice and an opportunity to obtain a cure of the violation.

e. Contractor shall not discharge, reduce in compensation, or otherwise discriminate against any employee for notifying City with regard to Contractor's noncompliance or anticipated noncompliance with the requirements of the HCAO, for opposing any practice proscribed by the HCAO, for participating in proceedings related to the HCAO, or for seeking to assert or enforce any rights under the HCAO by any lawful means.

f. Contractor represents and warrants that it is not an entity that was set up, or is being used, for the purpose of evading the intent of the HCAO.

g. Contractor shall maintain employee and payroll records in compliance with the California Labor Code and Industrial Welfare Commission orders, including the number of hours each employee has worked on the City Contract.

h. Contractor shall keep itself informed of the current requirements of the HCAO.

i. Contractor shall provide reports to the City in accordance with any reporting standards promulgated by the City under the HCAO, including reports on Subcontractors and Subtenants, as applicable.

j. Contractor shall provide City with access to records pertaining to compliance with HCAO after receiving a written request from City to do so and being provided at least ten business days to respond.

k. Contractor shall allow City to inspect Contractor's job sites and have access to Contractor's employees in order to monitor and determine compliance with HCAO.

l. City may conduct random audits of Contractor to ascertain its compliance with HCAO. Contractor agrees to cooperate with City when it conducts such audits.

m. If Contractor is exempt from the HCAO when this Agreement is executed because its amount is less than $25,000 ($50,000 for nonprofits), but Contractor later enters into an agreement or agreements that cause

Contractor's aggregate amount of all agreements with City to reach $75,000, all the agreements shall be thereafter subject to the HCAO. This obligation arises on the effective date of the agreement that causes the cumulative amount of agreements between Contractor and the City to be equal to or greater than $75,000 in the fiscal year.

45. First Source Hiring Program

a. **Incorporation of Administrative Code Provisions by Reference.** The provisions of Chapter 83 of the San Francisco Administrative Code are incorporated in this Section by reference and made a part of this Agreement as though fully set forth herein. Contractor shall comply fully with, and be bound by, all of the provisions that apply to this Agreement under such Chapter, including but not limited to the remedies provided therein. Capitalized terms used in this Section and not defined in this Agreement shall have the meanings assigned to such terms in Chapter 83.

b. **First Source Hiring Agreement.** As an essential term of, and consideration for, any contract or property contract with the City, not exempted by the FSHA, the Contractor shall enter into a first source hiring agreement ("agreement") with the City, on or before the effective date of the contract or property contract. Contractors shall also enter into an agreement with the City for any other work that it performs in the City. Such agreement shall:

1) Set appropriate hiring and retention goals for entry level positions. The employer shall agree to achieve these hiring and retention goals, or, if unable to achieve these goals, to establish good faith efforts as to its attempts to do so, as set forth in the agreement. The agreement shall take into consideration the employer's participation in existing job training, referral and/or brokerage programs. Within the discretion of the FSHA, subject to appropriate modifications, participation in such programs maybe certified as meeting the requirements of this Chapter. Failure either to achieve the specified goal, or to establish good faith efforts will constitute noncompliance and will subject the employer to the provisions of Section 83.10 of this Chapter.

2) Set first source interviewing, recruitment and hiring requirements, which will provide the San Francisco Workforce Development System with the first opportunity to provide qualified economically disadvantaged individuals for consideration for employment for entry level positions. Employers shall consider all applications of qualified economically disadvantaged individuals referred by the System for employment; provided however, if the employer utilizes nondiscriminatory screening criteria, the employer shall have the sole discretion to interview and/or hire individuals referred or certified by the San Francisco Workforce Development System as being qualified economically disadvantaged individuals. The duration of the first source interviewing requirement shall be determined by the FSHA and shall be set forth in each agreement, but shall not exceed 10 days. During that period, the employer may publicize the entry level positions in accordance with the agreement. A need for urgent or temporary hires must be evaluated, and appropriate provisions for such a situation must be made in the agreement.

3) Set appropriate requirements for providing notification of available entry level positions to the San Francisco Workforce Development System so that the System may train and refer an adequate pool of qualified economically disadvantaged individuals to participating employers. Notification should include such information as employment needs by occupational title, skills, and/or experience required, the hours required, wage scale and duration of employment, identification of entry level and training positions, identification of English language proficiency requirements, or absence thereof, and the projected schedule and procedures for hiring for each occupation. Employers should provide both long-term job need projections and notice before initiating the interviewing and hiring process. These notification requirements will take into consideration any need to protect the employer's proprietary information.

4) Set appropriate record keeping and monitoring requirements. The First Source Hiring Administration shall develop easy-to-use forms and record keeping requirements for documenting compliance with the agreement. To the greatest extent possible, these requirements shall utilize the employer's existing record keeping systems, be nonduplicative, and facilitate a coordinated flow of information and referrals.

5) Establish guidelines for employer good faith efforts to comply with the first source hiring requirements of this Chapter. The FSHA will work with City departments to develop employer good faith effort requirements appropriate to the types of contracts and property contracts handled by each department. Employers

shall appoint a liaison for dealing with the development and implementation of the employer's agreement. In the event that the FSHA finds that the employer under a City contract or property contract has taken actions primarily for the purpose of circumventing the requirements of this Chapter, that employer shall be subject to the sanctions set forth in Section 83.10 of this Chapter.

6) Set the term of the requirements.

7) Set appropriate enforcement and sanctioning standards consistent with this Chapter.

8) Set forth the City's obligations to develop training programs, job applicant referrals, technical assistance, and information systems that assist the employer in complying with this Chapter.

9) Require the developer to include notice of the requirements of this Chapter in leases, subleases, and other occupancy contracts.

c. **Hiring Decisions.** Contractor shall make the final determination of whether an Economically Disadvantaged Individual referred by the System is "qualified" for the position.

d. **Exceptions.** Upon application by Employer, the First Source Hiring Administration may grant an exception to any or all of the requirements of Chapter 83 in any situation where it concludes that compliance with this Chapter would cause economic hardship.

e. **Liquidated Damages.** Contractor agrees:

1) To be liable to the City for liquidated damages as provided in this section;

2) To be subject to the procedures governing enforcement of breaches of contracts based on violations of contract provisions required by this Chapter as set forth in this section;

3) That the contractor's commitment to comply with this Chapter is a material element of the City's consideration for this contract; that the failure of the contractor to comply with the contract provisions required by this Chapter will cause harm to the City and the public which is significant and substantial but extremely difficult to quantity; that the harm to the City includes not only the financial cost of funding public assistance programs but also the insidious but impossible to quantify harm that this community and its families suffer as a result of unemployment; and that the assessment of liquidated damages of up to $5,000 for every notice of a new hire for an entry level position improperly withheld by the contractor from the first source hiring process, as determined by the FSHA during its first investigation of a contractor, does not exceed a fair estimate of the financial and other damages that the City suffers as a result of the contractor's failure to comply with its first source referral contractual obligations.

4) That the continued failure by a contractor to comply with its first source referral contractual obligations will cause further significant and substantial harm to the City and the public, and that a second assessment of liquidated damages of up to $10,000 for each entry level position improperly withheld from the FSHA, from the time of the conclusion of the first investigation forward, does not exceed the financial and other damages that the City suffers as a result of the contractor's continued failure to comply with its first source referral contractual obligations;

5) That in addition to the cost of investigating alleged violations under this Section, the computation of liquidated damages for purposes of this section is based on the following data:

(a) The average length of stay on public assistance in San Francisco's County Adult Assistance Program is approximately 41 months at an average monthly grant of $348 per month, totaling approximately $14,379; and

(b) In 2004, the retention rate of adults placed in employment programs funded under the Workforce Investment Act for at least the first six months of employment was 84.4%. Since qualified individuals

under the First Source program face far fewer barriers to employment than their counterparts in programs funded by the Workforce Investment Act, it is reasonable to conclude that the average length of employment for an individual whom the First Source Program refers to an employer and who is hired in an entry level position is at least one year;

Therefore, liquidated damages that total $5,000 for first violations and $10,000 for subsequent violations as determined by FSHA constitute a fair, reasonable, and conservative attempt to quantify the harm caused to the City by the failure of a contractor to comply with its first source referral contractual obligations.

6) That the failure of contractors to comply with this Chapter, except property contractors, may be subject to the debarment and monetary penalties set forth in Sections 6.80 et seq. of the San Francisco Administrative Code, as well as any other remedies available under the contract or at law; and

Violation of the requirements of Chapter 83 is subject to an assessment of liquidated damages in the amount of $5,000 for every new hire for an Entry Level Position improperly withheld from the first source hiring process. The assessment of liquidated damages and the evaluation of any defenses or mitigating factors shall be made by the FSHA.

f. **Subcontracts.** Any subcontract entered into by Contractor shall require the subcontractor to comply with the requirements of Chapter 83 and shall contain contractual obligations substantially the same as those set forth in this Section.

46. Prohibition on Political Activity with City Funds. In accordance with San Francisco Administrative Code Chapter 12.G, Contractor may not participate in, support, or attempt to influence any political campaign for a candidate or for a ballot measure (collectively, "Political Activity") in the performance of the services provided under this Agreement. Contractor agrees to comply with San Francisco Administrative Code Chapter 12.G and any implementing rules and regulations promulgated by the City's Controller. The terms and provisions of Chapter 12.G are incorporated herein by this reference. In the event Contractor violates the provisions of this section, the City may, in addition to any other rights or remedies available hereunder, (i) terminate this Agreement, and (ii) prohibit Contractor from bidding on or receiving any new City contract for a period of two (2) years. The Controller will not consider Contractor's use of profit as a violation of this section.

47. Preservative-treated Wood Containing Arsenic. Contractor may not purchase preservative-treated wood products containing arsenic in the performance of this Agreement unless an exemption from the requirements of Chapter 13 of the San Francisco Environment Code is obtained from the Department of the Environment under Section 1304 of the Code. The term "preservative-treated wood containing arsenic" shall mean wood treated with a preservative that contains arsenic, elemental arsenic, or an arsenic copper combination, including, but not limited to, chromated copper arsenate preservative, ammoniacal copper zinc arsenate preservative, or ammoniacal copper arsenate preservative. Contractor may purchase preservative-treated wood products on the list of environmentally preferable alternatives prepared and adopted by the Department of the Environment. This provision does not preclude Contractor from purchasing preservative-treated wood containing arsenic for saltwater immersion. The term "saltwater immersion" shall mean a pressure-treated wood that is used for construction purposes or facilities that are partially or totally immersed in saltwater.

48. Modification of Agreement. This Agreement may not be modified, nor may compliance with any of its terms be waived, except by written instrument executed and approved in the same manner as this Agreement.

49. Administrative Remedy for Agreement Interpretation – DELETED by mutual agreement of the parties

50. Agreement Made in California; Venue. The formation, interpretation and performance of this Agreement shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this Agreement shall be in San Francisco.

51. Construction. All paragraph captions are for reference only and shall not be considered in construing this Agreement.

52. **Entire Agreement.** This contract sets forth the entire Agreement between the parties, and supersedes all other oral or written provisions. This contract may be modified only as provided in Section 48, "Modification of Agreement."

53. **Compliance with Laws.** Contractor shall keep itself fully informed of the City's Charter, codes, ordinances and regulations of the City and of all state, and federal laws in any manner affecting the performance of this Agreement, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

54. **Services Provided by Attorneys.** Any services to be provided by a law firm or attorney must be reviewed and approved in writing in advance by the City Attorney. No invoices for services provided by law firms or attorneys, including, without limitation, as subcontractors of Contractor, will be paid unless the provider received advance written approval from the City Attorney.

55. **Supervision of Minors.** Contractor, and any subcontractors, shall comply with California Penal Code section 11105.3 and request from the Department of Justice records of all convictions or any arrest pending adjudication involving the offenses specified in Welfare and Institution Code section 15660(a) of any person who applies for employment or volunteer position with Contractor, or any subcontractor, in which he or she would have supervisory or disciplinary power over a minor under his or her care. If Contractor, or any subcontractor, is providing services at a City park, playground, recreational center or beach (separately and collectively, "Recreational Site"), Contractor shall not hire, and shall prevent its subcontractors from hiring, any person for employment or volunteer position to provide those services if that person has been convicted of any offense that was listed in former Penal Code section 11105.3 (h)(1) or 11105.3(h)(3). If Contractor, or any of its subcontractors, hires an employee or volunteer to provide services to minors at any location other than a Recreational Site, and that employee or volunteer has been convicted of an offense specified in Penal Code section 11105.3(c), then Contractor shall comply, and cause its subcontractors to comply with that section and provide written notice to the parents or guardians of any minor who will be supervised or disciplined by the employee or volunteer not less than ten (10) days prior to the day the employee or volunteer begins his or her duties or tasks. Contractor shall provide, or cause its subcontractors to provide City with a copy of any such notice at the same time that it provides notice to any parent or guardian. Contractor shall expressly require any of its subcontractors with supervisory or disciplinary power over a minor to comply with this section of the Agreement as a condition of its contract with the subcontractor. Contractor acknowledges and agrees that failure by Contractor or any of its subcontractors to comply with any provision of this section of the Agreement shall constitute an Event of Default. Contractor further acknowledges and agrees that such Event of Default shall be grounds for the City to terminate the Agreement, partially or in its entirety, to recover from Contractor any amounts paid under this Agreement, and to withhold any future payments to Contractor. The remedies provided in this Section shall not limited any other remedy available to the City hereunder, or in equity or law for an Event of Default, and each remedy may be exercised individually or in combination with any other available remedy. The exercise of any remedy shall not preclude or in any way be deemed to waive any other remedy.

56. **Severability.** Should the application of any provision of this Agreement to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this Agreement shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

57. **Protection of Private Information.** Contractor has read and agrees to the terms set forth in San Francisco Administrative Code Sections 12M.2, "Nondisclosure of Private Information," and 12M.3, "Enforcement" of Administrative Code Chapter 12M, "Protection of Private Information," which are incorporated herein as if fully set forth. Contractor agrees that any failure of Contactor to comply with the requirements of Section 12M.2 of this Chapter shall be a material breach of the Contract. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract, bring a false claim action against the Contractor pursuant to Chapter 6 or Chapter 21 of the Administrative Code, or debar the Contractor.

58. **Graffiti Removal.** Graffiti is detrimental to the health, safety and welfare of the community in that it promotes a perception in the community that the laws protecting public and private property can be disregarded with

impunity. This perception fosters a sense of disrespect of the law that results in an increase in crime; degrades the community and leads to urban blight; is detrimental to property values, business opportunities and the enjoyment of life; is inconsistent with the City's property maintenance goals and aesthetic standards; and results in additional graffiti and in other properties becoming the target of graffiti unless it is quickly removed from public and private property. Graffiti results in visual pollution and is a public nuisance. Graffiti must be abated as quickly as possible to avoid detrimental impacts on the City and County and its residents, and to prevent the further spread of graffiti. Contractor shall remove all graffiti from any real property owned or leased by Contractor in the City and County of San Francisco within forty eight (48) hours of the earlier of Contractor's (a) discovery or notification of the graffiti or (b) receipt of notification of the graffiti from the Department of Public Works. This section is not intended to require a Contractor to breach any lease or other agreement that it may have concerning its use of the real property. The term "graffiti" means any inscription, word, figure, marking or design that is affixed, marked, etched, scratched, drawn or painted on any building, structure, fixture or other improvement, whether permanent or temporary, including by way of example only and without limitation, signs, banners, billboards and fencing surrounding construction sites, whether public or private, without the consent of the owner of the property or the owner's authorized agent, and which is visible from the public right-of-way. "Graffiti" shall not include: (1) any sign or banner that is authorized by, and in compliance with, the applicable requirements of the San Francisco Public Works Code, the San Francisco Planning Code or the San Francisco Building Code; or (2) any mural or other painting or marking on the property that is protected as a work of fine art under the California Art Preservation Act (California Civil Code Sections 987 et seq.) or as a work of visual art under the Federal Visual Artists Rights Act of 1990 (17 U.S.C. §§ 101 et seq.).

Any failure of Contractor to comply with this section of this Agreement shall constitute an Event of Default of this Agreement.

59. **Food Service Waste Reduction Requirements.** Effective June 1, 2007 Contractor agrees to comply fully with and be bound by all of the provisions of the Food Service Waste Reduction Ordinance, as set forth in San Francisco Environment Code Chapter 16, including the remedies provided, and implementing guidelines and rules. The provisions of Chapter 16 are incorporated herein by reference and made a part of this Agreement as though fully set forth. This provision is a material term of this Agreement. By entering into this Agreement, Contractor agrees that if it breaches this provision, City will suffer actual damages that will be impractical or extremely difficult to determine; further, Contractor agrees that the sum of one hundred dollars ($100) liquidated damages for the first breach, two hundred dollars ($200) liquidated damages for the second breach in the same year, and five hundred dollars ($500) liquidated damages for subsequent breaches in the same year is reasonable estimate of the damage that City will incur based on the violation, established in light of the circumstances existing at the time this Agreement was made. Such amount shall not be considered a penalty, but rather agreed monetary damages sustained by City because of Contractor's failure to comply with this provision.

60. **Left blank by agreement of the parties. (Slavery era disclosure)**

61. **Cooperative Drafting.** This Agreement has been drafted through a cooperative effort of both parties, and both parties have had an opportunity to have the Agreement reviewed and revised by legal counsel. No party shall be considered the drafter of this Agreement, and no presumption or rule that an ambiguity shall be construed against the party drafting the clause shall apply to the interpretation or enforcement of this Agreement.

62. **Dispute Resolution Procedure.** A Dispute Resolution Procedure is attached under the Appendix G to address issues that have not been resolved administratively by other departmental remedies.

63. **Additional Terms.** Additional Terms are attached hereto as Appendix D and are incorporated into this Agreement by reference as though fully set forth herein.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day first mentioned above.

CITY

Recommended by:

MITCHELL H. KATZ, M.D.
Director of Health

10-28-10
Date

Approved as to Form:

DENNIS J. HERRERA
City Attorney

By: TERENCE HOWZELL
Deputy City Attorney

11/4/10
Date

Approved:

NAOMI KELLY
Director Office of Contract
Administration and Purchaser

12/15/10
Date

CONTRACTOR

Family Service Agency of San Francisco

ROBERT BENNETT
Executive Director
1010 Gough Street
San Francisco, CA 94109

22 Oct 10
Date

City vendor number: 07426

Appendices
A: Services to be provided by Contractor
B: Calculation of Charges
C: N/A (Insurance Waiver) Reserved
D: Additional Terms
E: HIPAA Business Associate Agreement
F: Invoice
G: Dispute Resolution
H: Private Policy Compliance
I: Emergency Response

Appendix A

COMMUNITY BEHAVIORAL HEALTH SERVICES

The following requirements are incorporated into Appendix A, as provided in this Agreement under Section 4. SERVICES.

A. Contract Administrator:

In performing the SERVICES hereunder, CONTRACTOR shall report to Hilda Jones, Contract Administrator for the CITY, or her designee.

B. Reports:

(1) CONTRACTOR shall submit written reports as requested by the CITY. The format for the content of such reports shall be determined by the CITY. The timely submission of all reports is a necessary and material term and condition of this Agreement. All reports, including any copies, shall be submitted on recycled paper and printed on double-sided pages to the maximum extent possible.

(2) CONTRACTOR agrees to submit to the Director of Public Health or his designated agent (hereinafter referred to as "DIRECTOR") the following reports: Annual County Plan Data; Utilization Review Data and Quarterly Reports of De-certifications; Peer Review Plan, Quarterly Reports, and relevant Peer Review data; Medication Monitoring Plan and relevant Medication Monitoring data; Charting Requirements, Client Satisfaction Data, Program Outcome Data, and Data necessary for producing bills and/or claims in conformance with the State of California Uniform Method for Determining Ability to Pay (UMDAP; the state's sliding fee scale) procedures.

C. Evaluation:

CONTRACTOR shall participate as requested with the CITY, State and/or Federal government in evaluative studies designed to show the effectiveness of CONTRACTOR'S SERVICES. CONTRACTOR agrees to meet the requirements of and participate in the evaluation program and management information systems of the CITY. The CITY agrees that any final written reports generated through the evaluation program shall be made available to CONTRACTOR within thirty (30) working days. CONTRACTOR may submit a written response within thirty working days of receipt of any evaluation report and such response will become part of the official report.

D. Possession of Licenses/Permits:

CONTRACTOR warrants the possession of all licenses and/or permits required by the laws and regulations of the United States, the State of California, and the CITY to provide the SERVICES. Failure to maintain these licenses and permits shall constitute a material breach of this Agreement.

Space owned, leased or operated by providers, including satellites, and used for SERVICES or staff shall meet local fire codes. Documentation of fire safety inspections and corrections of any deficiencies shall be made available to reviewers upon request.

E. Adequate Resources:

CONTRACTOR agrees that it has secured or shall secure at its own expense all persons, employees and equipment required to perform the SERVICES required under this Agreement, and that all such SERVICES shall be performed by CONTRACTOR, or under CONTRACTOR'S supervision, by persons authorized by law to perform such SERVICES.

F. Admission Policy:

Admission policies for the SERVICES shall be in writing and available to the public. Such policies must include a provision that clients are accepted for care without discrimination on the basis of race, color, creed, religion, sex, age, national origin, ancestry, sexual orientation, gender identification, disability, or AIDS/HIV status, except to the extent that the SERVICES are to be rendered to a specific population as described in Appendix A. CONTRACTOR shall adhere to Title XIX of the Social Security Act and shall conform to all applicable Federal and

State statues and regulations. CONTRACTOR shall ensure that all clients will receive the same level of care regardless of client status or source of reimbursement when SERVICES are to be rendered.

G. San Francisco Residents Only:

Only San Francisco residents shall be treated under the terms of this Agreement. Exceptions must have the written approval of the Contract Administrator.

H. Grievance Procedure:

CONTRACTOR agrees to establish and maintain a written Client Grievance Procedure which shall include the following elements as well as others that may be appropriate to the SERVICES: (1) the name or title of the person or persons authorized to make a determination regarding the grievance; (2) the opportunity for the aggrieved party to discuss the grievance with those who will be making the determination; and (3) the right of a client dissatisfied with the decision to ask for a review and recommendation from the community advisory board or planning council that has purview over the aggrieved service. CONTRACTOR shall provide a copy of this procedure, and any amendments thereto, to each client and to the Director of Public Health or his/her designated agent (hereinafter referred to as "DIRECTOR"). Those clients who do not receive direct SERVICES will be provided a copy of this procedure upon request.

I. Infection Control, Health and Safety:

(1) CONTRACTOR must have a Bloodborne Pathogen (BBP) Exposure Control plan as defined in the California Code of Regulations, Title 8, §5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and record keeping.

(2) CONTRACTOR must demonstrate personnel policies/procedures for protection of staff and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

(3) CONTRACTOR must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

(4) CONTRACTOR is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

(5) CONTRACTOR shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

(6) CONTRACTOR shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

(7) CONTRACTOR assumes responsibility for procuring all medical equipment and supplies for use by their staff, including safe needle devices, and provides and documents all appropriate training.

(8) CONTRACTOR shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

J. Acknowledgment of Funding:

CONTRACTOR agrees to acknowledge the San Francisco Department of Public Health in any printed material or public announcement describing the San Francisco Department of Public Health-funded SERVICES. Such documents or announcements shall contain a credit substantially as follows: "This program/service/ activity/research project was funded through the Department of Public Health, CITY and County of San Francisco."

K. Client Fees and Third Party Revenue:

(1) Fees required by federal, state or CITY laws or regulations to be billed to the client, client's family, or insurance company, shall be determined in accordance with the client's ability to pay and in conformance with all applicable laws. Such fees shall approximate actual cost. No additional fees may be charged to the client or the client's family for the SERVICES. Inability to pay shall not be the basis for denial of any SERVICES provided under this Agreement.

(2) CONTRACTOR agrees that revenues or fees received by CONTRACTOR related to SERVICES performed and materials developed or distributed with funding under this Agreement shall be used to increase the gross program funding such that a greater number of persons may receive SERVICES. Accordingly, these revenues and fees shall not be deducted by CONTRACTOR from its billing to the CITY.

(3) CONTRACTOR agrees that funds received by CONTRACTOR from a source other than the CITY to defray any portion of the reimbursable costs allowable under this Agreement shall be reported to the CITY and deducted by CONTRACTOR from its billings to the CITY to ensure that no portion of the CITY'S reimbursement to CONTRACTOR is duplicated.

L. Billing and Information System

CONTRACTOR agrees to participate in the CITY'S Community Mental Health Services (CMHS) and Community Substance Abuse Services (CSAS) Billing and Information System (BIS) and to follow data reporting procedures set forth by the CMHS/CSAS BIS and Quality Improvement Units.

M. Patients Rights:

All applicable Patients Rights laws and procedures shall be implemented.

N. Under-Utilization Reports:

For any quarter that CONTRACTOR maintains less than ninety percent (90%) of the total agreed upon units of service for any mode of service hereunder, CONTRACTOR shall immediately notify the Contract Administrator in writing and shall specify the number of underutilized units of service.

O. Quality Improvement:

CONTRACTOR agrees to develop and implement a Quality Improvement Plan based on internal standards established by CONTRACTOR applicable to the SERVICES as follows:

(1) Staff evaluations completed on an annual basis.

(2) Personnel policies and procedures in place, reviewed and updated annually.

(3) Board Review of Quality Improvement Plan.

P. Compliance with Community Mental Health Services and Community Substance Abuse Services Policies and Procedures

In the provision of SERVICES under Community Mental Health Services or Community Substance Abuse Services contracts, CONTRACTOR shall follow all applicable policies and procedures established for contractors by Community Mental Health Services or Community Substance Abuse Services, as applicable, and shall keep itself duly informed of such policies. Lack of knowledge of such policies and procedures shall not be an allowable reason for noncompliance.

Q. Working Trial Balance with Year-End Cost Report

If CONTRACTOR is a Non-Hospital Provider as defined in the State of California Department of Mental Health Cost Reporting Data Collection Manual, it agrees to submit a working trial balance with the year-end cost report.

R. Harm Reduction

The program has a written internal Harm Reduction Policy that includes the guiding principles per Resolution # 10-00 810611 of the San Francisco Department of Public Health Commission.

2. **Description of Services**

Detailed description of services are listed below and are attached hereto

Appendix A-1 Older Adult IFSO
Appendix A-2 Older Adult Peer-Based Wellness And Recovery Center
Appendix A-3a Community After Care Program
Appendix A-3b Adult Care Management (ACM)
Appendix A-3c Adult Full Service Partnership
Appendix A-4 Transitional –Age Youth Full Service Partnership
Appendix A-5 Administrative Service Organization
Appendix A-6 Full Circle Family Program (FCFP)
Appendix A-7 FCFP /Early Periodic Screening, Diagnosis and treatment (EPSDT) Program
Appendix A-8 Early Childhood Mental Health Initiative
Appendix A-9 Youth Striving for Excellence – Teen Resource to Achieve Positive Practice (TRAPP)
Appendix A-10 Prevention and Recovery in Early Intervention (PREP) Project
Appendix A-11 Felton Institute – Training in Older Adult Behavioral Health Screening

SUMMARY

Service Provider(s):	Family Service Agency Of San Francisco
Fiscal Agency:	Family Service Agency Of San Francisco
Total Contract Amount:	$7,5226,671
System of Care:	Community Behavioral Health Services
Provider Address:	1010 Gough Street, San Francisco, CA 94109
Provider Phone:	415-474-7310 **Provider Fax:**415-931-3773
Contact Person:	Al Gilbert, COO/CFO & Treasurer **Direct Phone #:** 415- 474-3169
	email: agilbert@fsasf.org

Program Name:	Older Adult IFSO		**Appendix A-1**
System of Care:	CBHS – Older Adult		
Amount Year One:	$2,938,458	**Funding Source:** General Fund and MHSA	
Term:	7.01.10 – 6.30.11		
Definition and # of UOS:	UOS is equivalent to 1 hour of service.		
	Case Management Brokerage		5,930
	MH Services		6,932
	Medication Support		2,755
	Crisis Intervention OP		415
	MH Promotion		2,008
Number of UDC/NOC:	605	**Total UOS**	18,040

Target Population:
Older adults 60 and older who need specialized geriatric mental health services beyond what is available through the Adult System of Care.

Description of Service:
The Older Adult Intensive-Case Management/Assertive Community Treatment/Full-Service Partnerships provides:

Direct Services:

Intake and Assessment: Intake occurs where best meets the client's needs; Assessment is completed using the ADEPT and other tools to measure current psychological, emotional and behavioral issues. *Care Plan Development:* Treatment plans are developed in partnership with the client. *Case Management/Brokerage:* Strength-based, recovery-oriented approach applies to all case management, based on motivational interviewing and wrap-around principles. *Individual and Group Therapy:* Evidence-based therapeutic interventions focused on symptom reduction, quality of life, and the recovery model. *Collateral:* A service activity to a significant support person in the consumer's life. *Crisis Intervention:* Emergency intervention, immediate face to face to prevent harm coming to the consumer. *Outcome-Guided Medication Support Services:* All clients needing medication management have access to an FSA psychiatrist or a nurse practitioner, who assesses, prescribes, monitors, treats, documents symptoms or side effects, and educates. *Evidence Based, Integrated Behavioral Health Treatment:* Includes substance abuse partners. *Peer Support and Volunteer Opportunities:* Is an important part of service delivery. *Community Integration Services:* Provides essential low threshold services to assist clients in transitioning to other program and natural supports in the community.

Indirect Services:

Include mental health promotion, trainings and Clinical Staff Development.

Program Name:	Older Adult Peer-Based Wellness And Recovery Center **Appendix A-2**
System of Care:	CBHS – Older Adult
Amount Year:	$ 185,400 **Funding Source:** MHSA, CSS
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service. Supplemental Support – Cost Reimbursement 1.0
Number of UDC/NOC:	N/A **Total UOS** 1.0
Target Population:	Older adults 60 and older who currently have mental health and/or substance abuse issues, who may be homeless or episodically homeless, and who may or may not have been connected to the behavioral health services before.
Description of Service:	In addition to outreach and assessment, the Core services include: *Case Management:* Staff refers to appropriate services upon quest request. Peers can escort to appointments, when appropriate, either on foot or on MUNI. *Treatment:* Staff utilizes a Harm Reduction approach coupled with Motivational Interviewing techniques to engage the individual where they are in their decision to seek out treatment services. If needed, staff or volunteers will meet individually with a client on a regular basis to build report and support the client in their decision to seek out appropriate treatment services. Wellness and Recovery is always promoted during the process. *Individual Advocacy:* Through the process of building group and individual supportive relationships with guests, staff and peers promote and encourage individual advocacy to guests. This is done through monthly Community meetings, as well as through encouraging guests to approach staff and/or volunteers with questions, concerns and needs they may have. By encouraging and supporting individual and group advocacy, the Peer-Based Wellness Center is helping to reduce the individual's feeling of stigma through Strength-Based empowerment. *Policy and Systemic Advocacy:* Reduction of stigma and the promotion of ideas incorporated in wellness and recovery. This contributes to a systems change in service delivery, particularly in reaching underserved and unidentified older persons in need.

Program Name:	Community After Care Program **Appendix A-3a**
System of Care:	CBHS - Adult
Amount Year Two:	$ 453,446 **Founding Source:** General Fund
Term (# of Months):	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service. Case Management Brokerage 2,000 MH Services 95 Medication Support 160 Crisis Intervention OP 33 MH Promotion 184
Number of UDC/NOC:	250 **Total UOS** 2,472
Target Population:	Severely and persistently mentally ill residents of San Francisco County, 18 years of age and older who are living in or being referred to residential care facilities (RCF's).
Description of Service:	The Community Aftercare Program provides case management, mental health services, medication support services and crisis intervention to the populations that they serve.

Program Name:	Adult Care Management (ACM) **Appendix A-3b**
System of Care:	CBHS - Adult
Amount Year:	$699,478 **Funding Source:** General Fund
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service.
	Case Management Brokerage 2,900
	MH Services 464
	Medication Support 800
	Crisis Intervention OP 90
	MH Promotion 270
Number of UDC/NOC:	108 **Total UOS** 4,524
Target Population:	Persistently mentally ill San Francisco residents who are 18 and up and struggle with substance abuse problems and/or homelessness issues in addition to their mental health problems.
Description of Service:	Case Management is the primary treatment modality. Case managers assist the client to access needed medical, education, social, prevocational, vocational, rehabilitative and other community related services. Case mangers communicate with clients to establish their treatment goals and to coordinate their services in the greater community; including all referrals for financial, housing, vocational, psychiatric, and medical and social service needs. Case managers monitor the delivery of services to ensure quality of care and delivery of services in the greater system. Case managers monitor the progress of the client's treatment plan and adherences to the system of care provided, and make adjustments to clients care services when necessary.

Program Name:	Adult Full Service Partnership **Appendix A-3c**
System of Care:	CBHS - Adult
Amount Year:	$596,636 **Funding Source:** MHSA, Federal
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service.
	Case Management Brokerage 2,806
	MH Services 608
	Medication Support 150
	Crisis Intervention OP 36
	MH Promotion 545
	Client Flexible Support 1
Number of UDC/NOC:	45 **Total UOS** 4,146
Target Population:	Adults ages 18 and older with severe mental illness and/or substance abuse problems.
Description of Service:	Mental Health Services are provided in individual therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities include assessment, collateral and therapy. *Assessment is* provided as a clinical analysis of the history and current status of a client's mental, emotional, and behavioral disorder; including relevant cultural

	issues and history and current diagnosis. *Collateral* services are provided as significant support to the client and those in the client's life with the intent of improving and maintaining the mental health status. The client may or may not be present for this service activity. *Therapy* is provided as a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or to a group of clients and may include some family therapy when the client is present. *Medication Support Services* means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary. *Crisis Intervention* A service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled. Service activities may include but are not limited to assessment, collateral and therapy.
Program Name:	Transitional –Age Youth Full Service Partnership (MAP) **Appendix A-4**
System of Care:	CBHS - Adult
Amount Year:	$417,940 **Funding Source:** MHSA, CSS
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service.
	Case Management Brokerage 1,650 MH Services 644 Medication Support 88 Crisis Intervention OP 17 MH Promotion 412 Client Flexible Support 1
Number of UDC/NOC:	30 **Total UOS** 2,812
Target Population:	Transition-age youth ages 16 to 25
Description of Service:	**Direct Services:** *Assessment and Plan Development*: for analysis of consumer's history and current psychological, emotional and behavioral issues. In addition to developing a treatment plan. *Case Management Brokerage:* for linking consumers to services and providing emotional support. *Individual and Group Therapy:* for providing therapeutic interventions that focus on symptom reduction. *Collateral:* a service activity to a significant support person in the consumer's life. *Individual and Group Therapy*: therapeutic interventions focused on symptom reduction. *Crisis Intervention*: emergency intervention, immediate face to face to prevent harm coming to the consumer. *Medication Support Services:* prescribing, administering, dispensing and monitoring of psychiatric medications and biological to alleviate psychiatric symptoms. **Indirect Services:** Services include *mental health promotion, by working with "Community Clients"* who are not registered to our program. *Trainings and Clinical Staff Development.*

Program Name:	Administrative Service Organization **Appendix A-5**
System of Care:	CBHS - Adult
Amount Year:	$191,686 **Funding Source:** General Fund and State Managed Care
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service.
	Support Services – Cost Reimbursement 1
Number of UDC/NOC:	N/A **Total UOS** 1
Target Population:	Adults, youth, women, homeless, multiply diagnosed, children and geriatric clients as defined by the San Francisco Mental Health Plan. Priority for services will be given to patients who are low income, Medi- Cal., and uninsured consumers.
Description of Service:	The Program provides on-site administrative support services to the SFMHP with a focus on intake and referral of patients to the Providers Network, credential coordination, and overall clerical support to the provider systems office staff.

Program Name:	Full Circle Family Program (FCFP) **Appendix A-6**
System of Care:	CBHS – CYF
Amount Year:	$302,029 **Funding Source:** General Fund and Federal Revenues
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service.
	Case Management Brokerage 87
	MH Services 1,184
	Medication Support 205
	Crisis Intervention OP 10
	MH Promotion 481
Number of UDC/NOC:	348 **Total UOS** 1,967
Target Population:	Children and adolescents up to 21 years old (and their families) whose mental health problems meet - medical necessity criteria for specialty mental health services.
Description of Service:	The program provides: **1. Direct Services** *Medication Support Services:* those services include prescribing, administering, dispensing and monitoring of psychiatric medications or biological which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary. *Mental Health Services:* Assessment, Collateral and Therapy. *Assessment is* a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures. *Collateral* a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity. *Therapy* a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries. *Targeted Case Management:* A service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's

progress; and plan development. *Crisis Intervention:* An emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

2. Indirect Services

These are *mental outreach and promotion activities;* they include the promotion of continuous staff development in evidence-based and best practices theory as the lens for which mental health treatment is to be provided. *Community Client Contact:* Assisting clients and families for whom there is no open case record to achieve a more adaptive level of functioning through single contact or occasional contact. *Human Service Staff Training:* Enhancing or expanding the knowledge and skills of human service agency staff in meeting the needs of mental health clients. *Clinical Staff Development:* Enhancing and/or expanding agencies' or organizations' knowledge and skills in the mental health field for the benefit of the community-at-large or special population groups.

Program Name: Full Circle Family Program /Early Periodic Screening, Diagnosis and treatment (EPSDT) Program — **Appendix A-7**

System of Care: CBHS - CYF

Amount Year: $423,225 **Funding Source:** General Fund, Federal Revenues, EPSDT

Term: 7.01.10 – 6.30.11

Definition and # of UOS: UOS is equivalent to 1 hour of service.

Case Management Brokerage	130
MH Services	2,287
Medication Support	160
Crisis Intervention OP	20

Number of UDC/NOC: 348 **Total UOS** 2,597

Target Population: Individuals less than 21 years of age who meet the criteria for medical necessity for specialty mental health services and who quality for EPSDT services (i.e. full-scope Medi-Cal coverage).

Description of Service: Same as Appendix A-6

Program Name: Early Childhood Mental Health Initiative — **Appendix A-8**

System of Care: CBHS - CYF

Amount Year: $229,890 **Funding Source:** GF, HSA, DCYF

Term: 7.01.10 – 6.30.11

Definition and # of UOS: UOS is equivalent to 1 hour of service.

Outreach Svc/ Consultation Group	731
Outreach Svc/ Consultation Individual	626
Outreach Svc/ Class Observation	438
Outreach Svc/ Training Group	510
Outreach Svc/ Direct Service Group	169
Outreach Svc/ Direct Service Individual	365
Outreach Svc/ Linkage	147
Outreach Svc/ Evaluation Services	6

Number of UDC/NOC: 450 **Total UOS** 2,987

Target Population:	Children 0-5 and their families
Description of Service:	**Services include:** *Consultation – Individual:* Discussions with a staff member on an individual basis about a child or a group of children, including possible strategies for intervention. It can also include discussions with a staff member on an individual basis about mental health and child development in general. *Consultation -Group:* Talking/working with a group of three or more providers at the same time about their interactions with a particular child, group of children and/or families. *Consultation – Class/Child Observation:* Observing a child or group of children within a defined setting. *Training/Parent Support Group:* Providing structured, formal in-service training to a group of four or more individuals comprised of staff/teachers, parents, and/or family care providers on a specific topic. Can also include leading a parent support group or conducting a parent training class. *Direct Services – Individual:* Activities directed to a child, parent, or caregiver. Activities may include, but are not limited individual child interventions, collaterals with parents/caregivers, developmental assessment, referrals to other agencies. Can also include talking to a parent/caregiver about their child and any concerns they may have about their child's development. *Direct Services – Group:* Conducting therapeutic playgroups/play therapy/socialization groups involving at least three children

Program Name:	Youth Striving for Excellence – Teen Resource to Achieve Positive Practice (TRAPP) **Appendix A-9**
System of Care:	CBHS - Adult
Amount Year:	$5,000 **Funding Source:** State
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service. Health Education Services – Cost Reimbursement 1
Number of UDC/NOC:	N/A **Total UOS** 1
Target Population:	SF High School Students
Description of Service:	Provides classroom presentations, including question and answer periods, to approximately 250 students attending Balboa Teen Health Center and other designated SFUSD schools.

Program Name:	Prevention and Recovery in Early Intervention (PREP) Project **Appendix A-10**
System of Care:	CBHS – Older Adult
Amount Year:	$1,065,883 **Funding Source:** MHSA & Federal Cost Reimbursement ($989,000) & Fee For Service ($76,883).
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service. Case Management Brokerage 20 MH Services 248 Medication Support 116 Crisis Intervention OP 10
Number of UDC/NOC:	N/A **Total UOS** 394
Target Population:	Youth and young adults ages 12 - 26 who have had their first major psychotic episode within the previous two years or who, on the basis of the PREP diagnostic interview, are

Description of Service:	at high risk for having their first episode within two years. **Core services include:** *Algorithm based medication management.* For the first phase of the project, the Medical Director, has adapted the Texas Medication Algorithm to focus specifically on medication for young adults in the early stages of psychosis. *Cognitive Rehabilitation:* PREP Team member, working with a nationally renowned brain plasticity researcher, Dr. Michael Merzenich, has developed a computer-based cognitive rehabilitation program specifically designed to address the cognitive deficits engendered by psychosis. Evidence-based individual therapy, as appropriate, based on Cognitive Behavioral therapy (CBT) for early psychosis which teaches techniques for specific symptom clusters (positive symptoms, negative symptoms, depression, skills for emotion regulation, etc). *Multifamily groups:* Provide all groups for the families of young adults suffering from psychosis, even when the primary client chooses not to participate in treatment. *Strength-based care management:* Intensive care management ensures that the broad spectrum of clients and family needs are addressed. *Neuropsychiatric and other advanced diagnostic services* is available as needed at 30% time.

Program Name:	Felton Institute – Training in Older Adult Behavioral Health Screening **Appendix A-11**
System of Care:	CBHS – Older Adult
Amount Year:	$17,600 **Funding Source:** MHSA
Term:	7.01.10 – 6.30.11
Definition and # of UOS:	UOS is equivalent to 1 hour of service. Training Development – Cost Reimbursement 1
Number of UDC/NOC:	N/A **Total UOS** 1
Target Population:	Clinicians and interns who work with the older adult population in San Francisco primary care clinics.
Description of Service:	The Felton Institute provides training for case workers and interns who serve older adults in the Project Impact model, addressing issues of depression, substance abuse, generalized anxiety, and social isolation. The training provides an overview of the collaborative care team, medication management, Behavioral Activation, stepped care management, Problem Solving Therapy, and SBIRT.

1. **Program Name: Older Adult Behavioral Health Integrated and Full-Service Outpatient Services**
   Program Address: 1010 Gough Street
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 447-9805

2. **Nature of Document** (check one)

   x **New** ☐ Renewal ☐ Modification

3. **Goal Statement**

FSA provides a full and seamless range of behavioral health services to older adults directly addressing the highest levels of need citywide and in Catchment Area 2, Catchment Area 5, and ICM/ACT/FSP. In collaboration with the other two geriatric mental health outpatient clinics, Central City and Southeast Mission, we provide a system of care that enhances the capacity of older adult consumers, with an overall goal to assist clients to move out of specialty mental health services and into mainstream peer services and supports in the community.

4. **Target Population**

The target population is clients aged 60 and older who need specialized geriatric mental health services beyond what is available through the Adult System of Care. These clients have multiple disabilities, complex medical needs, dual diagnoses, or other specialized needs related to mental health and aging, and are best served by clinicians with geriatric mental health expertise. The population in each catchment area in this modality also has additional needs related to engagement, language, cultural awareness, stigma, social isolation, substance abuse, or cognitive deficits. Many suffer from long-term, chronic mental illness and/or substance abuse that have led to alienation from family members and friends, social skills deficits, isolation, and poverty. Many have not experienced routine medical treatment or connection to primary care. Many have a history of homelessness and/or institutionalization. FSA has long served LGBTQQ clients and continues to specialize in providing services for this under-served and under-identified older adult population. The following highlights the specific target populations in the catchment areas:

Catchment Area 2: Western Addition/Marina/Presidio
Many of these clients are dually diagnosed with both mental illness and substance abuse issues, and some multi-diagnosed with mental illness, substance abuse, severe medical conditions, physical frailties, and cognitive challenges. A significant number of clients are self-identified at LGBTQQ. Many suffer social isolation and lack family supports. Most require medications and may require home visits to provide services. Many require substance abuse intervention and dual-diagnosis services, related to a long history of alcohol use and other drugs. Many cannot take advantage of senior centers due to social skill deficits and symptoms related to their mental illness, and they benefit from our Day Support Center/Community Integration Services in developing these skills and receiving supportive services. The majority are in the lowest economic category. Some are homeless or at risk of homelessness.

Catchment Area 5: Richmond and Sunset Districts
This target population is mostly similar to the above, with additional specialized needs that reflect the diversity of older adults living in the western part of the city. This catchment area, therefore, specializes in providing linguistically and culturally appropriate services, targeting the specific needs of monolingual clients in Cantonese, Mandarin, Russian,

Tagalog, Korean, and Spanish languages, as well as other diverse populations. Similar to above, a significant number require a focused substance abuse intervention and dual-diagnosis services, but these needs are often more related to overuse and misuse of pain and sleeping medication. This catchment area will also work in close coordination with the city's Older Adult System of Care to meet the growing needs with this population across all catchment areas, such as providing psychiatric services by bilingual and bicultural Cantonese and case management in Cantonese, Mandarin, and Russian.

Special Older-Adult Intensive Case Management/Assertive Community Treatment/Full-Service Partnerships (Citywide Coverage)

In addition to the above, this higher level of service reaches older adults across the city with severe functional impairments and very complex needs, requiring intensive case management (ICM), Assertive Community Treatment (ACT), or services provided by the Full-Service Partnerships (FSPs) in order to remain safely in the community. Many are high emergency service users, with repeat hospitalizations, have been incarcerated, or are at risk to themselves or others. Many require outreach by peers in order to agree to services. Most require wellness and recovery services to aid empowerment and overcome behavioral health challenges. Many of these clients have substantial substance abuse disorder in addition to chronic mental illness. It is not unusual for an ICM/ACT/FSP client to be homeless and unknown to the current system of care. There is also a high number with significant cognitive impairment. This is the city's most vulnerable mentally ill population with the highest need for specialized case management.

Summary of target population:

Target population will be seniors ages 60 and above with a moderate to severe behavioral health condition (mental ill and/or substance abuse). We will serve:

1. All individuals citywide who need either an FSP or an ICM level of service.
2. All individuals living in Catchment Areas 2 or 5.

In addition, we have historically served all monolingual Cantonese and Russian speaking clients referred to us, regardless of their place of residence. Total Numbers to be served on an annual basis:

FSP: 64 unduplicated individuals, annually
ICM: 100 unduplicated individuals annually
Outpatient: 1,100 unduplicated individuals

5. Modality(ies)/Interventions

Modalities of Services used in the Older Adult Intensive-Case Management/Assertive Community Treatment/Full-Service Partnerships:

Direct Services:
Intake and Assessment: Intake will occur where best meets the client's needs; Assessment will be completed using the ADEPT and other tools to measure current psychological, emotional and behavioral issues.
Care Plan Development: Treatment plans will be developed in partnership with the client.
Case Management/Brokerage: Strength-based, recovery-oriented approach will apply to all case management, based on motivational interviewing and wrap-around principles.
Individual and Group Therapy: Evidence-based therapeutic interventions focused on symptom reduction, quality of life, and the recovery model.
Collateral: A service activity to a significant support person in the consumer's life.

Crisis Intervention: Emergency intervention, immediate face to face to prevent harm coming to the consumer.
Outcome-Guided Medication Support Services: All clients needing medication management have access to an FSA psychiatrist or a nurse practitioner, who assesses, prescribes, monitors, treats, documents symptoms or side effects, and educates.
Evidence Based, Integrated Behavioral Health Treatment: Will include substance abuse partners.
Peer Support and Volunteer Opportunities: Will be an important part of service delivery.
Community Integration Services: Will provide essential low threshold services to assist clients in transitioning to other program and natural supports in the community.

Indirect Services:
Providing mental health promotion
Providing trainings
Clinical Staff Development

Note: The FSP program can also utilize Mode 60 functions. These are either services provided to consumers who do not meet MediCal standards for reimbursement, such as, transportation, shopping, or socialization activities; in addition to in-kind services that are purchased for our consumers out of this program's flex fund budget. ICM does not have the flexible funding, or the capacity to bill under Mode 60.

6. Methodology

A. Program's outreach, recruitment, promotion, and advertisement.

Outreach is conducted with all collaborative partners, including primary care clinics, substance abuse treatment providers, residential care providers, residential behavioral health providers, hospitals, homeless shelters and adult correctional system, emergency crisis services, and other partners. All levels of service conduct direct outreach to older adults in communities where service connection is needed the most and in locations where the various populations feel the safest, such as cultural centers, senior centers, religious organizations, and other formal and informal support systems. Case Aides and Peer Volunteers are an essential part of outreach, engagement, and retention because of their direct experience as clients of the treatment system. Other outreach to the most fragile and disconnected consumers may be by an FSA's Psychiatric Nurse Practitioner (PNP). Consumers otherwise distrustful of treatment services are often willing to receive health care, if it is offered in a non-institutional setting, so the PNP will be an important element of our engagement strategy. The PNP will provide health screening and first aid, dispense minor medications (such as over-the-counter painkillers and analgesics, and topical skin medications), and unless already linked, will arrange for medical treatment through our primary care partners. In addition to street outreach, referrals are accepted from multiple sources, including SF General, Project Homeless Connect, APS, senior centers, Project Open Hand, other mental health and substance abuse agencies, PES, Sheriff, SFPD, hospital emergency rooms, and family referrals.

B. Program's admission, enrollment and/or intake criteria and process.

Intake will occur in our offices, at client homes, in hospitals, or wherever best meets a client's needs. At screening, we insure clients have a safe place to live, enough to eat, and medical care for acute conditions, before proceeding to assessment. Those who cannot be placed in housing immediately receive temporary housing while the assessment and housing placement process continues. Clinicians work with the housing placement and

stabilization process, offering clients a variety of housing resources, including through housing partners. Clients may also get assistance with food, clothing needs, and primary care examinations. Pressing health needs will be treated through our primary care partners. Many core program activities may need to be delivered in other settings, including where client live in their own homes, board and care homes, SRO hotels, the shelters, or streets. With basic health and safety assured, clients will receive comprehensive assessment using our "assessment toolkit", developed in collaboration with the Over 60 Project of UCSF. The toolkit is strength-based, comprehensive across all life domains, and designed to give care managers and consumers an understanding of the consumer's goals, aspirations, and challenges. Elements of the toolkit (available in English, Spanish, and Chinese) include:

The ADEPT: A strength-based assessment tool that assesses strengths and challenges in the domains of health, housing, basic needs, legal, social, family, and behavioral health.

The Diagnostic Tree: This comprehensive diagnostic process assesses clients for the nine most common types of mental health issues and establishes a severity baseline for each condition. This is tool is very helpful in identifying major behavioral health problems that have gone undiagnosed, as well as undiagnosed and untreated secondary conditions. The tool is used to identify which EBPs would benefit and be most acceptable to the consumer.

The WHOQOL and the CLSS: These tools are self-administered by the client and measure quality of life and daily life skills respectively. Completed every three months, they provide a method for measuring outcomes as experienced by consumers themselves, providing a basis for service that is simultaneously outcome-driven and consumer-driven.

Mini Mental Status Exam: Administered annually as a test for cognitive impairment.

C. Program's service delivery model.

Overview of the Service Model:

We will provide older adults with a full and seamless range of behavioral health services, directly addressing the highest levels of need citywide, and in close partnership with the other two specialized geriatric mental health outpatient clinics, Central City and Southeast Mission. Under this modality, we will also partner closely with Curry Senior Center, in their proposal for Catchment Area 4, providing mental health outpatient services (homeless case management) and specialized substance abuse outpatient services for older adults in the North of Market/Tenderloin/South of Market neighborhoods, as well as Walden House for substance abuse treatment throughout the city and Golden Gate for Seniors residential substance abuse treatment. An important part of our services will be out close partnership with four primary care clinics: Curry Senior Center, Maxine Hall Health Center, Ocean Park Health Center, and UCSF Lakeside Senior Medical Center. With these collaborating partners, our services will be fully dual diagnosis-competent at all levels and provide a full range of evidence-based, culturally and linguistically competent, recovery-oriented services throughout the spectrum of behavioral and physical health needs. We aim to enhance the capacity of older adult consumers, so that as many as appropriate are able to move out of specialty mental health services and into mainstream, peer services, and supports in the community, including aging services. We will provide all levels of care, including 24/7 crisis assessment and intervention, through telephone and face-to-face contact with a clinician known to the client, as well as budgeted transportation services for 5150s to PES. The goal is to transition clients out of the program within 12 to 18 months, and if that is not possible, to be routinely assessed for that treatment goal, and when possible, stepped-down to a lower threshold program. Our levels of care, consistent with the levels outlined in the RFP, are:

1. Full Service Partnerships: The most intensive level of care, with a caseload of approximately 13-1. Services are provided by a multidisciplinary team: a psychiatrist, psychiatric nurse practitioner, mental health clinician/care managers, substance abuse counselor, and peer case aides, and the team maintains fidelity to the assertive community treatment model. In our three years of operating this Senior FSP, we have found that engagement—and

particularly re-engagement after a treatment relapse—is best accomplished through gentle persistence, personal connections with staff maintained even through a period of non-compliance, and by being willing to help clients at whatever their level of readiness. Core program activities may need to be delivered in non-office settings wherever clients may be found, and flex spending may be used for basic needs and other items to assist them to stabilize and remain engaged in the program.

2. Intensive Case Management: Available to clients citywide, caseloads will be approximately 20-1 and will also be provided on a multidisciplinary team model. This will be an enhancement of our current ICM program, adding core components of the MHSA programs, as well as *under one roof* on-site substance abuse outreach and education and seamless connection to substance abuse treatment by partners; enriched group therapy using evidence-based practices, and added socialization and other supports by Peer Case Aides and Peer Stipended Volunteers.

3. Outpatient Case Management and Treatment: We will continue to offer two outpatient treatment programs, one in Catchment 2 and one in Catchment 5 at our existing offices in these districts, with substantial innovation meeting the requirements and vision put forth in this RFP, such as the greater use of peers and partnerships. These programs will serve individuals who require fewer than four visits per month, and similarly offer integrated care management, medication management, and evidence-based mental health and substance abuse treatment.

4. Community Integration Services: To assist our older adult clients overcome social isolation, improve social and personal skills, and become better integrated in their communities, we offer a variety of opportunities in our day support centers, partnering senior centers and adult day health care centers, and other senior programs in the city, including connections to natural supports and peer opportunities. Group therapy is a large part of this model, as research has shown it offers additional benefits to older adults, such as mutual aid and a sense of belonging.

The following highlights the phases of care for FSP, ICM, and Outpatient levels of care, which will be essentially the same, although the frequency of contacts and the mix of needed services will vary between levels.

Intake and Assessment: (described above)

Care Planning and Care Management: At the core of all services is strength-based recovery-oriented care management. FSA has developed a rigorous approach to care management built on motivational interviewing and wrap-around principles. Each FSA team member (including peer case aides and medical staff) receives intensive training on assessment, care planning, and culturally competent service delivery, motivational interviewing, and working in a multidisciplinary team, as well as intensive training on outreach, engagement, and re-engagement. In addition, staff who work in our senior programs receive ongoing specialized training in geriatric mental health.

In the FSP/ACT/ICM programs, service contact will be available 24-7. Each client will have an assigned case manager as the primary point of contact, and together they will develop a strength-based plan of care with measurable outcome objectives. Case management will include brokerage services, as well as brief, evidence-based treatment therapy, when appropriate. Daily living support services will be offered as part of the care coordination process and may include problem solving, skills training, and assistance – often by peers and case aides – to help clients carry out personal hygiene and grooming tasks; perform household activities; housing supports including working with board and care operators; improving money-management skills; using available transportation; and finding and using healthcare services. Every client will be linked to primary care, either through our clinic partners or by enrolling in Healthy San Francisco. For clients resistant to primary care for a variety of reasons, FSA is working on providing primary care services onsite, with primary care partners providing satellite clinic services, but will continue to provide peer escort services to help reduce barriers to visiting primary care doctors and clinics The goal is to establish a rapport with primary care staff so these clients will feel comfortable receiving services in their neighborhood clinic.

Outcome-guided medication regimens: All clients needing medication management have access to an FSA psychiatrist or a nurse practitioner, who assesses, prescribes, monitors, treats, documents symptoms or side

effects, and educates. All case managers assess and document client symptoms and behavior in response to medication. Medication policies and procedures identify all processes and safety procedures around medications. FSA is developing a medication decision support tool to assist clients to communicate clearly with their providers about medications and to guide physicians in prescribing, monitoring, and following up. FSA intends to utilize an NIMH stimulus grant to develop a computer kiosk system for clients to self-track positive benefits of drugs and potential side effects to facilitate discussion with staff.

Evidence based, integrated behavioral health treatment: Case managers and clients can access an extensive, organized system of treatments and supports to promote and sustain recovery. FSA will follow all requests by CBHS in this area, and in addition, through its Felton Institute, provides national-caliber faculty to train, supervise, and certify staff in a range of evidence-based treatments that span the spectrum of diagnoses of clients. In most cases, FSA has staff with diverse linguistic competencies trained in each of these approaches. These include:

Substance Abuse: FSA clinicians are trained in Motivational Interviewing and offer adjunct substance abuse group therapy. In addition, FSA partners with Walden and Golden Gate for Seniors to provide more extensive substance abuse outpatient and residential treatment. In collaboration, these partners will continue to develop more accessible and effective treatment strategies for clients with substance abuse issues. **Other Evidence-Based Practices.** FSA has trained staff in numerous evidence-based practices including PST for depression, PST for psychosis, CBT for Depression, CBT for Psychosis, Trauma-focused CBT, DBT, Life Review, and Multifamily Psycho-education Groups. Many treatments are available in Spanish and Cantonese.

Peer Support and Volunteer Opportunities: Older consumers interested and able to participate in meaningful competitive employment are assisted in that effort. For many others, making a meaningful contribution remains important and is key to maintaining robust physical and mental health throughout the lifespan. FSA offers its clients a range of volunteer opportunities both within our agency and at other partner programs throughout the community. ***Community Integration Services:*** Participants in all levels of care are offered opportunities in community integration as an integral part of the recovery process. These services are designed to help higher functioning clients transition to other support systems in the community, as well as provide effective outreach and engagement for individuals who are socially isolated, need mental health services, and benefit from evidence-based and innovative group therapy. Full assessments, preventive screening, and care plans lead to appropriate transitions and treatment options. Transition and escort services, often by case aides and peer volunteers, help clients feel comfortable going to senior centers, or make appointments at primary care clinics. Other services include education and assistance for more healthy living, including smoking cessation assistance and exercise, and meaningful joint activities in the community. The Older Adult Day Support Center at 1010 Gough provides group Paratransit services, hot lunch, and a full range of low threshold services, including groups and peer-led programming.

FSA's Senior Programs participate in the CBHS Advanced Access initiative, including timely data measurement at the site and reporting of data to CBHS as required. They provide and document the initial risk assessment using the CBHS IRA form within 24-48 hours of request for service, and adhere to CBHS guidelines regarding assessment and treatment of uninsured clients. All services are ADA compliant. Clinic services are provided in the client's home, other senior sites (health clinics, Adult Day Health, senior centers, etc.), and at FSA offices.

D. Program's exit criteria and process.

Guidelines for discharge include CBHS definitions of medical necessity, stabilization of debilitating psychiatric symptoms, resolving of problems on plan of care and successfully linking client to alternative services for care (i.e.

PCP , Adult Day Health, etc.). Clients will be stepped-down from FSP/ICM services to less intensive services upon meeting CBHS exit criteria. Clients will be continuously assessed in their recovery process, and when appropriate, stepped down along a continuum of care that best meets their needs, through FSA's Community Integration Services, when appropriate. Also, when appropriate, clients will be discharged to other programs in the community that can best meet their current needs in recovery and allow for less dependence on mental health

E. Program's staffing - Please see Exhibit B.

7. Objectives and Measurements

OUTCOME 1: IMPROVE CLIENT SYMPTOMS

Objective A.1: Reduce Psychiatric Symptoms

A.1a. Applicable to: Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Children, Youth, Families, Adults and Older Adults except supported housing programs

The total number of acute inpatient hospital episodes used by clients in Fiscal Year 2010-11 will be reduced by at least 15% compared to the number of acute inpatient hospital episodes used by these same clients in Fiscal Year 2009-10. This is applicable only to clients opened to the program no later than July 1, 2010, and had no IMD or CTF episode during FY 2000-10. Data collected for July 2010 – June 2011 will be compared with the data collected in July 2009– June 2010.

Programs will be exempt from meeting this objective if more than 50% of the total number of inpatient episodes was used by 5% or less of the clients hospitalized.

Data Source:
CBHS Billing Information System - CBHS will compute.

A.1e. Applicable to: Providers of Behavioral Health Services who provide mental health treatment services to children, youth, families, adults and older adults except 24 hour programs

50% of clients who have been served for two months or more will have met or partially met their treatment goals at discharge.

Client Inclusion Criteria:
Clients discharged between July 1, 2010 and June 30, 2011 who have been served continuously for 2 months or more.

Data Source:
BIS Reason for Discharge Field.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

A.1k. Applicable to: ***Intensive Care Management (ICM) Providers of Adult and Older Adult Behavioral Health Services***

ICM providers will require that clinicians evaluate level of functioning for ALLCLIENTS by completing the Milestones of Recovery Scale (MORS).

New clients will complete the MORS at intake, every month thereafter, and at discharge. Continuing clients will complete the MORS within 90 days of the new contract year, and every month thereafter, and at discharge.

Providers must submit 75% of required MORS forms for all clients to pass this objective.

Data Source:
MORS submitted to website and summarized by Program Evaluation Unit.

Program Review Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

OUTCOME 2: Reduce Substance Use

Objective A.2: Reduce Substance Use

A.2a. Applicable to: **Providers of Behavioral Health Services who provide Substance Abuse Treatment Services**

During Fiscal Year 2008-09, at least 40% of discharged clients will have successfully completed treatment or will have left before completion with satisfactory progress as measured by BIS discharge codes.

Data Source:
CBHS CalOMS BIS discharge status field, codes #11, 12, 13 and 14.

Client Inclusion Criteria:
Clients discharged between July 1, 2010 and June 30, 2011

Program Review Measurement:
Objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011

A.2b. Applicable to: **Providers of Behavioral Health Services who provide Substance Abuse Treatment Services to adults, older adults, children, youth, and families.**

Substance Abuse Outpatient Treatment Providers will show a reduction of AOD use from admission to discharge for 60% of clients who remain in the program for 60 days or longer. For Substance Abuse Residential Treatment Providers, this will be measured from admission to discharge for clients who remain in the program for 30 days or longer.

Client Inclusion Criteria:
Clients discharged between July 1 2010 and June 30, 2011.

Data Source:
CalOMS.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

A.2c. Applicable to: **Providers of Behavioral Health Services who provide Substance Abuse Treatment**

Services to adults, older adults, children, youth, and families.

Substance Abuse Treatment Providers will show a reduction of days in jail or prison from admission to discharge for 60% of new clients admitted during Fiscal Year 2009-10, who remained in the program for 60 days or longer. For Substance Abuse Residential Providers, this objective will be measured on new clients admitted during Fiscal Year 09-10, who remained in the program for 30 days or longer.

Client Inclusion Criteria:
Clients discharged between July 1, 2010 and June 30, 2011.

Data Source:
CalOMS.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

OUTCOME 3: IMPROVE CLIENT FUNCTIONING

Objective A.3: Increase Stable Living Environment

A.3a. Applicable to: **Providers of Behavioral Health Services for Children, Youth, Families, Adult or Older Adult Mental Health Programs, except 24-hour programs**

35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI.

Data Source:
BIS Living Situation Codes.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

B. OTHER MEASURABLE OBJECTIVES/PROCESS OBJECTIVES

Objective 1: Access to Services

B.1a. Applicable to: **All Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Adult and Older Adults Health Programs, except 24-hour programs**

50% of uninsured active clients, with a DSM-IV diagnosis code that likely indicates disability, who are open in the program as of July 1, 2010, will have SSI linked Medi-Cal applications submitted by June 30, 2011.

Programs are also strongly encouraged to refer eligible clients to Healthy San Francisco.

Client Inclusion Criteria:

Uninsured active clients (seen by the program at least once between April 1, 2010 and June 30, 2011) with a DSM-IV diagnosis code that likely indicates disability (list of DSM-IV diagnosis codes will be provided by CBHS) and open in the program as of July 1, 2010, will be included in the calculation.

Data Source:
Program Director will show proof of SSI applications submitted for/by clients (such as copies of applications, or proof of online application submission). Provider shall email DPH SSI Program Coordinator a list containing names and Social Security numbers of clients who applied for SSI through the Agency's assistance at luciana.garcia@sfdph.org.

Program Director shall keep in files proof of SSI applications submitted for/by clients (such as copies of applications or proof of online application submission).

Program Review Measurement:
Objective will be evaluated based on the first 12-month period from July 1, 2010 to June 30, 2011. Program Director shall send their lists to SSI Program Coordinator by June 30, 2011.

Objective 4. Collect Client Outcomes

B.4a. Applicable to: **Providers of Behavioral Health Services who provide Substance Abuse Treatment Services**

During Fiscal Year 2008-09, 70% of closed treatment episodes will show three or more service days of treatment as measured by BIS indicating clients engaged in the treatment process.

Data Source:
CBHS Billing Information System - includes outpatient, day treatment, residential single adult and residential family, methadone detoxification and methadone maintenance and excludes residential social or residential medical detoxification. CBHS will compute.

Program Review Measurement:
Objective will be evaluation based on discharges during a 12-month period from July 1, 2010 to June 30, 2011.

Objective 5. Documentation/Authorization

B.5a. Applicable to: **All Providers of Behavioral Health Services who provide Adult and Older Adult Mental Health Outpatient Services that are not exempt from having services authorized**

At least 90% of a sample reviewed by CBHS of open, active clients (defined as those having received a billable service in a program within 90 days) will have a current authorization, and 100% will have a current plan of care. Programs with multiple non-exempt reporting units will have data from those RU's combined before computation.

Data Source:
PURQC oversight audit. A random sample generated by CBHS and proportional to program caseload but not more than 25 clients will be used for PURQC oversight.

Objective 6. Client Satisfaction

B.6b. Applicable to: **Providers of Behavioral Health Services who provide Children, Youth, Families, Adult**

or Older Adult Mental Health Treatment Services (excluding crisis services, suicide prevention and conservatorship)

During Fiscal Year 2010-11, 100% of unduplicated clients who received a face-to-face billable service during the survey period will be given and encouraged to complete a Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on the survey administration closest to the 12-month period from July 1, 2010 to June 30, 2011.

B.6c. Applicable to: ***Providers of Behavioral Health Services who provide Substance Abuse Services***

During Fiscal Year 2010-11, 100% of unduplicated treatment clients or prevention participants in attendance at the program on the targeted satisfaction survey days will be given and encouraged to complete the Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on the survey administration closest to the 12-month period from July 1, 2010 to June 30, 2011.

C. CONTINUOUS QUALITY IMPROVEMENT, PROGRAM PRODUCTIVITY AND SERVICE ACCESS

Objective 1. Program Productivity

C.1a. Applicable to: ***All Providers of Behavioral Health Services who provide Substance Abuse Treatment and Prevention and Mental Health Services***

During Fiscal Year 2010-11, 19,657 units of service (UOS) will be provided consisting of treatment, prevention, or ancillary services as specified in the unit of service definition for each modality and as measured by BIS and documented by counselors' case notes and program records.

Date Source:
CBHS Billing Information System – DAS 800 DW Report or program records. For programs not entering data into BIS, CBHS will compute or collect documentation.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 2. Access to Services

C.2a. Applicable to: ***All Adult and Older Adult & CYF Behavioral Health Intensive Case Management Programs including SPR's***

The program will have at least 40 new client episode openings for Fiscal Year 2010-11.

(The number of targeted new client episode openings during FY 2010-11 will be individually negotiated with the Program Manager for each specific Intensive Case Management Program based on historical rate of episode openings and baseline profile of psychiatric stability of caseload.)

Client Inclusion Criteria:
All new unique client episode openings into the ICM program during FY 2009-10.

Data Source:
CBHS Billing Information System - CBHS will compute.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

Objective 4. Client Outcomes Data Collection

C.4d. Applicable to: ***All providers of Behavioral Health Services who provide substance abuse prevention services***

During Fiscal Year 2009-10, all Substance Abuse Prevention providers will complete a common risk assessment tool for 60% of the program participants, with recurring services.

Data Source:
Program Self Report

Program Review Measurement:
Objective will be evaluated quarterly during the 12 month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

C.4e. Applicable to: ***Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services for Adults and Older Adults***

For clients on atypical antipsychotics, at least 50% will have completed the documentation of the CBHS Antipsychotic Metabolic Monitoring Form or equivalent, in the clients' medical record. At a minimum, the record should include annual monitoring of weight, blood pressure, and fasting glucose (or Hemoglobin A1:C).

Client Inclusion Criteria:
Adult and Older Adult clients on any atypical antipsychotic medication (aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone) prescribed by Provider any time during July 1, 2010 to June 30, 2011.

Data Source:
Program Self Report and/or Client medical record audit. / **MUIC** Metabolic Monitoring Subcommittee

Program Review Measurement
Objective will be evaluated based on a 12 month period from July 1, 2010 to June 30, 2011. To meet objective, Metabolic Monitoring Form should show at minimum annual monitoring of weight, blood pressure, and fasting

glucose (or Hemoglobin A1.C). Upon request, Provider to submit copies of Metabolic Monitoring Forms for randomly selected clients.

C.4f. Applicable to: ***All Substance Abuse Treatment Providers***

100% of active substance abuse treatment staff who collect CalOMS data must complete the ADP CalOMS web-based training by September 30, 2010. All new substance abuse treatment staff must complete the web-based training within 30 days of their start date.

Program Review Measurement
Staff must complete a sign-in indicating the date on which they completed the training. Sign-in Sheets will be collected from all substance abuse treatment programs after September 30, 2010, and will be compared to active staff lists generated from the INSYST billing data provider tables.

Objective 5. Integration Activities **

C.5a. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Each program will complete a new self-assessment with the revise COMPASS every two (2) years (a new COMPASS must be completed every other fiscal year).

Data Source:
Program managers to review information sent to CBHSIntegration@sfdph.org via the shared folder to monitor compliance.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

C.5b. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Using the results of the most recently completed COMPASS (which must be completed every 2 years); each program will identify at least one program process improvement activity to be implemented by the end of the fiscal year using an Action Plan format to document this activity. Copies of the program Action Plan will be sent via email to CBHSIntegration@sfdph.org.

Data Source:
Each program will complete the COMPASS self assessment process and submit a summary of the scores to CBHSIntegration@sfdph.org. The program manager for each program will review completed COMPASS during the month of January and submit a brief memorandum certifying that the COMPASS was completed.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

C.5c. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Each behavioral health partnership will identify, plan, and complete a minimum of six (6) hours of joint partnership activities during the fiscal year. Activities may include but are not limited to: meetings, training, case conferencing, program visits, staff sharing, or other integration activities in order to fulfill the goals of a successful partnership. Programs will submit the annual partnership plan via email to CBHSIntegration@sfdph.org.

Data Source: Program self report such as activity attendance sheets with documentation of time spent on integration activities. The program manager will certify documentation of this plan.
Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

C.5d. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Each program will select and utilize at least one of the CBHS approved list of valid and reliable screening tools to identify co-occurring mental health and substance abuse problems as required by CBHS Integration Policy (Manual Number: 1.05-01).

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings to be held by December 2010 and March 2011 will be included in the program review.

C.5e. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

During Fiscal Year 2010-11, each program will participate in one Primary Care partnership activity. The Primary Care Partner for this activity must be the DPH Oriented Primary Care Clinic located in closest proximity to the program, or most appropriate for the program population. Primary care program which cannot be Primary Care Partner for this purpose, include primary care program which are part of the same overall agency as the Behavioral Health Program. Optimal activities will be designed to promote cooperative planning and response to natural disaster or emergency events, neighborhood health fairs to increase joint referrals, or mutual open house events to promote cross-staff education and program awareness.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

C.5f. Applicable to: ***All CBHS programs, including contract and civil service mental health and substance***

abuse programs providing prevention, early intervention and treatment service in Fiscal Year 2010-11.

Providers will have all program service staff including physicians, counselors, social workers, and outreach workers each complete a self assessment of integration practices using the CODECAT. This self assessment must be updated every two years.

Data Source:
Program self report with submission of document of staff completion of CODECAT sent to CBHSIntegration@sfdph.org. The program manager will document this activity.

Objective 6. Cultural Competency

C.6a. Applicable to: ***All Providers of Behavioral Health Services***

Working with their CBHS program managers, programs will develop three (3) mutually agreed upon opportunities for improvement under their 2008 Cultural Competency Reports and report out on the identified program-specific opportunities for improvement and progress toward these improvements by September 30, 2010. Reports should be sent to both program managers and the DPH/EEO.

Data Source:
Program managers will review progress utilizing the DPH Cultural Competency Report Evaluation Tool.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 8: Program and Service Innovation & Best Practice

C.8a. Applicable to: ***Providers of Behavioral Health Services that provide Mental Health and Substance Abuse Services to Children, Youth, Families, Adults or Older Adults***

If applicable each program shall report to CBHS Administrative Staff on innovative and/or best practices being used by the program including available outcome data.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

B. Other Measurable Objectives
Describe any other objectives for the program. These could include for example, start-up and process objectives. Process objectives are important activities or tasks to be accomplished by the program staff during the contract period. See Section instructions for more information.

Outcomes

1) Within the first month of service, all consumers will be enrolled in a primary care home.
2) Within the first month of service, all consumers with acute medical conditions will have received treatment.
3) Within the first month of service, all consumers who are homeless and who are willing to be housed will have been placed in at least temporary housing.
4) Episodes of mental health hospitalization will decrease by 50% in the first year of service compared to the year prior to service entry.
5) Episodes of homelessness will decrease by 80% in the first year of service compared to the year prior to service entry.
6) 60% of clients will show an increase in quality of life by six months of service as measured by WHOQOL-BREF; 80% will show improvement the first year.
7) 50% of clients will show an increase in life skills over the first six months of service as measured by the CLSS; 75% will show improvement in the first year.
8) 75% of clients with substance abuse problems at intake will show a reduction in harmful practices, through abstinence, reduction in use, transition to a safer drug, or more sterile conditions of use.
9. 50% of clients with mental health or substance abuse problems will demonstrate statistically significant symptom remission as measured by the Diagnostic Tree.

8. Continuous Quality Improvement

Describe your program's CQI activities to enhance, improve and monitor the quality of services delivered. The CQI section must include a guarantee of compliance with Health Commission, Local, State, Federal and/or Funding Source policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, and Client Satisfaction.

FSA has appointed a separate division, called The Felton Institute, to roll out its training, CQI, and evaluation components for the agency at large. The Felton Institute is the seat of quality assurance and program innovations, implementing evidence-based practice, CIRCE (our on-line data collection system) and program evaluation across all divisions at FSA. CIRCE tracks all CBHS requirements per contract. We are currently collaborating with CBHS to have CIRCE integrated with the new AVATAR system.

1. **Program Name: FSA Older Adult Peer-Based Wellness and Recovery Center**
   Program Address: 1010 Gough Street
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 474-9934

2. **Nature of Document** (check one)

   x **New** ☐ Renewal ☐ Modification

3. **Goal Statement**

FSA's Curry Drop-In Center is a Senior Peer-Based Wellness and Recovery Center that operates as a program of attraction and socialization at the Curry Senior Center at 333 Turk Street, in the Tenderloin section of the city. The Center is run in conjunction with the congregate meal program provided by Project Open Hand for breakfast and lunch, Wednesday through Sunday. The program utilizes peers and peer networks and provides group and one-to-one activities, peer support mentoring and assistance, socialization, and skill development, and a safe place to be with friends. The program links seniors with treatment, medical care, support services, and resources in the community, while providing a supportive, low-threshold, non-judgmental environment in which elders proceed at their own pace. The aim is to connect elders to the support they need.

4. **Target Population**

The target population is older adults 60 and older who currently have mental health and/or substance abuse issues, who may be homeless or episodically homeless, and who may or may not have been connected to the behavioral health services before. Some may have cognitive impairments, severe disabilities, chronic health conditions, or living with HIV/AIDS. Some require a focused substance abuse intervention. The Tenderloin and surrounding neighborhood in San Francisco have large numbers of isolated older adults, with severe mental illness and co-occurring disorders. The center will serve an average of 40 clients per day in FY 2010-2011. About 40% are African American, 25% Latino, 10% white, 1% Native American, and about 25% Asian/Pacific Islander. We estimate about 20% are LGBTHQQ. About one-fourth are women.

5. **Modality(ies)/Interventions** - Please see CRDC.

6. **Methodology**

A. Program outreach, recruitment, promotion, and advertisement.

Recruitment: The Senior Peer Recovery Center operated in conjunction with the Curry Senior Center. The first point of recruitment is the meal program and its attraction of regular attendees. Through regular contact with both staff and peer counselors, the program builds rapport and engages the participants in Recovery Center programming. FSA also recruits via flyers, brochures, and through direct connection with the many agencies serving elderly clients, and information passed through external peer networks. The Center works with Project Open Hand and Project Homeless Connect and conducts repeated engagement to identify potential participants.

The Center has established a non-threatening, ultra-low threshold of service free of intrusive sign-in practices. We use logs (such as peer assistance or referral logs) to track participation.

Engagement: Peer staff and their supervisor at the meal site introduce themselves and engage with the clients to establish a trusting relationship, recognizing that trust and rapport take time and require skills and sensitivity. As recommended by the focus groups, a friendly system has been developed by peer staff and volunteers that allow people to be introduced warmly when they "drop in," and a great amount of effort is made to make everyone feel welcome and comfortable. We have group activities in the meal room between breakfast and lunch that allows participants to feel that they are part of a community. Repeated attempts are made to engage clients, without imposing value judgments on those individuals who choose not to participate.

Retention: Retention is the goal only if the participant continues to gain benefit from the community, but efforts toward community integration are pursued for all participants, so that they can meet their needs and find greater fulfillment within the neighborhood community or beyond.

B. Program's admission, enrollment and/or intake criteria and process.

Admission: Based on low threshold engagement to bring the targeted population into a comfortable area of engagement, so that services can be offered and more easily accepted.

Outreach and Community Speakers: Staff contact community agencies and arrange outreach visits a minimum of twice a month, and community agencies are encouraged to speak at the Center from two to four times a month. Staff make appointments with community based agencies to conduct outreach up to four times per month. These efforts can lead to new guests attending the center, getting new ideas for groups, and lead to agencies sending out guest speakers to the Drop-In Center.
Assessment: Staff presents each new guest with a Welcome Packet. The packet includes the monthly activities calendar, the center rules, and a Curry Center brochure. Staff and volunteers use this time to engage, listen, and assess through an informal welcoming interview process. Staff are encouraged to "meet the client where they are" when assessing for service needs. Even if a new guest declines services, the individual knows when they have questions or are ready for services that staff are happy to meet and help them get services they need.

C. Program's service delivery model.

Since 2007, FSA has been providing a drop-in Senior Peer-Based Wellness and Recovery Center (Curry Drop-In Center) at the Curry Senior Center at 333 Turk Street, in the Tenderloin section of the city, in conjunction with the congregate meal program provided by Project Open Hand for breakfast and lunch. The Curry Drop-In offers programming Wednesday through Friday, from 9am-3pm, and Saturday and Sunday, from 9am-1pm. Essential to this program are the weekend hours, when little is available for troubled and isolated seniors in the Central City.

The program provides group and one-to-one activities, peer support mentoring and assistance, socialization, and skill development, as well as a safe place to be with friends. The program works to link seniors with treatment, medical care, support services, and other resources in the community, while providing a supportive, low-threshold, non-judgmental environment in which elders can proceed at their own pace. A range of volunteer, stipend, and regular employment opportunities are provided for consumers. Consumers offer ideas that are then integrated into operation by program staff. Volunteers help to set up and run the groups with constant staff over-site with most of

the activities being planned and carried out by consumers themselves, including self-help support groups. The program conducts extensive outreach to recruit participants, as well as peer counselors and other volunteers. Peer support staff carry a client case load and provide assistance with activities of daily living as well as other necessary and beneficial supports.

Forty participants will attend the center daily, participating in various capacities. Core services include the above descriptions of outreach and assessment, and:

Case Management: Staff will refer to appropriate services upon quest request. Peers can escort to appointments, when appropriate, either on foot or on MUNI.
Treatment: Staff utilizes a Harm Reduction approach coupled with Motivational Interviewing techniques to engage the individual where they are in their decision to seek out treatment services. If needed, staff or volunteers will meet individually with a client on a regular basis to build report and support the client in their decision to seek out appropriate treatment services. Wellness and Recovery is always promoted during the process.
Individual Advocacy: Through the process of building group and individual supportive relationships with guests, staff and peers promote and encourage individual advocacy to guests. This is done through monthly Community meetings, as well as through encouraging guests to approach staff and/or volunteers with questions, concerns and needs they may have. By encouraging and supporting individual and group advocacy, the Peer-Based Wellness Center is helping to reduce the individual's feeling of stigma through Strength-Based empowerment.
Policy and Systemic Advocacy: Reduction of stigma and the promotion of ideas incorporated in wellness and recovery. This contributes to a systems change in service delivery, particularly in reaching underserved and unidentified older persons in need.

A Welcoming Hub to Services

All older adults in the city, aged 60 and older are welcomed into the Wellness and Recovery Center. Following the "Every Door is the Right Door" approach, one of the goals of this project is to encourage older adults to seek treatment for mental health or substance abuse issues, as well as be provided medical services at a primary care home. All new participants are given an orientation to the center on an individual basis, including information about activities, Curry Center rules and guidelines, and a tour of the center and the Project Open Hands meal site. If the consumer expresses a desire for case management or mental health services, they are referred to appropriate services at Family Service Agency, Curry Senior Center, or other partnering agencies. All participants who do not already have a primary care home will be connected to Curry Senior Center's medical clinic or to another appropriate primary care clinic. Participants requesting assistance with substance abuse will be connected to Curry Senior Center's substance abuse program or other partnering treatment providers. Those needing housing services will be connected to Curry Senior Center's Housing Services, or other housing services provided by partnering agencies. All participants will be offered these connections to services in a non-threatening, low-key approach; In addition, the door remains open to revisit the discussion towards connecting to services at any time. All participants are asked to sign a log sheet for attendance for safety reasons, as well as program tracking purposes, and these records are used to track unduplicated attendance each quarter

The Recovery Model

Although some view recovery from a more traditional medical definition of the absence of illness, the psych-rehabilitative recovery model definition is understood as an ongoing, individualized process for persons with mental illness to be able to live their lives as fully as possible, even while enduring the symptoms and issues involved with their illness. The Wellness and Recovery Center fully embraces this second model and seeks to assist participants in locating jobs, meaningful activities and hope in their lives.

Peer Volunteers

The Peer Volunteer Program is an essential component of the center. Volunteers support the needs of the all participants of the center. The program helps the volunteers reach goals in building self-confidence, esteem, and other aspects of the Recovery Model. Monthly meetings are held with the Peer Volunteer Staff for planning and information sharing. Basic training in Motivational Interviewing is offered to give peers greater skills for assisting center participants. Peer Volunteers also help plan group activities. The Peer Volunteers solicit feedback from guests around activities they would like to see implemented at the Center and report back to staff.

Group Activities

Group activities are offered for outreach, socialization, education, community integration, health and wellness. Accessible, low-key therapeutic groups begin to address mental health, co-occurring disorders and substance abuse from a Harm Reduction perspective.

Activities that assist with Outreach

Peer volunteers and center participants, through focus groups, decide what activities they would like to attend at the center. So far, these have included Music Appreciation, Current Events, Cooking with a Microwave, and Educational Documentaries with Post-Film Discussion.

Socialization

Participants enjoy interactive games, allowing opportunities to develop interpersonal skills, make friends, and have fun. Many of the participants do not live in housing that promotes a sense of well-being and relaxation. Following the Recovery Model, hope and joy are a goal that the center strives to promote by providing a safe, friendly, and warm environment. The games and opportunities for socialization help increase motivation for on-going attendance. Games have included various organized board games, a monthly (magnetic) dart tournament game, memory games, historical quizzes, "Do You Remember" discussions, arts and crafts, etc.

Education

The center's lead peer case aide has been very active in soliciting other programs and resources in the neighborhood to come to the center and present opportunities. These guest speakers provide information about resources, health issues, and community opportunities, including:

- Curry Nursing Staff: Education about important health issues
- Tom Waddell: Education about healthy eating
- RAMS: About job opportunities in their HireAbility Program
- Hospitality House, where participants are linked to creative expression through the arts
- Office on Aging, Case Manager: To provide information about housing opportunities
- The Living Room, for socialization opportunities

Substance Abuse Treatment

The center strives to provide greater access to service needs by the participants. It is the Wellness and Recovery Center's goal to create an environment that emphasizes awareness of substance abuse issues and encourages entry into treatment, but does not stigmatize or drive away those participants who are not ready to address their substance abuse problems. Education is offered about co-occurring issues (including smoking), from guest speakers and videos, which follow with open discussions and encourage individuals to accept referrals for treatment. Participants are informed and encouraged to attend AA and NA groups when they are ready to attend treatment, as well as Curry Senior Center's range of substance abuse treatment programs on-site. The Center requires sobriety among participants and asks obviously intoxicated or participants under the influence of substances to leave the premises immediately. Participants are allowed to return to the Center, however, at which

time attempts are made to provide clients with targeted outreach and follow-up with additional linkages to other services.

In 2008, the Center participants took part in a smoking cessation study with UCSF. Participants offered their input to a number of focus groups. From that study has come a recommendation for a smoking cessation program at the Center, which is currently being developed and will be implemented in 2010.

Other Connections

Starting in the Fall of 2009, Canon Kip Senior Center has been coming to the Center twice a month to provide information and referral services; as part of their contract with the Department of Aging and Adult Services. Participants are provided hands-on assistance with filling out social security forms and other service applications, as well as information about a number of programs for older adults in the city. In addition, a connection to Canon Kip services is made, such as computer classes, weekend socialization opportunities, and the CHEFS program to develop skills for older adults in professional cooking.

Community Integration

Community Integration of the mentally ill is viewed as a benchmark for success of community mental health. The Wellness and Recovery Center fosters community integration with opportunities to engage in activities outside the center. Outside activities have included:

- Joint BBQs at Family Service Agency's Day Support Center
- Participating in an elder abuse awareness rally at City Hall or another advocacy effort on behalf of older adults
- Performing at a city-wide, older adult talent show at the War Memorial Building
- Joining an art class at Hospitality House

Providing additional meaningful opportunities for community integration will continue to be an important goal for the Center.

Health and Wellness

Many studies have shown that exercise is important for improving mental health as well as higher medical outcomes and longevity of life. The Center strives to connect all clients to primary care services, but to also provide opportunities for more healthy living, including a daily exercise program, walking, healthy eating, and relaxation methods.

Therapeutic Groups

WRAP: As part of the strengths-based assessment and case planning model FSA embraces, the Center has started a group to assist participants develop a Wellness and Recovery Action Plan (WRAP). WRAP is a self-management and recovery system developed by consumers, designed to monitor uncomfortable and distressing symptoms and to reduce, modify or eliminate those symptoms by using planned responses. WRAP is an important relapse prevention and recovery tool that helps to increase the consumer's control.

Problem-Solving Therapy:

Through a research grant with UCSF and the National Institutes of Mental Health, FSA clinicians are being trained and certified in Problem Solving Therapy in treating depression and psychosis in older adults. Our own experience with PST at FSA is that older adults with severe and persistent mental illnesses are able to participate actively in treatment and report improved quality of life and social engagement as a result.

Ongoing Training for FSA Staff, including Peer Case Aides

All Center staff and peer case aides will take part in FSA's extensive training offered through the FSA's

Felton Institute. FSA has placed a high priority on training staff in evidence-based practices to meet the needs of their clients. In collaboration with experts at UCSF, UC Berkeley, UC San Diego, clinicians working with older adults have been trained in Strengths-Based Care Management, Problem-Solving Therapy, Motivational Interviewing, and Cognitive Behavioral Therapy. During the 2009/10 fiscal year, clients were introduced to Reminiscence Therapy and Problem Solving Therapy for Psychosis. Through the Felton Institute, FSA has been offering geriatric training for its clinicians and other older adult mental health providers. Topics include issues around delirium, depression and dementia; medical conditions and complications; substance abuse; elder abuse, cognitive impairment, and cultural diversity.

In addition, FSA has been a leader in providing services to clients with hoarding and cluttering issues through its work on the Hoarding and Cluttering Task Force, as well as support group. The Center's staff will continue to attend hoarding and cluttering conferences and trainings.

D. Program's exit criteria and process.
As described above, the goal of this program is to connect participants to whatever services can meet their needs. Please see details above.

E. Program's staffing - Please see Appendix *B*

7. Objectives and Measurements

Short Term Outcomes are to: Provide non-traditional hours of service (weekends) in the Tenderloin, provide introduction to community services through outreach and in-house educational programming, provide a sense of community and safety in the Tenderloin, offer access and connection to services: case management, mental health treatment, substance abuse treatment, primary care, offer greater connection to housing, a 25% reduction in homelessness, and offer elders a better perception of their quality of life, increasing in 25% of cases.

Long Term Outcomes include: connecting participants to on-going primary care and preventive measures, providing a safe and comfortable community center to increase the likelihood that participants will have access to appropriate services, contributing to a more stable living condition for participants, contribute to a more stable mental health an/or substance abuse condition, reduced social isolation, serving participants with evidence-based practices and a wellness/recovery model, continuing to promote "every door is the right door" model, reducing the number of high end users of services in the City (i.e., ER visits, 911 calls, Police, Fire, Paramedics, and Mobile Crisis), eliminating duplication of services, and contributing to a seamless system of care.

We will also use the DPH's process objectives as described by the state of California. In particular, these outcomes will include the following:

1. A brief semi-annual report listing major accomplishments and challenges during the report period, how the challenges were addressed, and any changes that were made to program implementation during the period.
2. Quarterly program visits by CBHS Evaluation staff will assess the quality of program implementation based on initial program plans and changes to implementation documented in semi-annual reports. Program visits may include "key informant" interviews or focus groups with staff and/or clients to gain

a fuller picture of program implementation and perceived benefits/challenges from the perspectives of different stakeholders.

3. Feedback sessions with staff to discuss fine-tuning the implementation strategy, if indicated.

8. Continuous Quality Improvement

Describe your program's CQI activities to enhance, improve and monitor the quality of services delivered. The CQI section must include a guarantee of compliance with Health Commission, Local, State, Federal and/or Funding Source policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, and Client Satisfaction.

FSA has appointed a separate division, called The Felton Institute, to roll out its training, CQI, and evaluation components for the agency at large. The Felton Institute is the seat of quality assurance and program innovations, implementing evidence-based practice, CIRCE (our on-line data collection system) and program evaluation across all divisions at FSA. CIRCE tracks all CBHS requirements per contract. We are currently collaborating with CBHS to have CIRCE integrated with the new AVATAR system.

1. Program Name: FSA Community Aftercare Program
Program Address: 6221 Geary Blvd, 3rd Floor
City, State, Zip Code: San Francisco, CA 94121
Telephone: (415)379-1040
Facsimile: (415)750-1544

2. Nature of Document (check one)

x New ☐ Renewal ☐ Modification

Please Note: This document covers only the period July 1, 2010-December 31, 2010. As of January 1, 2011, this program will be integrated into the Adult IFSO.

3. Goal Statement

The Goal of Community Aftercare Program is to provide case management and mental health treatment services to severely and persistently mentally ill individuals in order that they can live in the community and maintain the greatest independence, stability and level of functioning possible.

4. Target Population

Clients served by CAP are severely and persistently mentally ill residents of San Francisco County, 18 years of age and older who are living in or being referred to residential care facilities (RCF's). Many of the RCF residents we serve have co-occurring mental health and substance abuse conditions; many also suffer a variety of medical complications due to aging, medication-related illness, and the misadventures arising from a life with persistent mental illness, which may have included homelessness. The program works with individuals with a range of service intensity needs, transitions aging clients to Geriatric/Older Adult Systems of care, and transitions clients to lower levels of care as their functional capacity improves. Referrals to the program come from the Community Placement Team, RCF operators and other service providers.

5. Modality(ies)/Interventions

A. The Community Aftercare Program provides case management, mental health services, medication support services and crisis intervention to the populations that they serve.

B. Case Management is the primary treatment modality. Case managers assist the client to access needed medical, education, social, prevocational, vocational, rehabilitative and other community related services. Case mangers communicate with clients to establish their treatment goals and to coordinate their services in the greater community; including all referrals for financial, housing, vocational; psychiatric, and medical and social service needs. Case managers monitor the delivery of services to ensure quality of care and delivery of services in the greater system. Case managers monitor the progress of the client's treatment plan and adherences to the system of care provided, and make adjustments to clients care services when necessary.

C. "Mental Health Services" are provided in individual therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the

goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities include assessment, collateral and therapy.

D. "Assessment" is provided as a clinical analysis of the history and current status of a client's mental, emotional, and behavioral disorder; including relevant cultural issues and history and current diagnosis.

E. "Collateral services are provided as significant support to the client and those in the client's life with the intent of improving and maintaining the mental health status. The client may or may not be present for this service activity.

F. "Therapy" is provided as a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or to a group of clients and may include some family therapy when the client is present.

G. "Medication Support Services" means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

H. "Crisis Intervention" means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled. Service activities may include but are not limited to assessment, collateral and therapy.

6. Methodology

A. The program accepts referrals for clients needing outpatient aftercare from other providers through the County Placement team, RCF operators, Psychiatric Emergency Services and other providers such as Community Focus. Due to our long-term service and reputation in the County, we have not needed to recruit clients, other than an occasional phone call to the County Program monitor who is automatically notified when caseloads for the program are nearing capacity for taking new referrals. No advertisement is necessary; however, community public relations is practiced by the Program Director, Division Director, and agency administration to ensure that linkage and program support keeps FSA-CAP in the minds of the other treatment providers.

B. Clients referred to Community aftercare need to meet the criteria of adults with an Axis I mental health diagnosis and are living in or being referred to live in the community in residential care facilities. Because of limited and shrinking mental health resources, coupled with the need to immediately serve many new acute clients coming in the front door, the program consistently applies utilization review and discharge /exit criteria to alleviate increasing caseload pressure, and to prioritize services to those most in need.

Clinicians making initial assessments for appropriateness of treatment consider such factors as: risk of harm, functional status, psychiatric stability, risk of decompensation, medication compliance, progress and failure in past treatment settings, and client's overall environment to determine which clients are most in need of and can be best served through targeted case management services.

The FSA Community Aftercare Program provides culturally appropriate Mental Health Services, Case Management/Brokerage and Crisis Intervention. A primary goal of the program is the prevention of

unnecessary hospitalizations of individuals. The provision for alternative treatment is done in the community in order to promote the highest possible level of rehabilitation and independent living compatible with the individuals desired outcomes, abilities and community resources.

The FSA Community Aftercare Program works in collaboration with the CBHS Placement Team to facilitate and coordinate placement of clients into the residential care homes served by CBHS. Case management staff is expected to seize the window of opportunity for connecting with a client by meeting face-to-face with new clients while they are hospitalized. In addition, the engagement process can sometimes require a long period of time when clients that have failed to engage with more traditional treatment models.

The FSA Community Aftercare Program will adhere to CBHS guidelines regarding assessment and treatment of indigent (uninsured) clients.

C. Upon referral to Community Aftercare Program, clients are assigned an individual case manager who is responsible to thoroughly access the client and provide a client driven plan of care specific to the criteria outlined by CBHS. After assessment by the case managers, treatment is coordinated by case managers with a Client's RCF operator, primary care physician (PCP), psychiatrist, any family members currently involved in the client's life, and other appropriate service providers; such as public guardian, conservator, pharmacists, podiatrist, County placement team and outside day treatment or vocational service staff as specific to the clients authorization for services.

Clients are visited in their respective living environments on average once every 3 to 4 weeks, unless a critical incident requires the case managers increased involvement in the form of crisis management. Case managers work with clients to determine the client's individual level of commitment to treatment and recovery. Case managers specify this agreed upon commitment on a plan of care (POC) in the form of individual goals and interventions, which are client driven and worked on with the clients on an on-going basis. Case Managers are often responsible to translate to physicians and other people involved in the client's care their specific needs, which the client is some times unable to specify due to their mental illness.

The CAP program staff use a case management model that emphasizes engagement and outreach to clients in their natural settings. All FSA clinical staff provides Mental Health Services, case management/brokerage and crisis intervention, and each staff also functions as care managers in the reauthorization process. Persistent support and outreach is done when a client does not keep medication or case management appointments.

Upon intake clients are assessed for medical necessity, medication compliance, dual diagnosis needs, medical, financial and social assistant needs. Clients are assigned to appropriate case managers who are either bi-lingual and or culturally sensitive to the clients needs when possible. Clients are screened for dual diagnosis needs and the appropriate program, linkage, and referrals are planned for the client. The program encourages the use of a Harm Reduction model in providing services to clients. Case managers encourage abstinence but will attempt to engage the individual in treatment who are continuing to use or abuse substances. The program works with clients where they are and moves toward reducing the harmful behaviors including substance use.

Program interventions include money management through the Public Guardians Office or an institutional Payee. Financial interventions are made to support sobriety and engage the client in treatment. Shopping plans are also used to assist a client with money management.

Referrals for the dual diagnosed client may include residential dual diagnosis treatment, substance abuse services, Walden, WITS, and appropriate 12 step meetings. Clients who are stable and can engage in outside socialization activities are referred to Sunset, OMI, Oasis, or encouraged toward vocational services such as CVE, TVP, STEP, RAMS Hire ability or Peer Intern Counseling programs. Programs providing vocational services are invited to provide FSA- CAP in-service trainings to program staff on a regular basis.

Program staff is located at 6221 Geary Boulevard, 3rd Floor, in San Francisco. Office hours are Monday through Friday 8:30 – 5:00, and services are provided at client residences throughout San Francisco County and beyond. After hour support is provided from 5:00 pm to 8:30 AM evenings, weekends and holidays through a 24 hour crisis telephone pager system staffed by CAP case managers and shared with sister program FSA Adult Care Management.

Many of the clients are suffering serious medical conditions due to growing elderly and/or due to the complications that arise from long-term psychotropic medications. These clients are linked to services with primary care physicians who are affiliated with the various RCF houses, and on occasion, when a client is unable to communicate due to their mental illness, the case manager will accompany the client to appointments and make the appropriate translations and medical appointments that arise through the course of treatment. This is often done in affiliation with the RCF operators, who by licensure ship are required to get clients to their medical appointments. In addition the CAP will start using senior student nurses as interns to provide clients with support regarding education and training to deal with their medical problems like diabetes, hypertension etc.

The program delivers services in the preferred language of the consumer, use community language resources and make provisions for the trained interpreters as needed. The program attempts to hire bilingual staff when openings occur.

The FSA CAP program has implemented a Wellness and Recovery perspective into its services by emphasizing measurable client-driven treatment goals that move toward recovery. Clients are viewed holistically in terms of providing support for physical, emotional, social and spiritual well-being. The program will also begin utilizing more of time-efficient group interventions to maximize the number of clients that can be helped, which has already begun by sending clinicians to trainings on these modalities.

D. The FSA –CAP program consistently applies utilization review and discharge/ exit criteria to alleviate increasing caseload pressure, and to prioritize services to those most in need. Clinicians will consider factors such as; risk of harm, functional status, psychiatric stability/ risk of decompensation, medication compliance, progress and status of Care Plan objectives and the clients ability to utilize services at the system's next lower level of care.

FSA Program staff shall notify the care manager and conservator (if conserved) of proposed discharge plans or services termination prior to the actual discharge, in order to allow for collaborative problem solving and or disposition planning.

To ensure continuity of care for clients moving out of residential care, FSA CAP case managers provide services to clients living in other settings other than RCF's for an interim period of time to allow the client to make the appropriate connections to on going support staff in their new modality of care.

E. The FSA – CAP program serves a minimum of 160 clients with 4.0 FTE case managers who carry a caseload of 43 clients for FTE. In addition we have an office manager and a peer case aide who provide

data entry and critical office support to the entire staff. The case management staff is primarily masters- and doctoral-level social workers and psychologists, who are dedicated to the well being and treatment of the severely mentally ill. The Program Director and Clinical Director provide supervision to staff, interns, and peers. They will also provide the training for the new staff. All staff is included in weekly staff meetings, which include case conferences with our Division Director. All staff is provided on-going clinical supervision and has a supervisor on hand should questions arise.

FSA CAP may utilize the services of student interns and peers to augment the regular staff services provided to our clients. Interns and peers will be provided with supervision by the clinical staff and will be recruited with the criteria of having the necessary education, training, experience and skills to competently provide services for the severely and persistently mentally ill individuals that constitute the program's caseload. In addition to school requirements, the interns will not be assigned to clients requiring more complex care management. Peers will be used in case management activities and support services according to their capacities.

7. Objectives and Measurements

A. Outcome Objectives

OUTCOME 1: IMPROVE CLIENT SYMPTOMS

Objective A.1: Reduce Psychiatric Symptoms

A.1a. Applicable to: Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Children, Youth, Families, Adults and Older Adults except supported housing programs

The total number of acute inpatient hospital episodes used by clients in Fiscal Year 2009-10 will be reduced by at least 15% compared to the number of acute inpatient hospital episodes used by these same clients in Fiscal Year 2008-09. This is applicable only to clients opened to the program no later than July 1, 2009, and had no IMD or CTF episode during FY 2008-09. Data collected for July 2009 – June 2010 will be compared with the data collected in July 2008– June 2009.

Programs will be exempt from meeting this objective if more than 50% of the total number of inpatient episodes was used by 5% or less of the clients hospitalized.

Data Source:
Avatar - CBHS will compute.

A.1e. Applicable to: Providers of Behavioral Health Services who provide mental health treatment services to children, youth, families, adults and older adults except 24 hour programs

50% of clients who have been served for two months or more will have met or partially met their treatment goals at discharge.

Client Inclusion Criteria:
Clients discharged between July 1, 2009 and June 30, 2010 who have been served continuously for 2 months or more.

Data Source:
Avatar - CBHS will compute.

Program Review Measurement:
Objective will be evaluated based on a 6-month period from July 1, 2010 to December 30, 2010.

OUTCOME 2: Reduce Substance Use - N/A

OUTCOME 3: IMPROVE CLIENT FUNCTIONING

Objective A.3: Increase Stable Living Environment

A.3a. Applicable to: ***Providers of Behavioral Health Services for Children, Youth, Families, Adult or Older Adult Mental Health Programs, except 24-hour programs***

35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI.

Data Source:
Avatar

Program Review Measurement:
Objective will be evaluated based on a 6-month period from July 1, 2010 to December 30, 2010.

B. OTHER MEASURABLE OBJECTIVES/PROCESS OBJECTIVES

Objective 1: Access to Services

B.1a. Applicable to: ***All Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Adult and Older Adults Health Programs, except 24-hour programs***

25% of uninsured active clients, with a DSM-IV diagnosis code that likely indicates disability, who are open in the program as of July 1, 2010, will have SSI linked Medi-Cal applications submitted by June December 30, 2010.

Programs are also strongly encouraged to refer eligible clients to Healthy San Francisco.

Client Inclusion Criteria:
Uninsured active clients (seen by the program at least once between July 1, 2010 and December 30, 2010) with a DSM-IV diagnosis code that likely indicates disability (list of DSM-IV diagnosis codes will be provided by CBHS) and open in the program as of July 1, 20109., will be included in the calculation.

Data Source:
Program Director will show proof of SSI applications submitted for/by clients (such as copies of applications, or proof of online application submission). Provider shall email DPH SSI Program Coordinator a list containing names and Social Security numbers of clients who applied for SSI through the Agency's assistance at luciana.garcia@sfdph.org.

Program Director shall keep in files proof of SSI applications submitted for/by clients (such as copies of applications or proof of online application submission).

Program Review Measurement:
Objective will be evaluated based on a 6-month period from July 1, 2010 to December 30, 2010.

Objective 4. Collect Client Outcomes for Substance Abuse - N/A

Objective 5. Documentation/Authorization

B.5a. Applicable to: ***All Providers of Behavioral Health Services who provide Adult and Older Adult Mental Health Outpatient Services that are not exempt from having services authorized***

At least 90% of a sample reviewed by CBHS of open; active clients (defined as those having received a billable service in a program within 90 days) will have a current authorization, and 100% will have a current plan of care. Programs with multiple non-exempt reporting units will have data from those RU's combined before computation.

Data Source:

PURQC oversight audit. A random sample generated by CBHS and proportional to program caseload but not more than 25 clients will be used for PURQC oversight.

Objective 6. Client Satisfaction

B.6b. Applicable to: ***Providers of Behavioral Health Services who provide Children, Youth, Families, Adult or Older Adult Mental Health Treatment Services (excluding crisis services, suicide prevention and conservatorship)***

During Fiscal Year 2009-10, 100% of unduplicated clients who received a face-to-face billable service during the survey period will be given and encouraged to complete a Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on the survey administration closest to the 6-month period from July 1, 2010 to December 31, 2010.

B.6c. Applicable to: ***Providers of Behavioral Health Services who provide Substance Abuse Services***

During Fiscal Year 2009-10, 100% of unduplicated treatment clients or prevention participants in attendance at the program on the targeted satisfaction survey days will be given and encouraged to complete the Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on a 6-month period from July 1, 2010 to December 30, 2010.

A. C CONTINUOUS QUALITY IMPROVEMENT, PROGRAM PRODUCTIVITY AND SERVICE ACCESS

All providers of Behavioral Health Services will be encouraged to meet quarterly with their CBHS program managers to evaluate progress toward meeting the following set of continuous quality improvement, productivity, and service access objectives. Other objectives may be added if mutually agreed to by the providers and their CBHS program managers. These objectives will be evaluated based on a summary of quarterly meetings held by March 2010. Providers are encouraged to continue quarterly meetings through the end of FY 2009-2010 and thereafter.

Objective 1. Program Productivity

C.1a. Applicable to: ***All Providers of Behavioral Health Services who provide Substance Abuse Treatment and Prevention and Mental Health Services***

During the period July 1, 2010 – December 31, 2010, 2,112 units of service (UOS) will be provided consisting of treatment, prevention, or ancillary services as specified in the unit of service definition for each modality and as measured by Avatar and documented by counselors' case notes and program records.

Date Source:
Avatar

Program Review Measurement:
Objective will be evaluated quarterly during the 6-month period from July 1, 2010 to December 31, 2010.

Objective 2. Access to Services

C.2a. Applicable to: ***All Adult and Older Adult & CYF Behavioral Health Intensive Case Management Programs including SPR's***

(The number of targeted new client episode openings during FY 2009-10 will be individually negotiated with the Program Manager for each specific Intensive Case Management Program based on historical rate of episode openings and baseline profile of psychiatric stability of caseload:)

Client Inclusion Criteria:
No new episode openings will take place during this period, as the program is ramping down.

Data Source:
CBHS Avatar System

Program Review Measurement:
Objective will be evaluated quarterly.

Objective 4. Client Outcomes Data Collection

C.4e. Applicable to: ***Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services for Adults and Older Adults***

For clients on atypical antipsychotics, at least 50% will have completed the documentation of the CBHS Antipsychotic Metabolic Monitoring Form or equivalent, in the clients' medical record. At a minimum, the record should include annual monitoring of weight, blood pressure, and fasting glucose (or Hemoglobin A1.C).

Client Inclusion Criteria:
Adult and Older Adult clients on any atypical antipsychotic medication (aripiprazole, clozapine, olanzapine, quetiapine, risperidone, and ziprasidone) prescribed by Provider any time during July 1, 2010 to December 31, 2010.

Data Source :
Program Self Report.

Program Review Measurement
To meet objective, Metabolic Monitoring Form should show at minimum annual monitoring of weight, blood pressure, and fasting glucose (or Hemoglobin A1.C). Upon request, Provider to submit copies of Metabolic Monitoring Forms for randomly selected clients.

Objective 5. Integration Activities **

** For providers who are not located in the City and County of San Francisco, contractors who do not provide client services and small programs with less than 3.0 FTEs, please refer to the attached Integration Inclusion Document for guidance on the implementation of objectives in this section of Integration Preparedness (see Addendum I). Please note that several Integration process objectives are included on the CBHS Compliance Checklist for FY2009-10. All providers of behavioral health services will be expected to meet these CBHS Compliance Checklist integration items. For all of the following items listed from D.5a – D.5f, programs will submit all reporting on integration preparedness items via email to CBHSIntegration@sfdph.org.

C.5a. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Each program will complete a new self-assessment with the revise COMPASS every two (2) years (a new COMPASS must be completed every other fiscal year).

Data Source:
Program managers to review information sent to CBHSIntegration@sfdph.org via the shared folder to monitor compliance.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2009 to June 30, 2010.

C.5b. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Using the results of the most recently completed COMPASS (which must be completed every 2 years), each program will identify at least one program process improvement activity to be implemented by the end of the fiscal year using an Action Plan format to document this activity. Copies of the program Action Plan will be sent via email to CBHSIntegration@sfdph.org.

Data Source:
Each program will complete the COMPASS self assessment process and submit a summary of the scores to CBHSIntegration@sfdph.org. The program manager for each program will review completed COMPASS during the month of January and submit a brief memorandum certifying that the COMPASS was completed.

Program Review Measurement:
Objective will be evaluated quarterly during the 6-month period from July 1, 2010 to December 31, 2010. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

C.5c. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Each behavioral health partnership will identify, plan, and complete a minimum of six (6) hours of joint partnership activities during the fiscal year. Activities may include but are not limited to: meetings, training, case conferencing, program visits, staff sharing, or other integration activities in order to fulfill the goals of a successful partnership. Programs will submit the annual partnership plan via email to CBHSIntegration@sfdph.org.

Data Source:
Program self report such as activity attendance sheets with documentation of time spent on integration activities. The program manager will certify documentation of this plan.

Program Review Measurement:
Objective will be evaluated quarterly during the 6-month period from July 1, 2010 to December 31, 2010. Only the summaries from the two first quarterly meetings held by March 2009 will be included in the program review.

C.5d. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

Each program will select and utilize at least one of the CBHS approved list of valid and reliable screening tools to identify co-occurring mental health and substance abuse problems as required by CBHS Integration Policy (Manual Number: 1.05-01).

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 6-month period from July 1, 2010 to December 31, 2010. Only the summaries from the two first quarterly meetings to be held by December 2009 and March 2010 will be included in the program review.

C.5e. Applicable to: ***All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services***

During Fiscal Year 2009-10, each program will participate in one Primary Care partnership activity. The Primary Care Partner for this activity must be the DPH Oriented Primary Care Clinic located in closest proximity to the program, or most appropriate for the program population. Primary care program which cannot be Primary Care Partner for this purpose, include primary care program which are part of the same overall agency as the Behavioral Health Program. Optimal activities will be designed to promote cooperative planning and response to natural disaster or emergency events, neighborhood health fairs to increase joint referrals, or mutual open house events to promote cross-staff education and program awareness.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 6-month period from July 1, 2010 to December 31, 2010. Only the summaries from the two first quarterly meetings held by March 2009 will be included in the program review.

C.5f. Applicable to: ***All CBHS programs, including contract and civil service mental health and substance abuse programs providing prevention, early intervention and treatment service in Fiscal Year 2009-10.***

Providers will have all program service staff including physicians, counselors, social workers, and outreach workers each complete a self assessment of integration practices using the CODECAT. This self assessment must be updated every two years.

Data Source:
Program self report with submission of document of staff completion of CODECAT sent to CBHSIntegration@sfdph.org. The program manager will document this activity.

Objective 6. Cultural Competency

C.6a. Applicable to: ***All Providers of Behavioral Health Services***

Working with their CBHS program managers, programs will develop three (3) mutually agreed upon opportunities for improvement under their 2009 Cultural Competency Reports and report out on the identified program-specific opportunities for improvement and progress toward these improvements by September 30, 2009. Reports should be sent to both program managers and the DPH/EEO.

Data Source:
Program managers will review progress utilizing the DPH Cultural Competency Report Evaluation Tool.

Program Review Measurement:
Objective will be evaluated quarterly during the 6-month period from July 1, 2010 to December 31, 2010.

Objective 8: Program and Service Innovation & Best Practice

C.8a. Applicable to: ***Providers of Behavioral Health Services that provide Mental Health and Substance Abuse Services to Children, Youth, Families, Adults or Older Adults***

If applicable each program shall report to CBHS Administrative Staff on innovative and/or best practices being used by the program including available outcome data.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 6-month period from July 1, 2010 to December 31, 2010. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

1. Program Name: FSA Adult Care Management (ACM)
   Program Address: 1010 Gough Street
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 931-3773

2. Nature of Document (check one)

   x New ☐ Renewal ☐ Modification

3. Goal Statement

The goal of **Adult Care Management (ACM)** is to support persistent mentally ill individuals and individuals with co-occurring disorders to live in the community and to maintain the greatest independence, stability, and level of functioning possible. The program will provide intensive case management to individuals in the community. Every attempt will be made to ensure continuity of care and to develop a community support system for these individuals by connecting them with appropriate resources, community health and mental health, development and implementation of their plans to achieve their desired outcomes.

4. Target Population

The target population consists of persistently mentally ill adults and those adults who struggle with substance abuse problems in addition to their mental health problems. The target population is also residents of San Francisco, who are age 18 and up who are experiencing persistent mental illness, which could be accompanied by a substance abuse and homelessness issues. We serve both men and women of any sexual orientation, and when possible we provide monolingual client's language specific case management. Currently, services can be provided in Spanish, Tagolog and English. The program will use criteria established by Community Behavioral Health Services (CBHS) in accepting individuals for services. Services will be provided to clients at the office and in the community as needed.

5. Modality(ies)/Interventions

Mental Health, Case Management Brokerage, Crisis Intervention, Group Therapy, Medication Support and Outreach Services will be provided to clients. The exact number of minutes used by staff providing a reimbursable service shall be reported and billed.

Mental Health Services.
"Mental Health Services" means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

Assessment:
"Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history procedures.

Collateral.
"Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Therapy.
"Therapy" means a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

Targeted Case Management.
"Targeted Case Management" means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

Crisis Intervention.
"Crisis Intervention" means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled. Service activities may include but are not limited to assessment, collateral and therapy.

Medication Support Services.
"Medication Support Services" means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Outreach Services/Consultation Services

"Outreach Services" are activities and projects directed toward 1) strengthening individuals' and communities' skills and abilities to cope with stressful life situations before the onset of such events, 2) enhancing and/or expanding agencies' or organizations' mental health knowledge and skills in relation to the community-at-large or special population groups, 3) strengthening individuals' coping skills and abilities during a stressful life situation through short-term intervention and 4) enhancing or expanding knowledge and skills of human services agency staff to handle the mental health problems of particular clients.

6. Methodology

A. Program's recruitment, promotion, and advertisement

Program will accept referrals from hospitals and other agencies of clients who meet the CBHS criteria for Intensive Case Management. Program will notify Program Monitor when caseloads for the program are nearing capacity to take new referrals.

B. Program's admission, enrollment and/or intake criteria.

The admission criteria to the ACM program is consistent with CBHS' admission criteria for intensive case management programs. All referrals the ACM program are approved by Sidney Lam of CBHS.
Once an approved referral is sent to the ACM office the case is assigned to the most appropriate case manager with an opening in their caseload. A transitional meeting between the referring case manager, the ACM case manager and the client is then held. During this meeting the ACM staff person introduces the client to the ACM program, by describing the services provided. In addition the grievance procedure and clients' rights are reviewed. The client is then asked to review and sign consent for mental health services, as well as the HIPAA consent form. Identifying information is also gathered from the client at this time. Depending on the individual client's attention span, the remainder of the intake procedure can either continue or resume at the next scheduled appointment.

C. Program's service delivery model.

The FSA ACM Program provides culturally appropriate Mental Health Services, Case Management/Brokerage and Crisis Intervention and care management in accordance with the provision of the Rehabilitation Model and Access/Reauthorization. Services are designed to promote the highest possible level of rehabilitation and independent living. It is the goal of ACM to assist our clients with living in the community, as independently as possible. To achieve this we hope to prevent hospitalizations whenever possible. Case Managers work with their clients to create a Plan of Care, which utilizes the clients' strengths, focuses on achieving the clients' desired outcomes and utilizes the community available resources. All FSA clinical staff in this program will provide Mental Health Services, Case Management/Brokerage, and Crisis Intervention. Medical staff, psychiatrist and nurse practitioner, provide Medication Support Services. Clinical staff will function in the role of care managers and reauthorization of services.

The ACM Program provides intensive case management services to adults living in the community. These services include providing individuals in the program an ongoing clinical relationship with their case manager and the case management team. The case manager will follow individuals over time and throughout the community. This continuity of care greatly improves the ability of clients to access needed services and to maintain stability in the community. The development of a trusting therapeutic relationship with a case manager is of utmost importance in motivating clients to follow trough with treatment and link to the necessary services. Frequency of contact with clients will depend on their individual needs. At the beginning and at times of crisis, client may be seen daily by the treatment team. Clients are seen at the program site and in the community.

In addition ACM will attempt to provide a "community" which our clients will hopefully feel that they can be a member of. We hope to do this by providing a welcoming environment, running groups, e.g., DBT and a dual diagnosis group and providing community celebrations/meals at the holiday time and during the summer.

The average length of stay in the program is between two and three years. Clients are generally seen weekly. Clients in crisis or going through a transition period are seen more frequently; clients who are achieving a degree of stability are seen less frequently. This is done to prepare the clients for the next lower level of care, were clients will receive services monthly rather than weekly.

Hours of operation are from 8:30 a.m. to 5:00 p.m. Monday trough Friday. An after hours dedicated emergency number is provided to clients and other providers that work with clients. This number is answered by staff from the Suicide Prevention Agency who will page the FSA staff on duty when the situation so requires. The FSA staff on duty will respond to page and will contact the calling person when deemed necessary.

Specific intensive case management services provided to individuals include:

1. Applying for and maintaining entitlements.
2. Engagement with clients who have not connected with services
3. Linkage to medical services
4. Assistance to access and maintain housing
5. Money management and liaison with representative payees.
6. Outreach: the majority of client contacts are in the field
7. Linkage and coordination with psychiatrists and medical staff
8. Resource development
9. Building collaborative relationships with service providers and community resources
10. Placement planning and referrals for clients in transition between programs, housing, and levels of care.
11. Providing supporting and problem solving focused therapy, including DBT
12. Providing basic individual and group substance abuse treatment.

Clients are screened at intake for special dual diagnosis needs. An attempt is made to assign clients with special dual diagnosis needs to staff with dual diagnosis experience, training, and skills. At intake, a client's dual diagnosis needs are assessed and the appropriate program, linkage and referrals are planned with the client. The program encourages the use of a Harm Reduction approach in providing services to clients. Case managers will encourage abstinence but will attempt to engage individuals in treatment who are continuing to use or abuse substances. Program interventions may include: 1) money management (through Public Guardians Office or other representative payee) to support sobriety and to engage the client in treatment. Additional uses of money management may include meal plans at local restaurants to ensure that food is available and to reduce money for buying drugs or alcohol. Shopping plans are also used to assist clients with money management; 2) individual therapy with case manager to review triggers and copy skills; and 3) group therapy. Referrals may include residential dual diagnosis treatment, substance abuse services, the Redwood Center, Walden House, WITS, the New Life Center and appropriate 12 step meetings. The program uses a harm reduction model to work with the client where they are and move towards reducing the harmful behaviors including substance abuse.

The program encourages staff to receive ongoing training in dual disorder treatment. Staff members attending trainings are requested to present information at in-service training for program staff and be available to provide ongoing consultation to the clinical staff. FSA is committed to provide trainings to all staff in the effort of making each FSA program welcoming and capable of providing services to the dually diagnosed population of clients.

D. Program's exit criteria and process

Clients will be discharged to a case management program at a lower level of care when they meet the following criteria:

1. Client entitlements are in place.
2. Client crises (such as housing, financial or payee services) are resolved.
3. Client has had no more than one ADU or PES episode, and/or hospitalization during the last 12 months.
4. Over a six-month period client has demonstrated stability by participating in services as scheduled, keeping appointments, and maintaining medication compliance.

5. Client requires less than 72 hours of outpatient services on an annual basis.

E. Program's staffing.

ACM will have 5.50 FTEs of case management time. The case manager caseload for a FTE is 20 clients. The total caseload for the program will be 110 clients The case managers provide individual treatment both in the office and outreach to the community (including symptom management and substance abuse treatment), and case management brokerage (including linkage to housing, benefits, necessary services and money management). Case managers also co-facilitate ACM therapy group ACM has a part time psychiatrist and part-time nurse practitioner who conducts evaluations, prescribes and disburses medication. Additionally, the medical staff provides consolation to the staff. ACM's Program Director's function is to: 1) provide clinical supervision to the staff, 2) act as the primary OD for walk in emergencies, 3) facilitate group supervision, 4) perform quality management function, including chart reviews and compliance with CBHS and Medical regulations, and 5) facilitates treatment group. ACM also has two part time support staff who's function is to: 1) receive and announce clients and visitors, 2) input medical billing, 3) answer the phones, 4) assure forms and supplies are on hand, and 5) responsible for office organization.

ACM may utilize the services of student interns, peers and volunteers to augment the regular staff services provided to our clients. Interns, peers and volunteers will be provided with supervision by the clinical staff and will be recruited with the criteria of having the necessary education, training, experience and skills to competently provide services for the severely and persistently mentally ill individuals that constitute the program's caseload. In addition to school requirements, the interns will not be assigned to clients requiring more complex care management. Peers and volunteers will be used in case management activities according to their capacities.

ACM

- Division Director (0.27 FTE) – responsible for program compliance
- Program Director (.50 FTE) – responsible for program supervision and outcomes
  and (.50 FTE) – provide mental health services and linkage
- Mental Health Case Manager (4.0 FTE) – provide mental health services and linkage
- Graduate Student Intern (.50 FTE) - provide mental health services and linkage
- Peer Professional Case Aides (1.0 FTE) – responsible to outreach, engagement, accompaniment and activity supervision
- Psychiatric Nurse Practitioners (0.25 FTE) – medication support
- Psychiatrist (0.20 FTE) – medication support and supervision of nurse practitioner
- Support Staff (.66 FTE) – everything else

7. PERFORMANCE/OUTCOME OBJECTIVES

Outcome A: Improve Client Symptoms

A.1a. Applicable to: All Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Children, Youth, Families, Adults and Older Adults except supported housing programs

The total number of acute inpatient hospital episodes used by clients in Fiscal Year 2010-11 will be reduced by at least 15% compared to the number of acute inpatient hospital episodes used by these same clients in Fiscal Year 2009-10. This is applicable only to clients opened to the program no later than December 31,

2010, and had no IMD or CTF episode during FY 2009-10. Data collected for July 2010 – June 2011 will be compared with the data collected in July 2009– June 2010.

Programs will be exempt from meeting this objective if more than 50% of the total number of inpatient episodes was used by 5% or less of the clients hospitalized.

Data Source:
CBHS Billing Information System - CBHS will compute.

A.1e. Applicable to: Providers of Behavioral Health Services who provide mental health treatment services to children, youth, families, adults and older adults except 24 hour programs

50% of clients who have been served for two months or more will have met or partially met their treatment goals at discharge.

Client Inclusion Criteria:
Clients discharged between July 1, 2010 and June 30, 2011 who have been served continuously for 3 months or more.

Data Source:
BIS Reason for Discharge Field.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

A.1k. Applicable to: Intensive Care Management (ICM) Providers of Adult and Older Adult Behavioral Health Services

ICM providers will require that clinicians evaluate level of functioning for ALL NEW CLIENTS by completing the Milestones of Recovery Scale (MORS) for all clients.

For all ICM providers, these ratings will be completed at intake, every month thereafter, and at discharge.

For clients who receive ICM services through other providers, it will be the responsibility of the ICM services provider to complete the MORS at intake and every month thereafter, and at discharge.

Providers must submit 75% of required MORS forms for all new clients to pass this objective.

Data Source:
MORS submitted to website and summarized by Program Evaluation Unit.

Program Review Measurement:
Objective will be evaluated on based on a 3-month period from March 1, 2011 to June 30, 2011.

OUTCOME 3: IMPROVE CLIENT FUNCTIONING

Objective A.3: Increase Stable Living Environment

A.3a. Applicable to: **Providers of Behavioral Health Services for Children, Youth, Families, Adult or Older Adult Mental Health Programs, except 24-hour programs**

35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI.

Data Source:
BIS Living Situation Codes.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

B. OTHER MEASURABLE OBJECTIVES/PROCESS OBJECTIVES

Objective 1: Access to Services

B.1a. Applicable to: **All Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Adult and Older Adults Health Programs, except 24-hour programs**

50% of uninsured active clients, with a DSM-IV diagnosis code that likely indicates disability, who are open in the program as of July 1, 2010, will have SSI linked Medi-Cal applications submitted by June 30, 2011.

Programs are also strongly encouraged to refer eligible clients to Healthy San Francisco.

Client Inclusion Criteria:
Uninsured active clients (seen by the program at least once between April 1, 2010 and June 30, 2011) with a DSM-IV diagnosis code that likely indicates disability (list of DSM-IV diagnosis codes will be provided by CBHS) and open in the program as of July 1, 2010., will be included in the calculation.

Data Source:
Program Director will show proof of SSI applications submitted for/by clients (such as copies of applications, or proof of online application submission). Provider shall email DPH SSI Program Coordinator a list containing names and Social Security numbers of clients who applied for SSI through the Agency's assistance at luciana.garcia@sfdph.org.

Program Director shall keep in files proof of SSI applications submitted for/by clients (such as copies of applications or proof of online application submission).

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 5: Documentation and Authorization

B.5a. Applicable to: **All Providers of Behavioral Health Services who provide Adult and Older Adult Mental Health Outpatient Services that are not exempt from having services authorized**

At least 90% of a sample reviewed by CBHS of open, active clients (defined as those having received a billable service in a program within 90 days) will have a current authorization, and 100% will have a current plan of care. Programs with multiple non-exempt reporting units will have data from those RU's combined before computation.

Data Source:
PURQC oversight audit. A random sample generated by CBHS and proportional to program caseload but not more than 25 clients will be used for PURQC oversight.

Objective 6: Client Satisfaction

B.6b. Applicable to: **Providers of Behavioral Health Services who provide Children, Youth, Families, Adult or Older Adult Mental Health Treatment Services (excluding crisis services, suicide prevention and conservatorship)**

During Fiscal Year 2009-10, 100% of unduplicated clients who received a face-to-face billable service during the survey period will be given and encouraged to complete a Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C. CONTINUOUS QUALITY IMPROVEMENT, PROGRAM PRODUCTIVITY AND SERVICE ACCESS

All providers of Behavioral Health Services will be encouraged to meet quarterly with their CBHS program managers to evaluate progress toward meeting the following set of continuous quality improvement, productivity, and service access objectives. Other objectives may be added if mutually agreed to by the providers and their CBHS program managers. These objectives will be evaluated based on a summary of quarterly meetings held by March 2010. Providers are encouraged to continue quarterly meetings through the end of FY 2009-2010 and thereafter.

Objective 1. Program Productivity

C.1a. Applicable to: **All Adult and Older Adult & CYF Behavioral Health Intensive Case Management Programs including SPR's**

During Fiscal Year 2010-11, 5,160 units of service (UOS) hours will be provided consisting of treatment, prevention, or ancillary services as specified in the unit of service definition for each modality and as measured by BIS and documented by counselors' case notes and program records.

Data Source:
CBHS Billing Information System – DAS 800 DW Report or program records. For programs not entering data into BIS, CBHS will compute or collect documentation.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 2. Access to Services

C.2a. Applicable to: **All Adult and Older Adult & CYF Behavioral Health Intensive Case Management Programs including SPR's**

Adult Care Management will have at least 22 new client episode openings (or 20% new clients) for Fiscal- Year 2009-10. (The number of targeted new client episode openings during FY 20109-11 will be individually negotiated with the Program Manager for each specific Intensive Case Management Program based on historical rate of episode openings and baseline profile of psychiatric stability of caseload.)

Client Inclusion Criteria:
All new unique client episode openings into the ICM program during FY 2010-11.

Data Source:
CBHS Billing Information System - CBHS will compute.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 5. Integration Activities

C.5a. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

Each program will complete a new self-assessment with the COMPASS every two (2) years (a new COMPASS must be completed every other fiscal year).

Data Source:
Program managers to review information sent to CBHSIntegration@sfdph.org via the shared folder to monitor compliance.

Program Review Measurement:

Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

C.5b. Applicable to: All CBHS programs including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

Using the results of the most recently completed COMPASS (which must be completed every 2 years); each program will identify at least one program process improvement activity to be implemented by the end of the fiscal year using an Action Plan format to document this activity. Copies of the program Action Plan will be sent via email to CBHSIntegration@sfdph.org.

Data Source:
Each program will complete the COMPASS self-assessment process and submit a summary of the scores to CBHSIntegration@sfdph.org. The program manager for each program will review completed COMPASS during the month of January and submit a brief memorandum certifying that the COMPASS was completed.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5c. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

Each behavioral health partnership will identify, plan, and complete a minimum of six (6) hours of joint partnership activities during the fiscal year. Activities may include but are not limited to: meetings, training, case conferencing, program visits, staff sharing, or other integration activities in order to fulfill the goals of a successful partnership. Programs will submit the annual partnership plan via email to CBHSIntegration@sfdph.org.

Data Source:
Program self report such as activity attendance sheets with documentation of time spent on integration activities. The program manager will certify documentation of this plan.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5d. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

Each program will select and utilize at least one of the CBHS approved list of valid and reliable screening tools to identify co-occurring mental health and substance abuse problems as required by CBHS Integration Policy (Manual Number: 1.05-01).

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5e. Applicable to: All CBHS programs, including contract and civil service mental health and substance abuse programs providing prevention, early I intervention and treatment services

During Fiscal Year 2010 -11, each program will participate in one Primary Care partnership activity with the Department of Public Health or Public Health Consortium Clinic located in closest proximity to their program. Optimal activities will be designed to promote cooperative planning and response to natural disaster or emergency events, neighborhood health fairs to increase joint referrals, or mutual open house events to promote cross-staff education and program awareness.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5f. Application to: All CBHS programs, including contract and civil service mental health and substance abuse programs providing prevention, early intervention and treatment service in Fiscal Year 2009-10.

Providers will have all program service staff including physicians, counselors, social workers, and outreach workers each complete a self assessment of integration practices using the CODECAT.

Data Source:
Program self report with submission of document of staff completion of CODECAT sent to CBHSIntegration@sfdph.org. The program manager will document this activity.

Objective 6. Cultural Competency

C.6a. Applicable to: All Providers of Behavioral Health Services

Working with their CBHS program managers, programs will develop three (3) mutually agreed upon opportunities for improvement under their 2009 Cultural Competency Reports and report out on the identified program-specific opportunities for improvement and progress toward these improvements by September 30, 2010. Reports should be sent to both program managers and the DPH/EEO.

Data Source:
Program managers will review progress utilizing the DPH Cultural Competency Report Evaluation Tool.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Designated Contact:
Jason Hashimoto, Director, EEO/Cultural Competency Programs, DPH.

Objective 8. Program and Service Innovation & Best Practices

C.8a. Applicable to: Providers of Behavioral Health Services that provide Mental Health and Substance Abuse Services to Children, Youth, Families, Adults or Older Adults

If applicable each program shall report to CBHS Administrative Staff on innovative and/or best practices being used by the program including available outcome data.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

1. **Program Name: FSA Adult Full Service Partnership**
   Program Address: 1010 Gough Street
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 474-9934

2. **Nature of Document** (check one)

   x **New** ☐ Renewal ☐ Modification

3. **Goal Statement**

Our primary goals are to encourage these people in becoming independent and productive members of their community; that they have the supports and resources to achieve successful outcomes and stability in independent living; that they have meaningful opportunities to improve their well-being and quality of life; that they be empowered with a sense of purpose and self-determination to achieve their potential, that they understand and have the resources to address their mental health issues, and that they have the skills and understanding to remain clean and sober.

4. **Target Population**

The target population is adults ages 18 and older with severe mental illness and/or substance abuse problems. Many will have HIV/AIDS; some may be homeless. We treat all genders and sexual orientations and work with family members, significant others, and support persons. FSA's Adult Full Service Partnership (FSP-A) will provide an integrated recovery and treatment approach for approximately 40 vulnerable adult San Franciscans living with serious mental illness or dual diagnosis. This represents an increase in the number of consumers this program will serve over last year. We will achieve this higher census by ramping up gradually over the course of this fiscal year.

5. **Modality(ies)/Interventions**

Modalities of Services used in the Adult Care Management and Adult FSP are:
Direct Services:
Assessment and Plan Development: for analysis of consumer's history and current psychological, emotional and behavioral issues. In addition to developing a treatment plan.
Case Management Brokerage: for linking consumers to services and providing emotional support.
Individual and Group Therapy: for providing therapeutic interventions that focus on symptom reduction.
Collateral: a service activity to a significant support person in the consumer's life.
Individual and Group Therapy: therapeutic interventions focused on symptom reduction.
Crisis Intervention: emergency intervention, immediate face to face to prevent harm coming to he consumer.
Medication Support Services: prescribing, administering, dispensing and monitoring of psychiatric medications and biological to alleviate psychiatric symptoms.
Indirect Services:
Providing mental health promotion
Working with "Community Clients" who are not registered to our program.

Giving trainings.
Clinical Staff Development, receiving training.
The FSP program can also utilize **Mode 60** functions. These are either services provided to consumers that do not meet Medical standards for reimbursement, such as, transportation, shopping, or socialization activities; in addition to in-kind services that are purchased for our consumers out of this program's flex fund budget.

6. Methodology

A. Program's outreach, recruitment, promotion, and advertisement.

Outreach and Engagement: Once a client has been identified by CBHS and referred to the FSP-A, the Consumer Services Team (CST) will be responsible for outreach, screening and assessment. Members of the CST will conduct street outreach to homeless encampments, parks, homeless shelters and food programs, and other service locations. Engagement with clients will include careful, systematic attempts to engage the most difficult and wary consumers, involving multiple contacts and a willingness to serve consumers on whatever level they are willing to receive assistance.

Primary responsibility for outreach will reside with the CST's two consumer-professional Outreach Worker. These will be Outreach Workers with direct experience as clients of the treatment system. Based upon national research that shows that the most effective outreach to the target population is by addressing immediate needs, the Case Aides will be able to offer food, clothing, temporary shelter, and other amenities (snacks, razors, personal hygiene supplies). A second key to the Initiative's outreach to the most fragile and disconnected consumers will be the CST's Psychiatric Nurse Practitioner. Because consumers who are otherwise distrustful of treatment services are often willing to receive health care if it is offered in a non-institutional setting, the PNP will be an important element of our engagement strategy. The PNP will provide health screening and first aid, dispense minor medications (such as over-the-counter painkillers and analgesics, and topical skin medications), prescribe psychotropic medications with supervision of the psychiatrist, and arrange for medical treatment through the Tom Waddell Health Center. With this beginning, it is hoped that a bond may be formed with the CST that will make the consumer more open to accepting assistance. In addition to street outreach, referrals will be accepted from multiple sources, including SF General, Project Homeless Connect, other homeless programs, other mental health and substance abuse agencies, PES, Sheriff, SFPD, hospital emergency rooms, and self and family referrals. All referrals will need to be authorized by CBHS.

Intake and Assessment: Once an individual has been identified as an FSP-A client, the first focus of the CST will be the consumer's basic needs for shelter, food, clothing, and medical care. Consumers who cannot be placed immediately into housing will receive temporary housing while the assessment and housing placement process goes on. Our CST will actively cooperate with the housing placement and stabilization process to offer a variety of housing resources. We will immediately assist the consumer with food, clothing needs, and a health checkup. Any pressing health needs will be immediately treated through the Tom Waddell Health Center. Within one week after a client enters the program, the Team will work with an Eligibility Worker from the Department of Human Services to initiate an application for food stamps, general assistance, and MediCal. The Team will continue to collaborate to obtain permanent consumer benefits, including SSI.

B. Program's admission, enrollment and/or intake criteria and process where applicable.

Once a client is identified as an FSP-A client, we will provide a welcoming "Every Door is the Right Door" approach. The first focus of the CST will be the consumer's basic needs for shelter, food, clothing, and medical

care. Consumers who cannot be placed immediately into housing will receive temporary housing while the assessment and housing placement process goes on. The client will be assisted with immediate food and clothing needs, and provided a health checkup. Any pressing health needs will receive immediate treatment through the Tom Waddell Health Center. For participants leaving an institution—jail, hospital, treatment center, or prison—we will be there for them prior to the discharge process and ensure on the day they leave the institution that they have transportation, food, and a place to live, which could include temporary shelter.

Within one week after a client enters the program, the Team will work with an Eligibility Worker from Human Services to initiate an application for food stamps, general assistance, and MediCal. The Team will continue to collaborate to obtain permanent benefits for the consumer, including SSI. All referrals will need to be authorized by CBHS.

C. Program's service delivery model.

Family Service Agency of San Francisco's Adult Full Service Partnership will provide an integrated recovery and treatment approach for vulnerable San Franciscans, between the ages of 18 and 59. FSA will serve 34 client slots utilizing an AB34 model of intensive service provision. A staff team will work with consumers 24/7 to provide a comprehensive array of recovery-oriented services and supports. Services will include housing and basic needs assistance (utilizing a housing first/harm reduction model), strength-based individualized care planning and care management, physical health care, benefits assistance, vocational rehabilitation, employment services, peer support, and integrated mental health and substance abuse treatment services.

Actual levels of client service will be determined by the client's needs and desires, with service intensity being extremely high in the beginning and reduced as the client is stabilized. At a minimum, clients will receive one weekly contact from the team. Additional services will be purchased through flexible funding or as part of the in-kind services each partner brings to this program.

The FSP-A will have physical health care, mental health treatment, medication management, substance abuse treatment, employment assistance, post-employment support, benefits assistance and advocacy, and peer support integrated into a single service team—the Consumer Services Team (CST). We understand that housing will be provided through the San Francisco Housing Authority. We plan to work closely with the Housing Authority, property management and the on sight support staff.

The FSP-A Team will have a substantial pool of flexible funding to purchase specialized services and supports, including support services for HIV+ individuals, for victims of violence and sexual exploitation, for LGBT clients, and for developmentally or physically disabled clients.

Care Coordination: Each participant will be assigned a primary Care Coordinator who coordinates and monitors the activities of the team and has primary responsibility to work with the participant in developing his/her own individual treatment plan, to ensure immediate changes are made in treatment plans as participants' needs change, and to advocate for participant rights and preferences. All care planning will be done used the Individualized and Tailored Care model. The Care Coordinator is also the first staff person called on when the client is in crisis and is the primary support person and educator to the participant's family. Members of the treatment team share these tasks with the Care Coordinator and are responsible to perform the tasks when the Care Coordinator is not working. As part of the strengths-based assessment and case planning model, we will help the consumer to develop a Wellness and Recovery Action Plan.

Crisis Assessment and Intervention: Crisis assessment and intervention is provided 24 hours per day, seven

days per week. These services include telephone and face-to-face contact. During normal working hours, an available FSP-A team member responds. After hours and on weekends, an FSP-A team member is on call and carries the team's crisis phone. This number is available to emergency service providers. During nights and weekends, the on-call staff assesses the situation and provides whatever intervention is clinically indicated.

Mental Health Treatment: Dual-Diagnosis: The FSP-A Team will be prepared to identify and address a range of substance abuse issues and multiple mental health disorders, ranging from moderate depression to schizophrenia. We will provide a particular focus on post-traumatic stress, behavioral and conduct disorders, and family issues, which we anticipate will be virtually universal in this population. Treatment for mental illness will include

- Ongoing assessment of the participant's mental illness symptoms and his/her response to treatment;
- Education of the participant regarding his/her illness and the effects and side effects of prescribed medications, where appropriate;
- Symptom-management efforts directed to help each participant identify the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen their effects; and
- Psychological support to participants, both on a planned and as-needed basis, to help them accomplish their personal goals and to cope with the stresses of day-to-day living.

Substance Abuse Treatment: The FSP-A will provide both one-to-one and group substance abuse treatment, integrated with mental health treatment. The FSP-A team will provide substance abuse treatment in stages throughout the service period, depending on the participant's level of readiness for treatment. Staff will be trained in Treatment planning appropriate to the stage of recovery our partner is in. Participants will also be referred to and encouraged to participate in NA and AA.

Medication Prescription, Administration, Monitoring, and Documentation: The AFSP psychiatric nurse practitioners will assess each participant's mental illness and prescribe appropriate medication; regularly review and document the participant's symptoms as well as his or her response to prescribed medication treatment; educate the participant regarding his/her mental illness on the effects and side effects of medication prescribed to regulate it; and monitor, treat, and document any medication side effects. All FSP-A team members assess and document the participant's symptoms and behavior in response to medication and monitor for medication side effects. The AFSP team program also has medication policies and procedures that identify processes to: record physician orders; order medication; arrange for all participant medications to be organized by the team and integrated into participants' weekly schedules and daily staff assignment schedules; and provide security for medications.

Employment Services: The employment/community integration specialist on the team works at finding community sites for our consumers to work at. Sites we have placed our consumers in over the past few years have been: Subways, AMC 1000, Open Hand and Glide. Our consumers have also volunteer at numerous FSA sites, e.g., the Older Adult Day Support Center, and Adult Care Management providing assistance with filing and office based work. We've tried to encourage consumers to help support each other, e.g., one consumer was accompanying another wheelchair bound consumer to the swimming pool for water physical therapy. This was meet with mixed success and as a program we decided to discontinue the idea of having consumers within the same "intensive" program become that involved in each other's physical/emotional treatment.

FSA created FSA Works as a pre-vocation "program". Consumers are paid a stipend of $10/hour and can work up to 4 hours/week. The work opportunities for FSA Works are mostly in house filing and organizing. Consumers are also able to get paid for any volunteer work they would like to pursue. Consumers can be part of FSA Works for 6 months at a time. At the end of the 6-month period that stipend would go to the next consumer on the program's waitlist. During that 6-month period consumers are encouraged to continue to look for work opportunities in the community. If they have not found one, consumers can then be placed on the bottom of the wait list, and can take the next opening when their turn comes. As you can imagine these stipends are quite popular. There are seven stipend positions available to this program.

Activities of Daily Living: Services to support activities of daily living in community-based settings include individualized assessment, problem solving, side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist participants to gain or use the skills required to: carry out personal hygiene and grooming tasks; perform household activities, including house cleaning, cooking, grocery shopping, and laundry; housing support including finding a roommate, landlord negotiations, cleaning, furnishing and decorating, procuring necessities (such as telephone, furnishings, linens); develop or improve money-management skills; use available transportation; and find and use healthcare services.

Social, Interpersonal Relationship, and Leisure-Time Skill Training: Services to support social, interpersonal relationship, and leisure-time skill training; side-by-side support and coaching; and organizing individual and group social and recreational activities. In addition, there will be monthly community meetings and cookouts for our partners to participate in.

Education, Support and Consultation to Participants' Families and Other Major Supports: With participant agreement or consent, services to participants' families and other major supports will include education about the participant's illness and the role of the family in the therapeutic process; intervention to resolve conflict; and ongoing, face-to-face, and telephone communication and collaboration between the FSP-A team, the family, and other major supports.

Wraparound Services: The program will provide the client a comprehensive range of service. These services include but are not limited to: supportive and cognitive therapies, case management brokerage (e.g., linkage to services such as housing, benefits and medical care), substance abuse treatment, medication services, vocational and pre-vocational assistance. Any services, supports, or products needed to complete the Care Plan and not readily available through the service constellation will be acquired through flexible funding.

Gender-Related and Sexual Orientation Issues: The FSP-A and its program partners will offer gender-specific programming for women, especially gender-focused trauma treatment, as well as special programming for LGBT clients. We will work with New Leaf to provide consultation and assistance to our clients through flexible funding, as well as referring LGBT clients to New Leaf and other appropriate services.

Aftercare: A-FSP will offer aftercare services to help clients remain stable and to facilitate ongoing connection to supportive services. FSA will continue providing services to mental health consumers as long as they meet criteria for medical necessity. A-FSP will assist clients in identifying and connecting with ongoing supportive services, such as AA and NA. Many of the consumers who will graduate from this program will continue to need some mental health support. The majority of these consumers will be transferred and served at a local mental health clinic and/or wellness centers

Hours of operation: FSA opens at 8:30 AM for staff and 9:00 AM for client care. Although, the building is only open Monday through Friday the FSPs have weekend programming, which are usually activities such as, movies and attending baseball games. Both ACM and the Adult FSP are open to deal with consumer emergencies 24 hours a day, 7 days per week. Consumers can reach an on-call clinician by calling an emergency phone number.

Location: most services are provided at the FSA building at 1010 Gough Street, San Francisco. FSA's partnering programs are located through out the city and consumer may be receiving services at their sites in addition.

Average Length of Stay: There is a range of length of stay depending on the individual needs of the consumer. The FSPs have only been around for about four years and there are some consumers that have been with us since the beginning, but the average length of stay here appears to be 2-3 years.

Strategies for service delivery: Our theory of change is that with the appropriate treatment and support our consumers' quality of life will improve. Additionally, as our consumers' lives improve so do the lives of each member of the larger community.

The service: thoughtful engagement, strength-based assessment and treatment planning, wrap around case management, metal health and substance abuse treatment, vocational support, individual and system wide advocacy on behalf of our consumers, all provided through a recovery oriented, harm reduction approach.

The short term outcomes: with the type of service listed above our consumers should experience an increase in social, psychological and behavioral skills, a decrease in loneliness, and increased sense of purpose and belonging, an increase degree of insight, and an increased openness to services.

The impact on the larger community/city: a decrease in homelessness, a decrease in days spent in the hospital and in detox, a decrease in the use of ER rooms and PES, an increase in the number of employed persons, an increase in the tax revenue for the city, a decreased in the illegal drugs purchased on the streets, a decreased burden on the legal system, a decrease in suicide attempts and health complications related to living on the streets.

D. Program's exit criteria and process.

As our consumers improve and require less support they could transfer to the level of our FSP program. These consumers are generally seen weekly, at a variety of settings. Over a 6-month period these consumers would work with the staff to increasingly attend meetings at our clinic. Skills that might be necessary to be reviewed might be how to use and tolerate using public transportation, how to use an organizer and appointment book to keep track of when and where appointment are, and developing an understanding for the importance of these appointments. This is an important skill for being successful at the next lower level of care.

As our consumers continue to improve and require even less support they could be transferred, at first to an outpatient clinic and then later serviced through a Wellness Center. Recovery is not a straight shot to a healthy lifestyle. Consumers would be able to transition up and back between levels of care as required by the level of functionality. Clinicians will also have to pay attention to working with consumers to prepare them for less support at the next lower level of care, in anticipation of transfers.

We will follow guidelines as established by DPH. Typical guidelines for discharge include CBHS definitions of medical necessity, stabilization of debilitating psychiatric symptoms, resolving of problems on plan of care and successfully linking client to alternative services for care.

E Program's staffing.

Adult FSP

- Division Director (0.11 FTE) – responsible for program compliance
- Program Director (0.48 FTE) – responsible for program supervision and outcomes
- Mental Health Case Manager (2.0 FTE) – provide mental health services and linkage
- Peer Professional Case Aides (1.4 FTE) – responsible to outreach, engagement, accompaniment and activity supervision
- Psychiatric Nurse Practitioners (0.22 FTE) – medication support
- Psychiatrist (0.03 FTE) – supervision of nurse practitioner
- Support Staff (.50 FTE) – everything else

All positions are funded by this grant.

7. PERFORMANCE/OUTCOME OBJECTIVES

A. OUTCOME OBJECTIVES

A. OUTCOME 1: IMPROVE CLIENT SYMPTOMS

Objective A.1: Reduce Psychiatric Symptoms

A.1a. Applicable to: Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Children, Youth, Families, Adults and Older Adults except supported housing programs

The total number of acute inpatient hospital episodes used by clients in Fiscal Year 2010-11 will be reduced by at least 15% compared to the number of acute inpatient hospital episodes used by these same clients in Fiscal Year 2009-10. This is applicable only to clients opened to the program no later than July 1, 2009 and had no IMD or CTF episode during FY 2009-10. Data collected for July 2010 – June 2011 will be compared with the data collected in July 2009– June 2010.

Programs will be exempt from meeting this objective if more than 50% of the total number of inpatient episodes was used by 5% or less of the clients hospitalized.

Data Source:
CBHS Billing Information System - CBHS will compute.

BIS Reason for Discharge Field.
Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

A.1k. Applicable to: **Intensive Care Management (ICM) Providers of Adult and Older Adult Behavioral Health Services**

ICM providers will require that clinicians evaluate level of functioning for ALLCLIENTS by completing the Milestones of Recovery Scale (MORS).

New clients will complete the MORS at intake, every month thereafter, and at discharge. Continuing clients will complete the MORS within 90 days of the new contract year, and every month thereafter, and at discharge.

Providers must submit 75% of required MORS forms for all clients to pass this objective.

Data Source:
MORS submitted to website and summarized by Program Evaluation Unit.

Program Review Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

OUTCOME 3: IMPROVE CLIENT FUNCTIONING

Objective A.3: Increase Stable Living Environment

A.3a. Applicable to: **Providers of Behavioral Health Services for Children, Youth, Families, Adult or Older Adult Mental Health Programs, except 24-hour programs**

35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI.

Data Source:
BIS Living Situation Codes.

Program Review Measurement:
This objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

B. OTHER MEASURABLE OBJECTIVES/PROCESS OBJECTIVES

Objective 1: Access to Services

B.1a. Applicable to: **All Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Adult and Older Adults Health Programs, except 24-hour programs**

50% of uninsured active clients, with a DSM-IV diagnosis code that likely indicates disability, who are open in the program as of July 1, 2010, will have SSI linked Medi-Cal applications submitted by June 30, 2011.

Programs are also strongly encouraged to refer eligible clients to Healthy San Francisco.

Client Inclusion Criteria:
Uninsured active clients (seen by the program at least once between April 1, 2010 and June 30, 2010) with a DSM-IV diagnosis code that likely indicates disability (list of DSM-IV diagnosis codes will be provided by CBHS) and open in the program as of July 1, 2010, will be included in the calculation.

Data Source:
Program Director will show proof of SSI applications submitted for/by clients (such as copies of applications, or proof of online application submission). Provider shall email DPH SSI Program Coordinator a list containing names and Social Security numbers of clients who applied for SSI through the Agency's assistance at luciana.garcia@sfdph.org.

Program Director shall keep in files proof of SSI applications submitted for/by clients (such as copies of applications or proof of online application submission).

Program Review Measurement:
Objective will be evaluated based on the first 12-month period from July 1, 2010 to June 30, 2011. Program Director shall send their lists to SSI Program Coordinator by June 30, 2011.

Objective 5. Documentation/Authorization

B.5a. Applicable to: **All Providers of Behavioral Health Services who provide Adult and Older Adult Mental Health Outpatient Services that are not exempt from having services authorized**

At least 90% of a sample reviewed by CBHS of open, active clients (defined as those having received a billable service in a program within 90 days) will have a current authorization, and 100% will have a current plan of care. Programs with multiple non-exempt reporting units will have data from those RU's combined before computation.

Data Source:
PURQC oversight audit. A random sample generated by CBHS and proportional to program caseload but not more than 25 clients will be used for PURQC oversight.

Objective 6. Client Satisfaction

B.6b. Applicable to: **Providers of Behavioral Health Services who provide Children, Youth, Families, Adult or Older Adult Mental Health Treatment Services (excluding crisis services, suicide prevention and conservatorship)**

During Fiscal Year 2010-11, 100% of unduplicated clients who received a face-to-face billable service during the survey period will be given and encouraged to complete a Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on the survey administration closest to the 12-month period from July 1, 2010 to June 30, 2011.

8.CONTINUOUS QUALITY IMPROVEMENT, PROGRAM PRODUCTIVITY AND SERVICE ACCESS

All providers of Behavioral Health Services will be encouraged to meet quarterly with their CBHS program managers to evaluate progress toward meeting the following set of continuous quality improvement, productivity, and service access objectives. Other objectives may be added if mutually agreed to by the providers and their CBHS program managers. These objectives will be evaluated based on a summary of quarterly meetings held by March 2010. Providers are encouraged to continue quarterly meetings through the end of FY 2009-2010 and thereafter.

Objective 1. Program Productivity

C.1a. Applicable to: **All Providers of Behavioral Health Services who provide Substance Abuse Treatment and Prevention and Mental Health Services**

During Fiscal Year 2010-11, AFSP=3,678 units of service (UOS) will be provided consisting of treatment, prevention, or ancillary services as specified in the unit of service definition for each modality and as measured by BIS and documented by counselors' case notes and program records.

Date Source:
CBHS Billing Information System – DAS 800 DW Report or program records. For programs not entering data into BIS, CBHS will compute or collect documentation.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

Objective 2. Access to Services

C.2a. Applicable to: **All Adult and Older Adult & CYF Behavioral Health Intensive Case Management Programs including SPR's**

Adult FSP will have at least 7 new client episode openings (or 20% new clients) for Fiscal Year 2010-11.(The number of targeted new client episode openings during FY 2010-11 will be individually negotiated with the Program Manager for each specific Intensive Case Management Program based on historical rate of episode openings and baseline profile of psychiatric stability of caseload.)

Client Inclusion Criteria:
All new unique client episode openings into the ICM program during FY 2010-11.

Data Source:
CBHS Billing Information System - CBHS will compute.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 4. Client Outcomes Data Collection

C.4e. Applicable to: **Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services for Adults and Older Adults**

For clients on atypical antipsychotics, at least 50% will have completed the documentation of the CBHS Antipsychotic Metabolic Monitoring Form or equivalent, in the clients' medical record. At a minimum, the record should include annual monitoring of weight, blood pressure, and fasting glucose (or Hemoglobin A1.C).

Client Inclusion Criteria:
Adult and Older Adult clients on any atypical antipsychotic medication (aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone) prescribed by Provider any time during July 1, 2010 to June 30, 2011.

Data Source :
Program Self Report and/or Client medical record audit./ MUIC Metabolic Monitoring Subcommittee

Program Review Measurement
Objective will be evaluated based on a 12 month period from July 1, 2010 to June 30, 2011. To meet objective, Metabolic Monitoring Form should show at minimum annual monitoring of weight, blood pressure, and fasting glucose (or Hemoglobin A1.C). Upon request, Provider to submit copies of Metabolic Monitoring Forms for randomly selected clients.

Objective 5. Integration Activities **

** For providers who are not located in the City and County of San Francisco, contractors who do not provide client services and small programs with less than 3.0 FTEs, please refer to the attached Integration Inclusion Document for guidance on the implementation of objectives in this section of Integration Preparedness (see Addendum I). Please note that several Integration process objectives are included on the CBHS Compliance Checklist for FY2009-10. All providers of behavioral health services will be expected to meet these CBHS Compliance Checklist integration items. For all of the following items listed from D.5a – D.5f, programs will submit all reporting on integration preparedness items via email to CBHSIntegration@sfdph.org.

C.5a. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each program will complete a new self-assessment with the revise COMPASS every two (2) years (a new COMPASS must be completed every other fiscal year).

Data Source:
Program managers to review information sent to CBHSIntegration@sfdph.org via the shared folder to monitor compliance.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

C.5b. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Using the results of the most recently completed COMPASS (which must be completed every 2 years), each program will identify at least one program process improvement activity to be implemented by the end of the fiscal year using an Action Plan format to document this activity. Copies of the program Action Plan will be sent via email to CBHSIntegration@sfdph.org.

Data Source:
Each program will complete the COMPASS self assessment process and submit a summary of the scores to CBHSIntegration@sfdph.org. The program manager for each program will review completed COMPASS during the month of January and submit a brief memorandum certifying that the COMPASS was completed.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5c. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each behavioral health partnership will identify, plan, and complete a minimum of six (6) hours of joint partnership activities during the fiscal year. Activities may include but are not limited to: meetings, training, case conferencing, program visits, staff sharing, or other integration activities in order to fulfill the goals of a successful partnership. Programs will submit the annual partnership plan via email to CBHSIntegration@sfdph.org.

Data Source:
Program self report such as activity attendance sheets with documentation of time spent on integration activities. The program manager will certify documentation of this plan.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

C.5d. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each program will select and utilize at least one of the CBHS approved list of valid and reliable screening tools to identify co-occurring mental health and substance abuse problems as required by CBHS Integration Policy (Manual Number: 1.05-01).

Data Source:
Program Self Report.

Program Review Measurement:

Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings to be held by December 2010 and March 2011 will be included in the program review.

C.5e. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

During Fiscal Year 2009-10, each program will participate in one Primary Care partnership activity. The Primary Care Partner for this activity must be the DPH Oriented Primary Care Clinic located in closest proximity to the program, or most appropriate for the program population. Primary care program which cannot be Primary Care Partner for this purpose, include primary care program which are part of the same overall agency as the Behavioral Health Program. Optimal activities will be designed to promote cooperative planning and response to natural disaster or emergency events, neighborhood health fairs to increase joint referrals, or mutual open house events to promote cross-staff education and program awareness.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2009 will be included in the program review.

C.5f. Applicable to: **All CBHS programs, including contract and civil service mental health and substance abuse programs providing prevention, early intervention and treatment service in Fiscal Year 2010-11.**

Providers will have all program service staff including physicians, counselors, social workers, and outreach workers each complete a self assessment of integration practices using the CODECAT. This self assessment must be updated every two years.

Data Source:
Program self report with submission of document of staff completion of CODECAT sent to CBHSIntegration@sfdph.org. The program manager will document this activity.

Objective 6. Cultural Competency

C.6a. Applicable to: **All Providers of Behavioral Health Services**

Working with their CBHS program managers, programs will develop three (3) mutually agreed upon opportunities for improvement under their 2008 Cultural Competency Reports and report out on the identified program-specific opportunities for improvement and progress toward these improvements by September 30, 2010. Reports should be sent to both program managers and the DPH/EEO.

Data Source:
Program managers will review progress utilizing the DPH Cultural Competency Report Evaluation Tool.

Program Review Measurement:

Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

Objective 8: Program and Service Innovation & Best Practice

C.8a. Applicable to: **Providers of Behavioral Health Services that provide Mental Health and Substance Abuse Services to Children, Youth, Families, Adults or Older Adults**

If applicable each program shall report to CBHS Administrative Staff on innovative and/or best practices being used by the program including available outcome data.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

1. **Program Name: TAY Full Service Partnership (MAP)**

2. **Program Address: 1010 Gough Street**
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 931-3773

3. **Nature of Document** (check one)

   x **New** ☐ Renewal ☐ Modification

4. **Goal Statement**

The aim for the TAY Full Services Partnership-MHSA is to improve the quality of life of the consumers' we work with, by assisting them with improving their abilities to manage their mental health and substance use difficulties, as well as assisting our consumers with pursuing the fulfillment of their dreams. We believe that our TAY consumers have some special needs of their own, such as developing life skills, interpersonal skills and have geared some programming around these needs. We believe in supporting our consumers in their mission to complete their education, become job ready and then get and maintain employment. We also believe in supporting our consumers with following whatever creative path they might choose for themselves. Recovery takes many different forms, as does treatment. We believe in pursuing effective treatments, studying and evaluating them and broadening the field's knowledge base around how to most effectively help one human being to another.

5. **Target Population**

Approximately 30 transition-age youth ages 16 to 25 will receive specialized and targeted assistance to help them make the transition to adulthood. This represents an increase in the number of consumers this program will serve over last year. We will achieve this higher census by ramping up gradually over the course of this fiscal year. (Over the course of the year we plan to work with 40 unduplicated consumers in this program). Our primary goals are that these young adults with severe mental illness be prepared to participate in becoming independent and productive members of their community; that they have the supports and resources to achieve successful outcomes and stability in independent living; that they have meaningful opportunities to improve their well-being and quality of life; that they be empowered with a sense of purpose and self-determination to achieve their potential, that they understand and have the resources to address their mental health issues, and that they have the skills and understanding to work toward being clean and sober.
TAY FSP will serve 30 consumers at a time. Last year our Adult FSP served 52 consumers.
Both program serve a similar demographic base of consumers. That is 35% African-America; 40% Caucasian, 15% Latino; 7% Asian, and 3% other.
Both programs will provide services citywide.

6. **Modality(ies)/Interventions**
   Modalities of Services used in the Adult Care Management and Adult FSP are:

Direct Services:
Assessment and Plan Development: for analysis of consumer's history and current psychological, emotional and behavioral issues. In addition to developing a treatment plan.
Case Management Brokerage: for linking consumers to services and providing emotional support.
Individual and Group Therapy: for providing therapeutic interventions that focus on symptom reduction.
Collateral: a service activity to a significant support person in the consumer's life.
Individual and Group Therapy: therapeutic interventions focused on symptom reduction.
Crisis Intervention: emergency intervention, immediate face to face to prevent harm coming to he consumer.
Medication Support Services: prescribing, administering, dispensing and monitoring of psychiatric medications and biological to alleviate psychiatric symptoms.
Indirect Services:
Providing mental health promotion
Working with "Community Clients" who are not registered to our program.
Giving trainings.
Clinical Staff Development, receiving training.
The FSP program can also utilize **Mode 60** functions. These are either services provided to consumers that do not meet Medical standards for reimbursement, such as, transportation, shopping, or socialization activities; in addition to in-kind services that are purchased for our consumers out of this program's flex fund budget.

7. Methodology

A. Program outreach, recruitment, promotion, and advertisement.

Consumers are referred to these two programs by most of the programs in the CBHS system, including but not limited to: the psychiatric hospitals, jail psych., SPR and ACT teams as their consumer reach a new level in their recovery, the outpatient clinics and other case management programs as their consumer may face some type of decompensation in their mental health and recovery and need a higher level of support. All referrals are authorized through CBHS. The program directors keep a wait list for admissions to these programs.

B. Program's admission, enrollment and/or intake criteria.

Once a consumer is placed on the wait list they are contacted and informed about when to schedule their intake for. A phone screening is done, and consumers (in addition to their referents) are informed about helpful community resources. In the situations where services are need immediately, either linkage to the appropriate service is made or the consumer might be prioritized on the wait list.
Once the client is referred for program participation by CBHS, enrollment will include careful, systematic, persistent attempts to engage the most difficult and wary consumers, involving multiple contacts and a willingness to serve consumers on whatever level they are willing to receive assistance. Upon agreeing to participate in the program, the first focus of the Team will be the consumer's basic needs for shelter, food, clothing, and medical care. Consumers who cannot be placed immediately into housing will receive temporary housing while the assessment and housing placement process goes on. The consumer will be assisted with immediate food and clothing needs, and provided a health checkup. Any pressing health needs will receive immediate treatment through Maxine Hall or the Tom Waddell Health Center. For

participants leaving an institution-jail, juvenile hall, or treatment center, we will be there for them prior to the discharge process and ensure on the day they leave the institution that they have transportation, food, and a place to live.

Within one week after a client enters the program, the Team will work with an Eligibility Worker from the Department of Human Services to initiate an application for food stamps, general assistance, and MediCal. The Team will continue to collaborate to obtain permanent benefits for the consumer, including SSI.

The following flow chart illustrates the comprehensive and integrated nature of this collaborative program:

During the first two weeks, the Team will complete a multidisciplinary strengths-based assessment and will work with the client to develop an individualized services plan. Elements will include:

• Physical Health	• Education	• Life Skills
• Mental Health	• Employment	• Finances
• Substance Abuse	• Family/Social supports	

C. Program's service delivery model.

Care Coordination: Each participant will be assigned a primary Care Coordinator who coordinates and monitors the activities of the team and has primary responsibility to work with the participant in developing his/her own individual treatment plan, to ensure immediate changes are made in treatment plans as participants' needs change, and to advocate for participant rights and preferences. The treatment team is comprised of personal who are capable of providing mental health treatment, medication management, treatment for dually diagnosed issues, employment assistance, post-employment support, benefits assistance and advocacy, and peer support integrated into a single service team. The Care Coordinator is also the first staff person called on when the client is in crisis and is the primary support person to both the consumer and their families. Members of the treatment team share these tasks with the Care Coordinator and are responsible to perform the tasks when the Care Coordinator is not working. As part of the strengths-based assessment and case-planning model, we will help the consumer to develop a Wellness and Recovery Action Plan (WRAP).

Crisis Assessment and Intervention: Crisis assessment and intervention is provided 24 hours per day, seven days per week. These services include telephone and face-to-face contact. During normal working hours, an available team member responds. After hours and on weekends, a team member is on call and carries the team's emergency cell phone. This number is available to emergency service providers, as well as our consumers. During nights and weekends, the on-call staff assesses the situation and provides whatever intervention is clinically indicated.

Mental Health Treatment: Dual-Diagnosis: The TFSP Teams will be prepared to identify and address a range of substance abuse issues and multiple mental health disorders, ranging from moderate depression to schizophrenia. We will provide an additional focus on post-traumatic stress. Treatment for mental illness will include 1) Ongoing assessment of the participant's mental illness symptoms and his/her response to treatment; 2) Education of the consumer regarding his/her illness and the effects and side effects of prescribed medications, where appropriate; 3) Symptom-management efforts directed to help each participant identify the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen their effects; and 4) Psychological support to participants, both on a planned and as-needed basis, to help them accomplish their personal goals and to cope with the stresses of day-to-day living.

Dually Diagnosed and Substance Abuse Treatment: The TFSP teams will provide dually diagnosed treatment in stages throughout the service period, depending on the participant's level of readiness for treatment. All dually diagnosed treatment phases include individual interventions (group interventions will also be available) to assist participants to identify substance use, effects, and patterns; recognize the relationship between substance use and mental illness and psychotropic medications; develop motivation for decreasing substance use; develop coping skills and alternatives to minimize substance use; and achieve abstinence and stability. Consumers will also be referred to and encouraged to participate in NA and AA. When our consumers are in need of substance abuse treatment they will be referred to our substance abuse partner, Walden House. Walden House has a vast array of services for both our Adult consumers and because of our long-standing relationship through the integration process there is an easy of referring and working with each other's consumers.

Medication Prescription, Administration, Monitoring, and Documentation: The team psychiatrist and psychiatric nurse practitioners will assess each participant's mental illness and prescribe appropriate medication; regularly review and document the participant's symptoms as well as his or her response to prescribed medication treatment; educate the consumer regarding his/her mental illness and the effects and side effects of medication prescribed to regulate it; and monitor, treat, and document any medication side effects. All service team members assess and document the consumer's symptoms and behavior in response to medication and monitor for medication side effects. Both program's have medication policies and procedures that identify processes to: record physician orders; order medication; arrange for all participant medications to be organized by the team and integrated into participants' weekly schedules and daily staff assignment schedules; and provide security for medications.

Employment Services: The employment/community integration specialist on the team works at finding community sites for our consumers to work at. Sites we have placed our consumers in over the past few years have been: Subways, AMC 1000, Open Hand and Glide. Our consumers have also volunteer at numerous FSA sites, e.g., the Older Adult Day Support Center, and Adult Care Management providing assistance with filing and office based work. We've tried to encourage consumers to help support each other, e.g., one consumer was accompanying another wheelchair bound consumer to the swimming pool for water physical therapy. This was meet with mixed success and as a program we decided to discontinue the idea of having consumers within the same "intensive" program become that involved in each other's physical/emotional treatment.

FSA created FSA Works as a pre-vocation "program". Consumers are paid a stipend of $10/hour and can work up to 4 hours/week. The work opportunities for FSA Works are mostly in house filing and organizing. Consumers are also able to get paid for any volunteer work they would like to pursue. Consumers can be part of FSA Works for 6 months at a time. At the end of the 6-month period that stipend would go to the next consumer on the program's waitlist. During that 6-month period consumers are encouraged to continue to look for work opportunities in the community. If they have not found one, consumers can then be placed on the bottom of the waitlist, and can take the next opening when their turn comes. As you can imagine these stipends are quite popular. There are seven stipend positions available to this program.

Activities of Daily Living: Our TAY population is going through the developmental task of separating from their care givers and learning to be independent. Services to support activities of daily living in community-based settings include individualized assessment, problem solving, side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist participants to gain or use the skills required to: carry out personal hygiene and grooming tasks; perform household activities, including house cleaning,

cooking, grocery shopping, and laundry; housing support including finding a roommate, landlord negotiations, cleaning, furnishing and decorating, procuring necessities (such as telephone, furnishings, linens); develop or improve money management skills; use available transportation; and find and use healthcare services, as well as educational support.

Social, Interpersonal Relationship, and Leisure-Time Skill Training: Services to support social, interpersonal relationship, and leisure-time skill training; side-by-side support and coaching; and organizing individual and group social and recreational activities. There are clearly a number of special needs that our TAY consumers have. In regards to interpersonal relationships our TAY consumers are dealing with a great deal of rejection from family, school and their peer group(s). There are numerous groups and activities for our consumers to practice their interpersonal and leisure time skills. Our TFSP program provides weekly groups such as, Art Group, Movie Group and Gardening Group. For the gardening group we have secured a public garden spot on Page St and Laguna St, and the consumers have really enjoyed the gardening and the produce they have produced. Other activities we have done are: urban hikes (around town), Muir Woods visits (monthly), weekend outings to the movies and baseball games. Regarding showcasing our consumers talents, we have had our first talent show and will soon be putting on our second. We have had consumers perform slam poetry at open mike nights at cafes around town and others perform in rock bands at Yerba Buena and other youth oriented venues A DBT group was started two years ago. This group currently accepts consumers from any of FSA's adult and older adult mental health programs. News Letter Group has been recently established. Prior to the onset of this group one consumer ran and wrote the FSP newsletter, now we have a staff of TAY FSP, Adult FSP and ACM consumers writing for the newsletter. The newsletter will highlight the stories of a couple of our consumers each month. There will also be investigative articles about what is going on the our consumers' world and the larger mental health system, in addition to reviews of movies, TV shows, as well as live and recorded music. Our Art Group is contributing artwork for the newsletter.

Family Strengthening: TFSP will provide intensive family treatment services for participants. A partnering FSP program is providing extensive Functional Family Therapy (an evidence based practice that has been developed for youth and young adults in the juvenile and criminal justice system). training this year. As part of our continuum of care this services would be available to our consumers' families, as long as a child in the family was exhibiting behaviors related to the ongoing family stress. The actual approach will depend on the age of the participant, the nature of the family structure, and the extent to which families can be engaged in the recovery process. One of the strengths of FFT is that is emphasizes the responsibility of the therapist to find ways to engage the family and provides the therapist with tools to accomplish this. Secondly, it is a highly strengths-based, asset-oriented approach that is non-judgmental about family functioning or composition and helps the family to understand and value their own culture, background, and worth as a family. The programs will help clients reconnect with children, parents, and other family members, if possible, or assist with the process of adjustment when reconnection is not possible. As a means to try to achieve this goal FSA has established a Family Support and Education group. This group has been running for about 6 months and we are still working hard to increase the number of families attending. We have had a consistent two families attend each month. This is not meant to be a family therapy group, but rather group for families to receive information about mental health issues and a place to tell their stories and get support from each other.

Wraparound Services: The program partners will constellate around the client a comprehensive range of services, many of which are provided to this program with substantial or complete in-kind matching funding. Any services, supports, or products needed to complete the Plan of Care and not readily available through the service constellation will be acquired through flexible funding, for FSP consumers.

Gender-Related and Sexual Orientation Issues: The TFSP and its program partners will offer gender-specific programming for women, especially gender-focused trauma treatment, as well as special programming for LGBT clients. Many female clients may be suffering parenting-related grief and loss concerning the loss of parenting rights for and relationships with their children. We will work with New Leaf to provide consultation and assistance to our clients through flexible funding, as well as referring LGBT clients to New Leaf and other appropriate services. Over the past few years we have worked with several youth with gender-related issues. A number of these consumers have chosen to receive services from FSA, instead of New Leaf. We have also worked with the LGBT Community Center, who has provided some volunteer opportunities for our consumers. Our partnership with Oasis and Hospitality House provide self help centers for our consumers to receive and provide support

Aftercare: TFSP will offer aftercare services to help clients remain stable and to facilitate ongoing connection to supportive services. FSA will continue providing services to mental health consumers as long as they meet criteria for medical necessity. TFSP will assist clients in identifying and connecting with ongoing supportive services, such as AA and NA. Many of the consumers who will graduate from this program will continue to need some mental health support. The majority of these consumers will be transferred and served at a local mental health clinic. As part of this RFP process FSA will be establishing an Adult Wellness Center (with Oasis) for consumer to graduate to when they no longer require clinic based level of service.

Hours of operation: FSA opens at 8:30 AM for staff and 9:00 AM for client care. Although, the building is only open Monday through Friday the FSPs have weekend programming, which are usually activities such as, movies and attending baseball games. Both ACM and the Adult FSP are open to deal with consumer emergencies 24 hours a day, 7 days per week. Consumers can reach an on-call clinician by calling an emergency phone number.

Location: most services are provided at the FSA building at 1010 Gough Street, San Francisco. FSA's partnering programs are located through out the city and consumer may be receiving services at their sites in addition.

Average Length of Stay: There is a range of length of stay depending on the individual needs of the consumer. The FSPs have only been around for about four years and there are some consumers that have been with us since the beginning, but the average length of stay here appears to be 2-3 years.

Strategies for service delivery: Our theory of change is that with the appropriate treatment and support our consumers' quality of life will improve. Additionally, as our consumers' lives improve so do the lives of each member of the larger community.

The service: thoughtful engagement, strength-based assessment and treatment planning, wrap around case management, metal health and substance abuse treatment, vocational support, individual and system wide advocacy on behalf of our consumers, all provided through a recovery oriented, harm reduction approach.

The short term outcomes: with the type of service listed above our consumers should experience an increase in social, psychological and behavioral skills, a decrease in loneliness, and increased sense of purpose and belonging, an increase degree of insight, and an increased openness to services.

The impact on the larger community/city: a decrease in homelessness, a decrease in days spent in the hospital and in detox, a decrease in the use of ER rooms and PES, an increase in the number of employed persons, an increase in the tax revenue for the city, a decreased in the illegal drugs purchased on the streets, a decreased burden on the legal system, a decrease in suicide attempts and health complications related to living on the streets.

D. Program's exit criteria and process.

As our consumers improve and require less support they could transfer to the level of our Intensive Case Management program. These consumers are generally seen weekly, at a variety of settings. Over a 6-month period these consumers would work with the staff to increasingly attend meetings at our clinic. Skills that might be necessary to be reviewed might be how to use and tolerate using public transportation, how to use an organizer and appointment book to keep track of when and where appointment are, and developing an understanding for the importance of these appointments. This is an important skill for being successful at the next lower level of care.

As our consumers continue to improve and require even less support they would be transferred to the outpatient clinic. Here's were we were we will collaborate with Westside to utilize their outpatient clinic. Here consumers could receive services every other week and see their psychiatrist or nurse practitioner monthly, for up to 20 sessions per year.

As consumers continue through their recovery and continue to need even less support and case management, they could be serviced through a Wellness Center established through a collaboration with Oasis and/or partnering self help centers, such as Oasis and Hospitality House's drop-in centers.

As we all know, recovery is not a straight shot to a healthy lifestyle. Consumers would be able to transition up and back between levels of care as required by the level of functionality. Clinicians will also have to pay attention to working with consumers to prepare them for less support at the next lower level of care, in anticipation of transfers.

E. Program's staffing.

TAY FSP

- Division Director (0.11 FTE) – responsible for program compliance
- Program Director (0.48 FTE) – responsible for program supervision and outcomes
- Mental Health Case Manager (2.0 FTE) – provide mental health services and linkage
- Peer Professional Case Aides (1.4 FTE) – responsible to outreach, engagement, accompaniment and activity supervision
- Psychiatric Nurse Practitioners (0.22 FTE) – medication support
- Psychiatrist (0.03 FTE) – supervision of nurse practitioner
- Support Staff (.50 FTE) – everything else

All positions are funded by this grant.

8. Objectives and Measurements

A. PERFORMANCE/OUTCOME OBJECTIVES

OUTCOME 1: IMPROVE CLIENT SYMPTOMS

Objective A.1: Reduce Psychiatric Symptoms

A.1a. Applicable to: Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Children, Youth, Families, Adults and Older Adults except supported housing programs

The total number of acute inpatient hospital episodes used by clients in Fiscal Year 2010-11 will be reduced by at least 15% compared to the number of acute inpatient hospital episodes used by these same clients in Fiscal Year 2009-10. This is applicable only to clients opened to the program no later than July 1, 2010, and had no IMD or CTF episode during FY 2009-10. Data collected for July 2010 – June 2011 will be compared with the data collected in July 2009– June 2010.

Programs will be exempt from meeting this objective if more than 50% of the total number of inpatient episodes was used by 5% or less of the clients hospitalized.

Data Source:
CBHS Billing Information System - CBHS will compute.

BIS Reason for Discharge Field.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

A.1k. Applicable to: Intensive Care Management (ICM) Providers of Adult and Older Adult Behavioral Health Services

ICM providers will require that clinicians evaluate level of functioning for ALLCLIENTS by completing the Milestones of Recovery Scale (MORS).

New clients will complete the MORS at intake, every month thereafter, and at discharge. Continuing clients will complete the MORS within 90 days of the new contract year, and every month thereafter, and at discharge.

Providers must submit 75% of required MORS forms for all clients to pass this objective.

Data Source:
MORS submitted to website and summarized by Program Evaluation Unit.

Program Review Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

OUTCOME 3: IMPROVE CLIENT FUNCTIONING

Objective A.3: Increase Stable Living Environment

A.3a. Applicable to: Providers of Behavioral Health Services for Children, Youth, Families, Adult or Older Adult Mental Health Programs, except 24-hour programs

35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI.

Data Source:
BIS Living Situation Codes.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1; 2009 to June 30, 2010.

B. OTHER MEASURABLE OBJECTIVES/PROCESS OBJECTIVES

Objective 1: Access to Services

B.1a. Applicable to: All Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Adult and Older Adults Health Programs, except 24-hour programs

50% of uninsured active clients, with a DSM-IV diagnosis code that likely indicates disability, who are open in the program as of July 1, 2010, will have SSI linked Medi-Cal applications submitted by June 30, 2011.

Programs are also strongly encouraged to refer eligible clients to Healthy San Francisco.

Client Inclusion Criteria:
Uninsured active clients (seen by the program at least once between April 1, 2010 and June 30, 2011) with a DSM-IV diagnosis code that likely indicates disability (list of DSM-IV diagnosis codes will be provided by CBHS) and open in the program as of July 1, 2010., will be included in the calculation.

Data Source:
Program Director will show proof of SSI applications submitted for/by clients (such as copies of applications, or proof of online application submission). Provider shall email DPH SSI Program Coordinator a list containing names and Social Security numbers of clients who applied for SSI through the Agency's assistance at luciana.garcia@sfdph.org.

Program Director shall keep in files proof of SSI applications submitted for/by clients (such as copies of applications or proof of online application submission).

Program Review Measurement:
Objective will be evaluated based on the first 12-month period from July 1, 2010 to June 30, 2011. Program Director shall send their lists to SSI Program Coordinator by June 30, 2011.

Objective 5. Documentation/Authorization

B.5a. Applicable to: All Providers of Behavioral Health Services who provide Adult and Older Adult Mental Health Outpatient Services that are not exempt from having services authorized

At least 90% of a sample reviewed by CBHS of open, active clients (defined as those having received a billable service in a program within 90 days) will have a current authorization, and 100% will have a current plan of care. Programs with multiple non-exempt reporting units will have data from those RU's combined before computation.

Data Source:
PURQC oversight audit. A random sample generated by CBHS and proportional to program caseload but not more than 25 clients will be used for PURQC oversight.

Objective 6. Client Satisfaction

B.6b. Applicable to: Providers of Behavioral Health Services who provide Children, Youth, Families, Adult or Older Adult Mental Health Treatment Services (excluding crisis services, suicide prevention and conservatorship)

During Fiscal Year 2010-11, 100% of unduplicated clients who received a face-to-face billable service during the survey period will be given and encouraged to complete a Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on the survey administration closest to the 12-month period from July 1, 2010 to June 30, 2011.

9. CONTINUOUS QUALITY IMPROVEMENT, PROGRAM PRODUCTIVITY AND SERVICE ACCESS

Objective 1. Program Productivity

C.1a. Applicable to: All Providers of Behavioral Health Services who provide Substance Abuse Treatment and Prevention and Mental Health Services

During Fiscal Year 2009-10, TFSP=2,884) units of service (UOS) will be provided consisting of treatment, prevention, or ancillary services as specified in the unit of service definition for each modality and as measured by BIS and documented by counselors' case notes and program records.

Date Source:
CBHS Billing Information System – DAS 800 DW Report or program records. For programs not entering data into BIS, CBHS will compute or collect documentation.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 2. Access to Services

C.2a. Applicable to: All Adult and Older Adult & CYF Behavioral Health Intensive Case Management Programs including SPR's

TAY FSP will have at least 5 new client episode openings (or 20% new clients) for Fiscal Year 2010-11.(The number of targeted new client episode openings during FY 2010-11 will be individually negotiated with the Program Manager for each specific Intensive Case Management Program based on historical rate of episode openings and baseline profile of psychiatric stability of caseload.)

Client Inclusion Criteria:
All new unique client episode openings into the ICM program during FY 2010-11.

Data Source:
CBHS Billing Information System - CBHS will compute.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011will be included in the program review.

Objective 4. Client Outcomes Data Collection

C.4e. Applicable to: Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services for Adults and Older Adults

For clients on atypical antipsychotics, at least 50% will have completed the documentation of the CBHS Antipsychotic Metabolic Monitoring Form or equivalent, in the clients' medical record. At a minimum, the record should include annual monitoring of weight, blood pressure, and fasting glucose (or Hemoglobin A1.C).

Client Inclusion Criteria:
Adult and Older Adult clients on any atypical antipsychotic medication (aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone) prescribed by Provider any time during July 1, 2010 to June 30, 2011.

Data Source :
Program Self Report and/or Client medical record audit./ MUIC Metabolic Monitoring Subcommittee

Program Review Measurement
Objective will be evaluated based on a 12 month period from July 1, 2010 to June 30, 2011. To meet objective, Metabolic Monitoring Form should show at minimum annual monitoring of weight, blood pressure, and fasting glucose (or Hemoglobin A1.C). Upon request, Provider to submit copies of Metabolic Monitoring Forms for randomly selected clients.

Objective 5. Integration Activities **

C.5a. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

Each program will complete a new self-assessment with the revise COMPASS every two (2) years (a new COMPASS must be completed every other fiscal year).

Data Source:
Program managers to review information sent to CBHSIntegration@sfdph.org via the shared folder to monitor compliance.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

C.5b. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services.

Using the results of the most recently completed COMPASS (which must be completed every 2 years), each program will identify at least one program process improvement activity to be implemented by the end of the fiscal year using an Action Plan format to document this activity. Copies of the program Action Plan will be sent via email to CBHSIntegration@sfdph.org.

Data Source:
Each program will complete the COMPASS self assessment process and submit a summary of the scores to CBHSIntegration@sfdph.org. The program manager for each program will review completed COMPASS during the month of January and submit a brief memorandum certifying that the COMPASS was completed.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5c. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

Each behavioral health partnership will identify, plan, and complete a minimum of six (6) hours of joint partnership activities during the fiscal year. Activities may include but are not limited to: meetings, training, case conferencing, program visits, staff sharing, or other integration activities in order to fulfill the goals of a successful partnership. Programs will submit the annual partnership plan via email to CBHSIntegration@sfdph.org.

Data Source:
Program self report such as activity attendance sheets with documentation of time spent on integration activities. The program manager will certify documentation of this plan.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

C.5d. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

Each program will select and utilize at least one of the CBHS approved list of valid and reliable screening tools to identify co-occurring mental health and substance abuse problems as required by CBHS Integration Policy (Manual Number: 1.05-01).

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings to be held by December 2010 and March 2011 will be included in the program review.

C.5e. Applicable to: All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services

During Fiscal Year 2010-11, each program will participate in one Primary Care partnership activity. The Primary Care Partner for this activity must be the DPH Oriented Primary Care Clinic located in closest proximity to the program, or most appropriate for the program population. Primary care program which cannot be Primary Care Partner for this purpose, include primary care program which are part of the same overall agency as the Behavioral Health Program. Optimal activities will be designed to promote cooperative planning and response to natural disaster or emergency events, neighborhood health fairs to increase joint referrals, or mutual open house events to promote cross-staff education and program awareness.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2009 will be included in the program review.

C.5f. Applicable to: All CBHS programs, including contract and civil service mental health and substance abuse programs providing prevention, early intervention and treatment service in Fiscal Year 2010-11.

Providers will have all program service staff including physicians, counselors, social workers, and outreach workers each complete a self assessment of integration practices using the CODECAT. This self assessment must be updated every two years.

Data Source:
Program self report with submission of document of staff completion of CODECAT sent to CBHSIntegration@sfdph.org. The program manager will document this activity.

Objective 6. Cultural Competency

C.6a. Applicable to: All Providers of Behavioral Health Services

Working with their CBHS program managers, programs will develop three (3) mutually agreed upon opportunities for improvement under their 2008 Cultural Competency Reports and report out on the identified program-specific opportunities for improvement and progress toward these improvements by September 30, 2010. Reports should be sent to both program managers and the DPH/EEO.

Data Source:
Program managers will review progress utilizing the DPH Cultural Competency Report Evaluation Tool.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

Objective 8: Program and Service Innovation & Best Practice

C.8a. Applicable to: Providers of Behavioral Health Services that provide Mental Health and Substance Abuse Services to Children, Youth, Families, Adults or Older Adults

If applicable each program shall report to CBHS Administrative Staff on innovative and/or best practices being used by the program including available outcome data.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

1. **Program Name: Family Service Agency (FSA) - Administrative Service Organization**
   Program Address: 1010 Gough Street
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 474-9934

2. **Nature of Document** (check one)

   x **New** ☐ Renewal ☐ Modification

3. **Goal Statement**

   The primary goal of this program is to provide on-site cost-efficient, high quality mental health administrative services to the SFMHP staff serving a low income, culturally diverse, Medi-Cal or uninsured population with mental health needs in San Francisco. The services of this program will promote higher satisfaction with treatment.

4. **Target Population**

   The target population includes consumers in need of mental health services. This severe need population includes adults, youth, women, homeless, multiply diagnosed, children and geriatric clients as defined by the San Francisco Mental Health Plan. Priority for services will be given to patients who are low income, Medi-Cal., and uninsured consumers.

5. **Modality(ies)/Interventions**

   The Program provides on site administrative support services to the SFMHP with a focus on intake and referral of patients to the Providers Network, credential coordination, and overall clerical support to the provider systems office staff.

6. **Methodology**

   Administration
   The administrative offices for the program are located in the Family Service Agency of San Francisco at 1010 Gough Street, San Francisco, California, 94109. The general duties of FSA staff will be hiring, supervision and administrative responsibilities. The FSA Adult Division Director oversees this contract and reports to the Executive Director.

   Intake and Referral Coordinator
   This position is responsible for receiving referrals of clients who have been authorized for care and matching these clients with certified preferred providers. This position requires familiarity and understanding of the referral needs of psychiatric clients and with the SFMHP Provider Network. The

position requires matching clients and their specialty mental health needs to the skills, availability of locations, accessibility, and clinical knowledge of the preferred providers in the SFMHP in order to affect a good clinical match for quality mental health care. This position works closely with SFMHP Provider Relations, Central Access Team and Provider Systems to assure effective and rapid placement of clients in treatment with providers who have openings in their practice and relevant clinical skills. The position requires a minimum of one year experience performing the above, knowledge of computer programs inclusive of Microsoft Word, Excel, and a data base program such as Access, knowledge of clinical psychiatric terminology and excellent telephone skills. This position requires the ability to work with multidisciplinary personnel, both internally and externally, establishing and maintaining "customer-focused" relationships.

Credential Coordinator
This position is responsible for assisting in tracking, verifying and entering provider credentials in accordance with National Credential Quality Association (NCQA) standards in accordance with all SFMHP credential requirements by the SFMHP. This includes querying various institutions, facilities, licensing boards and insurance companies to primary source verify the credentials of providers. This involves data entry into the SFMHP's credentialing software and provider tracking software, mass mailings, and frequent contact with providers, and continuous updating of provider electronic and paper files. Minimum requirements to fill this position include familiarity with NCQA credentialing and re-credentialing standards, knowledge, experience and use of credentialing software, understanding of managed care certification and re-certification procedures. This position also requires excellent communication skills, both verbal and written, excellent telephone skills, high level of accuracy and timeliness in follow-ups, and the ability to handle multiple tasks. This position requires computer skills and specifically data entry

Administrative Assistant
This position provides clerical support to the Provider System's office staff. This includes answering telephones, filing, word processing, research, problem solving with providers and data entry. The position requires knowledge of basic computer programs and data entry, telephone skills, ability to work with multidisciplinary personnel, both internally and externally, establishing and maintaining "customer-focused" relationships This position requires extensive telephone work with providers, excellent verbal skills is essential.

7. Objectives and Measurements

A. Performance/Outcome Objectives

a) FSA will participate in satisfaction measures as requested by SFMHP,
b) FSA will incorporate cultural competency goals and objectives as identified by the SFMHP. collateral information when available, and documented in the counselor's case notes and program records.

B. Other Measurable objectives

a) FSA and the administrative service staff will continue to be trained in system-wide changes, i.e. outpatient consolidation of Short Doyle/Medi-Cal with Fee-For-Service and implementation of managed care in San Francisco City/County.
b) FSA will notify SFMHP when staffing capacity issues arise or other implementation obstacles arise so that appropriate problem solving strategies can be jointly developed and implemented by SFMHP and FSA.
c) A copy of the FSA Policy and Procedures Manual will be provided to the SFMHP.
d) Patients in the target population will participate and provide feedback by utilization of the SFMHP satisfaction survey as implemented by the SFMHP.

Outcome Objectives

a) FSA will participate in satisfaction measures as requested by SFMHP,
b) FSA will incorporate cultural competency goals and objectives as identified by the SFMHP.

8. Continuous Quality Improvement

The quality assurance mechanism for the program at FSA first involves the FSA Adult Division Director, who oversees all aspects of this program. FSA's Senior Management Team oversees agency planning, policy development, and the ethical conduct of all staff. This committee reviews monthly utilization of services as projected in the contracts. The Division Director, along with this committee is responsible for establishing and maintaining overall contractual guidelines for the program along with other mental health contracts. The FSA Senior Management Team reviews the practice patterns in the respective contractual programs using the following standards: quality of services, patient satisfaction, and treatment outcomes. The Senior Management Team meets monthly and is composed of the Executive Director of FSA and the Division Directors of FSA responsible for the mental health contracts. Changes or additions to program policy, protocol, and procedures are distributed to staff via written information, orientations and training.

Adult Division Director will meet monthly with the Program Monitor to receive feedback on the performance of the contract and implement any needed correction.
Staff is encouraged to attend related training offered by the SFMHP, their professional associations and other sources.

Family Service Agency Administrative Service Organization adheres to all CBHS CQI recommendations and complies with Health Commission, Local, State, and Federal Policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency and Client Satisfaction.

1. FSA Full Circle Family Program (FCFP)
   1010 Gough Street
   San Francisco, CA 94109
   Telephone: (415) 474-7310 Ext 453
   Facsimile: (415) 673-2488

2. Nature of Document

   x New ☐ Renewal ☐ Modification

3. Goal Statement

The overall goals of the Full Circle Family Program (FCFP) are to assist minors in the Tenderloin, South of Market, Western Addition, Mission, Bayview-Hunters Point and Visitacion Valley areas of San Francisco with their presenting problems (which could include, but are not limited to: child neglect and abuse situations; acting out at school and/or at home, issues of depression, and low self-esteem; additionally there are issues of trauma and lack of safety at the community level due to issues of violence and premature death that are rampant in their community) and maintain them within the community. Outpatient mental health services and assistance in accessing supportive services are provided with cultural appropriateness and sensitivity. Early identification and treatment of these multi problem families (families dealing with issues related to symptoms of mental health and substance abuse, marital discord, as well as, abuse and neglect problems) will be provided through collaboration and consultation with community-based agencies. Clinical services offered include: individual, group and family therapy; diagnostic evaluation; consultation, case management, information and referral. They will be provided at our clinic and participating schools. FCFP also has a child psychiatrist who provides medication evaluation/management for our clients as needed

4. Target Population

Our target population includes children and adolescents up to 21 years old (and their families) whose mental health problems meet - medical necessity criteria for specialty mental health services. Members of our target population are San Francisco residents who reside, for the most part, in Tenderloin, Western Addition, or South of Market, Mission, Bayview-Hunters Point and Visitacion Valley neighborhoods. Clients have Medi-Cal, AB 3632, Healthy Families, Healthy Kids, or no insurance. Only clients who have private insurance as their primary payer source are not eligible; these applicants are referred back to their health provider for services.

5. Modality(ies)/Interventions

These include **B. Mental Health Billable Services:**

- Medication Support Services:
  - "Medication Support Services "means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include

evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

- Mental Health Services: Assessment, Collateral and Therapy
  - "Mental Health Services" means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive Service activities may include are not limited to assessment, plan development, therapy, rehabilitation and collateral.
    - Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
    - Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.
    - Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.

- Targeted Case Management
  - "Targeted Case Management" means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

- Crisis Intervention
  - Crisis intervention is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

- Indirect
  - These are mental outreach and promotion activities; they include the promotion of continuous staff development in evidence-based and best practices theory as the lens for which mental health treatment is to be provided. The objective of the methodology is:

- MH Promotion: Providing education and/or consultation to clients and communities regarding mental health service programs in order to prevent the onset of mental health problems.

- Community Client Contact: Assisting clients and families for whom there is no open case record to achieve a more adaptive level of functioning through single contact or occasional contact.

- Human Service Staff Training: Enhancing or expanding the knowledge and skills of human service agency staff in meeting the needs of mental health clients.

- Clinical Staff Development: Enhancing and/or expanding agencies' or organizations' knowledge and skills in the mental health field for the benefit of the community-at-large or special population groups.

6. Methodology

A. Outreach is conducted through consistent networking (e.g., regular Provider meetings) and site visits to various schools, community based organizations. Recruitment will also be conducted internally, within the Children, Youth and Family Services Division, for those participants who will be pregnant and parenting and/or adjudicated during this new contract year. Additionally, staff routinely utilize health fairs and other such events for outreach, recruitment, and promotion and advertisement purposes.

B. Eligibility for FCFP program's admission, enrollment and/or intake criteria is predicated on whether the potential participant is age 4-21, an SF resident, and meets medical necessity for specialty mental health services.

The intake process is initiated when a parent, youth, family friend, or agency worker calls FCFP for a brief phone screening to determine eligibility. An intake session is scheduled within 24-48 hours to assess client presenting problems, needs, resources, priorities, and so forth, to determine disposition. The program will provide timely measurement of data at the site and reporting of data to CBHS as required and which may be changed periodically with prior notice from CBHS.

C. FCFP provides individual, group and family therapy, including play therapy, and sand tray therapy. During the 09-10 year, staff will be trained in Functional Family Therapy, and a focus on Family Systems assessment and interventions will begin to predominate. Case management and medication support services will be provided as well (e.g. targeted case management program, AB3632 Unit, Human Services Agency). Regular hours of operation are nine to five, Monday through Friday; services are provided at main clinic site, and local schools; home visits are conducted as needed. Services are additionally provided on-site and in the community, as warranted, outside of these hours, but generally between 8 am and 9 pm. Typical service protocol includes weekly family-based therapy including child therapy, regular parent meetings, collateral contacts and interventions and medication appointments as appropriate. Length of stay is dependent on client needs and progress towards meeting the plan of care goals. Service improvement efforts over this fiscal year will include staff

training and implementation in evidence-based practices (ex. Functional Family Therapy) targeted toward adolescents with behavioral disorders.

D. Discharge criteria include client/family attainment of plan of care goals, mutual agreement to discontinue services, or lack of participation which precludes progress. Clinicians discuss discharge with the family as well as with the FCFP clinical supervisor as part of the treatment plan. The CANS will be utilized as a measurement tool to examine and inform treatment decisions. If the case status is to change (i.e., step-down, transfer, referral, or closure) the clinician consults with the program director. The FCFP Provider will enter an appropriate code for "Reason for Discharge" in the BIS Insyst database when a client case is closed in the BIS Insyst.

NOTE: the FCFP Program Utilization Review Quality Committee (PURQC) reviews all cases at the 3-month and one year anniversary dates for status updates including continuance of services.

E. Clinical services are provided by licensed and license-eligible registered MFT, MSW (and deemed equivalent or greater) clinicians on-site at 1010 Gough Street and at collaborating schools throughout the target area. Therapists collaborate closely with all various site staff, parents and teachers. Case Management may be provided by experienced BA in Psychology, Social Work (or related field) staff. In addition, a licensed staff Psychiatrist provides ongoing medication assessment and support.

7. Objectives and Measurements

A. PERFORMANCE/OUTCOME OBJECTIVES

OUTCOME 1: IMPROVE CLIENT SYMPTOMS

Objective A.1: Reduce Psychiatric Symptoms

A.1a. Applicable to: Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Children, Youth, Families, Adults and Older Adults except supported housing programs

The total number of acute inpatient hospital episodes used by clients in Fiscal Year 2010-11 will be reduced by at least 15% compared to the number of acute inpatient hospital episodes used by these same clients in Fiscal Year 2009-10. This is applicable only to clients opened to the program no later than July 1, 2010, and had no IMD or CTF episode during FY 2010-11. Data collected for July 2010 – June 2011 will be compared with the data collected in July 2009– June 2010.

Programs will be exempt from meeting this objective if more than 50% of the total number of inpatient episodes was used by 5% or less of the clients hospitalized.

Data Source:
CBHS Billing Information System - CBHS will compute.

A.1e. Applicable to: Providers of Behavioral Health Services who provide mental health treatment services to

children, youth, families, adults and older adults except 24 hour programs

50% of clients who have been served for two months or more will have met or partially met their treatment goals at discharge.

Client Inclusion Criteria:
Clients discharged between July 1, 2010 and June 30, 2011 who have been served continuously for 2 months or more.

Data Source:
BIS Reason for Discharge Field.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

A.1f. Applicable to: All Providers of Behavioral Health Services who provide Outpatient Mental Health Treatment Services and Day treatment to Children, Youth and Families, including School-Mental Health Partnership Programs

Providers will ensure that all clinicians who provide mental health services are certified in the use of the Child & Adolescent Needs and Strengths (CANS). New employees will have completed the CANS training within 30 days of hire

Data Source:
CANS Certificates of completion with a passing score.

Program Review Measurement:
Objective will be evaluated based on program submission of CANS training completion certificates for all new employees from July 1, 2010 to June 30, 2011

A.1g. Applicable to: Providers of Behavioral Health Services who provide Outpatient Mental Health Services and Day Treatment to children, youth, and families, including school-based programs

Clients with an open episode, for whom two or more contacts had been billed within the first 30 days, should have both the initial CANS assessment and treatment plans completed in the online record within 30 days of episode opening.

For the purpose of this program performance objective, an 85% completion rate will be considered a passing score.

Data Source:
CANS submitted to CANS database website, summarized by CYF System of Care

Program Review Measurement:
This objective will be evaluated based on data from July 1, 2010 to June 30, 2011.

A.1h. Applicable to: Providers of Behavioral Health Services who provide Outpatient Mental Health Services and Day Treatment to children, youth, and families, including school-based programs

CYF agency representatives attend regularly scheduled SuperUser calls.

For the purpose of this performance objective, an 80% attendance of all calls will be considered a passing score.

Date Source:
SuperUser calls attendance log, summarized by CYF System of Care.

Program Review Measurement:
This objective will be evaluated based on data from July 1, 2010 to June 30, 2011.

A.1i. Applicable to: **Providers of Behavioral Health Services that provide Outpatient Mental Health Services and Day Treatment to children, youth and families, including school-based programs**

Outpatient clients opened will have a Re-assessment/Outpatient Treatment Report in the online record within 30 days of the 6 month anniversary of their Episode Opening date and every 6 months thereafter.

Day Treatment clients have a Reassessment/Outpatient Treatment report in the online record within 30 days of the 3 month anniversary of their episode opening date, and every 3 months thereafter

For the purpose of this program performance objective, a 100% completion rate will be considered a passing score.

Data Source:
CANS data submitted to CANS website and summarized by CYF System of Care.

Program Review and Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

A.1j. Applicable to: **Providers of Behavioral Health Services that provide Outpatient Mental Health Services and Day Treatment to children, youth and families, including school-based programs.**

Outpatient clients opened will have an updated Treatment Plan in the online record within 30 days of the 6 month anniversary of their Episode Opening

Day Treatment clients have an updated Treatment Plan in the online record within 30 days of the 3 month anniversary and every 3 months thereafter.

For the purpose of this program performance objective, a 100% completion rate will be considered a passing score.

Data Source:
CANS data submitted to CANS website and summarized by CYF System of Care

Program Review and Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

OUTCOME 2: Reduce Substance Use

n/a

OUTCOME 3: IMPROVE CLIENT FUNCTIONING

Objective A.3: Increase Stable Living Environment

A.3a. Applicable to: **Providers of Behavioral Health Services for Children, Youth, Families, Adult or Older Adult Mental Health Programs, except 24-hour programs**

35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI.

Data Source:
BIS Living Situation Codes.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

B. OTHER MEASURABLE OBJECTIVES/PROCESS OBJECTIVES

Objective 1: Access to Services

n/a

Objective 2. Reliance on Institutions

n/a

Objective 3. Quality of Care

n/a

Objective 4. Collect Client Outcomes

n/a

Objective 5. Documentation/Authorization

n/a

Objective 6. Client Satisfaction

B.6b. Applicable to: **Providers of Behavioral Health Services who provide Children, Youth, Families, Adult or Older Adult Mental Health Treatment Services (excluding crisis services, suicide prevention and conservatorship)**

During Fiscal Year 2010-11 100% of unduplicated clients who received a face-to-face billable service during the survey period will be given and encouraged to complete a Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on the survey administration closest to the 12-month period from July 1, 2009 to June 30, 2010.

8. CONTINUOUS QUALITY IMPROVEMENT, PROGRAM PRODUCTIVITY AND SERVICE ACCESS

Objective 1. Program Productivity

C.1a. Applicable to: **All Providers of Behavioral Health Services who provide Substance Abuse Treatment and Prevention and Mental Health Services**

During Fiscal Year 2010-11, 1,966 outpatient units of service (UOS) will be provided consisting of treatment, prevention, or ancillary services as specified in the unit of service definition for each modality and as measured by BIS and documented by counselors' case notes and program records.

Date Source:
CBHS Billing Information System – DAS 800 DW Report or program records. For programs not entering data into BIS, CBHS will compute or collect documentation.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2009 to June 30, 2010. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

Objective 2. Access to Services

n/a

Objective 3. Quality of Care

C.3a. Applicable to: **All providers of Behavioral Health Services who provide Outpatient , Day Treatment and Intensive Care Management Mental Health Services to Children, Youth and Families**

CYF providers will review quarterly CANS data provided by CBHS CYF-SOC with their CBHS program manager

Data Source:
Minutes of quarterly meetings kept by CYF providers, and submitted to CBHS by June 30 2011.

Program Review Measurement:
Objective will be evaluated quarterly during the 12 month period from July 1, 2010 to June 30, 2011. Only the minute from the first three quarterly meetings will be included in the program review.

Objective 4. Client Outcomes Data Collection

n/a

Objective 5. Integration Activities **

C.5a. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each program will complete a new self-assessment with the revise COMPASS every two (2) years (a new COMPASS must be completed every other fiscal year).

Data Source:
Program managers to review information sent to CBHSIntegration@sfdph.org via the shared folder to monitor compliance.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

C.5b. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Using the results of the most recently completed COMPASS (which must be completed every 2 years), each program will identify at least one program process improvement activity to be implemented by the end of the fiscal year using an Action Plan format to document this activity. Copies of the program Action Plan will be sent via email to CBHSIntegration@sfdph.org.

Data Source:
Each program will complete the COMPASS self assessment process and submit a summary of the scores to CBHSIntegration@sfdph.org. The program manager for each program will review completed COMPASS during the month of January and submit a brief memorandum certifying that the COMPASS was completed.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5c. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each behavioral health partnership will identify, plan, and complete a minimum of six (6) hours of joint partnership activities during the fiscal year. Activities may include but are not limited to: meetings, training, case conferencing, program visits, staff sharing, or other integration activities in order to fulfill the goals of a successful partnership. Programs will submit the annual partnership plan via email to CBHSIntegration@sfdph.org.

Data Source:
Program self report such as activity attendance sheets with documentation of time spent on integration activities. The program manager will certify documentation of this plan.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2009 to June 30, 2010. Only the summaries from the two first quarterly meetings held by March 2009 will be included in the program review.

C.5d. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each program will select and utilize at least one of the CBHS approved list of valid and reliable screening tools to identify co-occurring mental health and substance abuse problems as required by CBHS Integration Policy (Manual Number: 1.05-01).

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings to be held by December 2010 and March 2011 will be included in the program review.

C.5e. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

During Fiscal Year 2010-11, each program will participate in one Primary Care partnership activity. The Primary Care Partner for this activity must be the DPH Oriented Primary Care Clinic located in closest proximity to the program, or most appropriate for the program population. Primary care program which cannot be Primary Care Partner for this purpose, include primary care program which are part of the same overall agency as the Behavioral Health Program. Optimal activities will be designed to promote cooperative planning and response to natural disaster or emergency events, neighborhood health fairs to increase joint referrals, or mutual open house events to promote cross-staff education and program awareness.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5f. Applicable to: **All CBHS programs, including contract and civil service mental health and substance abuse programs providing prevention, early intervention and treatment service in Fiscal Year 2009-10.**

Providers will have all program service staff including physicians, counselors, social workers, and outreach workers each complete a self assessment of integration practices using the CODECAT. This self assessment must be updated every two years.

Data Source:
Program self report with submission of document of staff completion of CODECAT sent to CBHSIntegration@sfdph.org. The program manager will document this activity.

Objective 6. Cultural Competency

C.6a. Applicable to: **All Providers of Behavioral Health Services**

Working with their CBHS program managers, programs will develop three (3) mutually agreed upon opportunities for improvement under their 2008 Cultural Competency Reports and report out on the identified program-specific opportunities for improvement and progress toward these improvements by September 30, 2010. Reports should be sent to both program managers and the DPH/EEO.

Data Source:
Program managers will review progress utilizing the DPH Cultural Competency Report Evaluation Tool.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2009 to June 30, 2010. Only the summaries from the two first quarterly meetings held by March 2010 will be included in the program review.

Objective 7: Family/Youth/Consumer Driven Care

C.7a. Applicable to: **Providers of Behavioral Health Services that provide Mental Health to Children, Youth, and Families**

Each program shall make available to youth receiving services the "Choose Your Therapist" Form and "Do You Feel Me" Form and develop internal processes and procedures for the incorporation of feedback received on the form in treatment planning, development and evaluation. This objective is only applicable to youth under 18 years of age, and for programs serving at least ten San Francisco youth in their programs.

Data Source:
Program Tracking Sheet and Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 8: Program and Service Innovation & Best Practice

C.8a. Applicable to: **Providers of Behavioral Health Services that provide Mental Health and Substance Abuse Services to Children, Youth, Families, Adults or Older Adults**

If applicable each program shall report to CBHS Administrative Staff on innovative and/or best practices being used by the program including available outcome data.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

1. FSA Full Circle Family Program (FCFP)/EPSDT
   1010 Gough Street
   San Francisco, CA 94109
   Telephone: (415) 474-7310 - Ext. 453
   Facsimile: (415) 673-2488

2. Nature of Document

   x New ☐ Renewal ☐ Modification

3. Goal Statement

   The program seeks to make outpatient mental health services more accessible to San Francisco residents by targeting EPSDT eligible residents who are not currently served by the San Francisco community mental health system.

4. Target Population

   The San Francisco Community Behavioral Health Services, Child, Youth and Family System of Care (SFCBHS CYF SOC) has identified specific gaps in the current system of care. There is an identified need for programs serving individuals less than 21 years of age who meet the criteria for medical necessity for specialty mental health services and who quality for EPSDT services (i.e. full-scope Medi-Cal coverage). This need is especially pronounced regarding the following target populations:

   - HSAS foster care children
   - Dually diagnosed, i.e., have both mental illness and substance abuse
   - Gay/Lesbian identified
   - Children and adolescents who have serious emotional problems but not currently at risk for out-of-home placement
   - Homeless children/youth
   - Specialized outpatient therapy groups open to clients from all parts of the City
   - Other underserved populations

   All San Francisco residents under the age of 21 who are eligible to receive the full scope of Medi-Cal service and meet medical necessity criteria for specialty mental health services, but who are not currently enrolled as clients in San Francisco County's outpatient mental health system, are eligible for EPSDT (full-scope Medi-Cal) services.

   Full Circle Family Program focuses on serving the above named target populations of greatest need. Participation requires that the identified client is age 4-21, an SF resident, has full-scope Medi-Cal insurance coverage and meets medical necessity for specialty mental health services. As regards the "other underserved populations," Full Circle Family Program has a focus on addressing the mental health needs of pregnant and parenting teens, further explained below.

   With this 09-10 contract, we will continue our project to serve adolescents who are either or both pregnant and parenting teens, through our collaboration with Teenage Pregnancy and Parenting Project (TAPP). Services will be provided in accordance with the contract deliverables delineated herein. Such services will address the needs of at-risk/high-risk adolescents as described below:

Teenage Pregnancy and Parenting Project (TAPP)

TAPP serves adolescents from all neighborhoods throughout the city. Although rates are declining, the U.S. still has the highest rates of teen pregnancy, birth, and abortion in the western industrialized world. The target population consists of pregnant and parenting adolescents (w/children) who have experienced a wide variety of mental health related problems including:

- Single Parent Households: A majority of these teens come from single parent households with low employment rates disproportionate to the larger San Francisco community; nearly all TAPP clients are economically disadvantaged.
- Dysfunctional Homes and Current/Past Abuse: Many come from homes with social, behavioral, and psychodynamic challenges Teen pregnancy is strongly linked to sexual abuse and such sexual abuse often occurs in conjunction with other problems in the family, including domestic violence, physical abuse and neglect and parental substance abuse
- School Drop-Out and/or Difficulty with Retention in School: A comparison of adolescent parents to those who delay childbearing (until the age of 20 or 21) found that adolescent parents are less likely to complete high school and more likely to end up on welfare.
- Children with Health Problems: Children of teen mothers are at increased risk of low birth weight and the attending health problems
- Children at Risk of Abuse and Neglect: Children of teen parents are twice as likely to be abused and neglected.
- Children not School Ready: Children born to teens enter kindergarten with lower levels of school readiness than children of mothers in their 20's. Girls born to teen mothers are more likely to become teen mothers themselves and sons of teen mothers are more likely to end up in jail.

Given the above, routine screening and interventions will be provided as appropriate.

5. Modality(ies)/Interventions

These include **B. Mental Health Billable Services:**

- Medication Support Services:
    - "Medication Support Services "means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluating of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

- Mental Health Services: Assessment, Collateral and Therapy
    - "Mental Health Services" means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provide as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive Service activities may include are not limited to assessment, plan development, therapy, rehabilitation and collateral.

- Assessment: "Assessment" means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.
- Collateral: "Collateral" means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.
- Therapy: "Therapy" means a service activity, which is a therapeutic intervention that focuses primarily on the symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries.

- Targeted Case Management
  - "Targeted Case Management" means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, other community services. The service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

- Crisis Intervention
  - Crisis intervention is an emergency service (unplanned). Crisis intervention is an immediate therapeutic response, which includes a face-to-face contact when an individual exhibits acute psychiatric symptoms to alleviate problems, which, if untreated, present an imminent threat to the individual or others.

- Indirect
  - These are mental outreach and promotion activities; they include the promotion of continuous staff development in evidence-based and best practices theory as the lens for which mental health treatment is to be provided. The objective of the methodology is:
    - MH Promotion: Providing education and/or consultation to clients and communities regarding mental health service programs in order to prevent the onset of mental health problems.
    - Community Client Contact: Assisting clients and families for whom there is no open case record to achieve a more adaptive level of functioning through single contact or occasional contact.
    - Human Service Staff Training: Enhancing or expanding the knowledge and skills of human service agency staff in meeting the needs of mental health clients.
    - Clinical Staff Development: Enhancing and/or expanding agencies' or organizations' knowledge and skills in the mental health field for the benefit of the community-at-large or special population groups.

6. Methodology

A. Outreach is conducted through consistent networking (e.g., regular Provider meetings) and site visits to various schools, community based organizations. Recruitment will also be conducted internally, within the Children, Youth and Family Division, for those participants who will be pregnant and parenting and/or adjudicated during this new contract year. Additionally, staff routinely utilizes health fairs and other such events for outreach, recruitment, and promotion and advertisement purposes.

B. Eligibility for FCFP program's admission, enrollment and/or intake criteria is predicated on whether the potential participant is age 4-21, an SF resident, and meets medical necessity for specialty mental health services. This contract serves only children with full-scope Medi-Cal.

The intake process is initiated when a parent, youth, family friend, or agency worker calls FCFP for a brief phone screening to determine eligibility. An intake session is scheduled within 24-48 hours to assess client presenting problems, needs, resources, priorities, and so forth, to determine disposition. The program will provide timely measurement of data at the site and reporting of data to CBHS as required and which may be changed periodically with prior notice from CBHS.

C. FCFP provides individual, group and family therapy, including play therapy, and sand tray therapy. During the 10-11 year, staff will be trained in Functional Family Therapy, and a focus on Family Systems assessment and interventions will begin to predominate. Case management and medication support services will be provided as well (e.g. targeted case management program, AB3632 Unit, Human Services Agency). Regular hours of operation are nine to five, Monday through Friday; services are provided at main clinic site, and local schools; home visits are conducted as needed. Services are additionally provided on-site and in the community, as warranted, outside of these hours, but generally between 8 am and 9 pm. Typical service protocol includes weekly family-based therapy including child therapy, regular parent meetings, collateral contacts and interventions and medication appointments as appropriate. Length of stay is dependent on client needs and progress towards meeting the plan of care goals. Service improvement efforts over this fiscal year will include staff training and implementation in evidence-based practices (ex. Functional Family Therapy) targeted toward adolescents with behavioral disorders.

D. Discharge criteria include client/family attainment of plan of care goals, mutual agreement to discontinue services, or lack of participation which precludes progress. Clinicians discuss discharge with the family as well as with the FCFP clinical supervisor as part of the treatment plan. If the case status is to change (i.e., step-down, transfer, referral, or closure) the clinician consults with the program director. The FCFP Provider will enter an appropriate code for "Reason for Discharge" in the BIS Insyst database when a client case is closed in the BIS Insyst.

NOTE: the FCFP Program Utilization Review Quality Committee (PURQC) reviews all cases at the 3-month and one year anniversary dates for status updates including continuance of services. At two years & beyond, the PURQC paperwork is reviewed by the FCFP PURQC Committee and then forwarded to the CYF Central PURQC Committee for authorization for continuous services.

E. Clinical services are provided by licensed and license-eligible registered MFT, MSW (and deemed equivalent or greater) clinicians on-site at 1010 Gough Street and at collaborating schools throughout the target area. Therapists collaborate closely with all various site staff, parents and teachers. Case Management may be provided by experienced BA in Psychology, Social Work (or related field) staff. In addition, a licensed staff Psychiatrist provides ongoing medication assessment and support.

7. Objectives and Measurements

A. PERFORMANCE/OUTCOME OBJECTIVES

OUTCOME 1: IMPROVE CLIENT SYMPTOMS

Objective A.1: Reduce Psychiatric Symptoms

A.1a. Applicable to: Providers of Behavioral Health Services who provide non-24 hour Mental Health Treatment Services to Children, Youth, Families, Adults and Older Adults except supported housing programs

The total number of acute inpatient hospital episodes used by clients in Fiscal Year 2010-11 will be reduced by at least 15% compared to the number of acute inpatient hospital episodes used by these same clients in Fiscal Year 2009-10. This is applicable only to clients opened to the program no later than July 1, 2010, and had no IMD or CTF episode during FY 2009-10. Data collected for July 2010 – June 2011 will be compared with the data collected in July 2009–June 2010.

Programs will be exempt from meeting this objective if more than 50% of the total number of inpatient episodes was used by 5% or less of the clients hospitalized.

Data Source:
CBHS Billing Information System - CBHS will compute.

A.1e. Applicable to: Providers of Behavioral Health Services who provide mental health treatment services to children, youth, families, adults and older adults except 24 hour programs

50% of clients who have been served for two months or more will have met or partially met their treatment goals at discharge.

Client Inclusion Criteria:
Clients discharged between July 1, 2010 and June 30, 2011 who have been served continuously for 2 months or more.

Data Source:
BIS Reason for Discharge Field.

Program Review Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

A.1f. Applicable to: All Providers of Behavioral Health Services who provide Outpatient Mental Health Treatment Services and Day treatment to Children, Youth and Families, including School-Mental Health Partnership Programs

Providers will ensure that all clinicians who provide mental health services are certified in the use of the Child & Adolescent Needs and Strengths (CANS). New employees will have completed the CANS training within 30 days of hire.

Data Source:
CANS Certificates of completion with a passing score.

Program Review Measurement:
Objective will be evaluated based on program submission of CANS training completion certificates for all new employees from July 1, 2010 to June 30, 2011

A.1g. Applicable to: Providers of Behavioral Health Services who provide Outpatient Mental Health Services and Day Treatment to children, youth, and families, including school-based programs

Clients with an open episode, for whom two or more contacts had been billed within the first 30 days, should have both the initial CANS assessment and treatment plans completed in the online record within 30 days of episode opening.

For the purpose of this program performance objective, an 85% completion rate will be considered a passing score.

Data Source:
CANS submitted to CANS database website, summarized by CYF System of Care

Program Review Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

A.1h. Applicable to: Providers of Behavioral Health Services who provide Outpatient Mental Health Services and Day Treatment to children, youth, and families, including school-based programs

CYF agency representatives attend regularly scheduled SuperUser calls.

For the purpose of this performance objective, an 80% attendance of all calls will be considered a passing score.

Date Source:
SuperUser calls attendance log, summarized by CYF System of Care.

Program Review Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

A.1i. Applicable to: **Providers of Behavioral Health Services that provide Outpatient Mental Health Services and Day Treatment to children, youth and families, including school-based programs**

Outpatient clients opened will have a Re-assessment/Outpatient Treatment Report in the online record within 30 days of the 6 month anniversary of their Episode Opening date and every 6 months thereafter.

Day Treatment clients have a Reassessment/Outpatient Treatment report in the online record within 30 days of the 3 month anniversary of their episode opening date, and every 3 months thereafter

For the purpose of this program performance objective, a 100% completion rate will be considered a passing score.

Data Source:
CANS data submitted to CANS website and summarized by CYF System of Care.

Program Review and Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

A.1j. Applicable to: **Providers of Behavioral Health Services that provide Outpatient Mental Health Services and Day Treatment to children, youth and families, including school-based programs.**

Outpatient clients opened will have an updated Treatment Plan in the online record within 30 days of the 6 month anniversary of their Episode Opening

Day Treatment clients have an updated Treatment Plan in the online record within 30 days of the 3 month anniversary and every 3 months thereafter.

For the purpose of this program performance objective, a 100% completion rate will be considered a passing score.

Data Source:
CANS data submitted to CANS website and summarized by CYF System of Care

Program Review and Measurement:
This objective will be evaluated based on data submitted between July 1, 2010 to June 30, 2011.

OUTCOME 2: Reduce Substance Use

n/a

OUTCOME 3: IMPROVE CLIENT FUNCTIONING

Objective A.3: Increase Stable Living Environment

A.3a. Applicable to: **Providers of Behavioral Health Services for Children, Youth, Families, Adult or Older Adult Mental Health Programs, except 24-hour programs**

35% of clients who 1) completed a discharge or annual CSI during this period; 2) have been open in the program for at least one year as of the date of this latest administration of CSI; and 3) were reported homeless at their immediately preceding completion of CSI will be reported in a stable living situation or an appropriate residential treatment facility at the latest CSI.

Data Source:
BIS Living Situation Codes.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2010.

B. OTHER MEASURABLE OBJECTIVES/PROCESS OBJECTIVES

Objective 1: Access to Services

n/a

Objective 2. Reliance on Institutions

n/a

Objective 3. Quality of Care

n/a

Objective 4. Collect Client Outcomes

n/a

Objective 5. Documentation/Authorization

n/a

Objective 6. Client Satisfaction

B.6b. Applicable to: **Providers of Behavioral Health Services who provide Children, Youth, Families, Adult or Older Adult Mental Health Treatment Services (excluding crisis services, suicide prevention and conservatorship)**

During Fiscal Year 2010-11, 100% of unduplicated clients who received a face-to-face billable service during the survey period will be given and encouraged to complete a Citywide Client Satisfaction Survey.

Data Source:
Program Tracking Sheet and Program Self Report

Program Review Measurement:
Objective will be evaluated based on the survey administration closest to the 12-month period from July 1, 2010 to June 30, 2011.

C. CONTINUOUS QUALITY IMPROVEMENT, PROGRAM PRODUCTIVITY AND SERVICE ACCESS

Objective 1. Program Productivity

C.1a. Applicable to: **All Providers of Behavioral Health Services who provide Substance Abuse Treatment and Prevention and Mental Health Services**

During Fiscal Year 2010-11, 2,549 outpatient units of service (UOS) will be provided consisting of treatment, prevention, or ancillary services as specified in the unit of service definition for each modality and as measured by BIS and documented by counselors' case notes and program records.

Date Source:
CBHS Billing Information System – DAS 800 DW Report or program records. For programs not entering data into BIS, CBHS will compute or collect documentation.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 2. Access to Services

n/a

Objective 3. Quality of Care

C.3a. Applicable to: **All providers of Behavioral Health Services who provide Outpatient , Day Treatment and Intensive Care Management Mental Health Services to Children, Youth and Families**

CYF providers will review quarterly CANS data provided by CBHS CYF-SOC with their CBHS program manager

Data Source:
Minutes of quarterly meetings kept by CYF providers, and submitted to CBHS by June 30 2011.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 4. Client Outcomes Data Collection

n/a

Objective 5. Integration Activities **

C.5a. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each program will complete a new self-assessment with the revise COMPASS every two (2) years (a new COMPASS must be completed every other fiscal year).

Data Source:
Program managers to review information sent to CBHSIntegration@sfdph.org via the shared folder to monitor compliance.

Program Review Measurement:
Objective will be evaluated based on a 12-month period from July 1, 2010 to June 30, 2011.

C.5b. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Using the results of the most recently completed COMPASS (which must be completed every 2 years), each program will identify at least one program process improvement activity to be implemented by the end of the fiscal year using an Action Plan format to document this activity. Copies of the program Action Plan will be sent via email to CBHSIntegration@sfdph.org.

Data Source:
Each program will complete the COMPASS self assessment process and submit a summary of the scores to CBHSIntegration@sfdph.org. The program manager for each program will review completed COMPASS during the month of January and submit a brief memorandum certifying that the COMPASS was completed.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5c. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each behavioral health partnership will identify, plan, and complete a minimum of six (6) hours of joint partnership activities during the fiscal year. Activities may include but are not limited to: meetings, training, case conferencing, program visits, staff sharing, or other integration activities in order to fulfill the goals of a successful partnership. Programs will submit the annual partnership plan via email to CBHSIntegration@sfdph.org.

Data Source:
Program self report such as activity attendance sheets with documentation of time spent on integration activities. The program manager will certify documentation of this plan.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5d. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

Each program will select and utilize at least one of the CBHS approved list of valid and reliable screening tools to identify co-occurring mental health and substance abuse problems as required by CBHS Integration Policy (Manual Number: 1.05-01).

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings to be held by December 2010 and March 2011 will be included in the program review.

C.5e. Applicable to: **All CBHS programs, including contract and civil service mental heath and substance abuse programs providing prevention, early intervention and treatment services**

During Fiscal Year 2010-11, each program will participate in one Primary Care partnership activity. The Primary Care Partner for this activity must be the DPH Oriented Primary Care Clinic located in closest proximity to the program, or most appropriate for the program population. Primary care program which cannot be Primary Care Partner for this purpose, include primary care program which are part of the same overall agency as the Behavioral Health Program. Optimal activities will be designed to promote cooperative planning and response to natural disaster or emergency events, neighborhood health fairs to increase joint referrals, or mutual open house events to promote cross-staff education and program awareness.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

C.5f. Applicable to: **All CBHS programs, including contract and civil service mental health and substance abuse programs providing prevention, early intervention and treatment service in Fiscal Year 2009-10.**

Providers will have all program service staff including physicians, counselors, social workers, and outreach workers each complete a self assessment of integration practices using the CODECAT. This self assessment must be updated every two years.

Data Source:
Program self report with submission of document of staff completion of CODECAT sent to CBHSIntegration@sfdph.org. The program manager will document this activity.

Objective 6. Cultural Competency

C.6a. Applicable to: **All Providers of Behavioral Health Services**

Working with their CBHS program managers, programs will develop three (3) mutually agreed upon opportunities for improvement under their 2008 Cultural Competency Reports and report out on the identified program-specific opportunities for improvement and progress toward these improvements by September 30, 2010. Reports should be sent to both program managers and the DPH/EEO.

Data Source:
Program managers will review progress utilizing the DPH Cultural Competency Report Evaluation Tool.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 7: Family/Youth/Consumer Driven Care

C.7a. Applicable to: **Providers of Behavioral Health Services that provide Mental Health to Children, Youth, and Families**

Each program shall make available to youth receiving services the "Choose Your Therapist" Form and "Do You Feel Me" Form and develop internal processes and procedures for the incorporation of feedback received on the form in treatment planning, development and evaluation. This objective is only applicable to youth under 18 years of age, and for programs serving at least ten San Francisco youth in their programs.

Data Source:
Program Tracking Sheet and Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

Objective 8: Program and Service Innovation & Best Practice

C.8a. Applicable to: **Providers of Behavioral Health Services that provide Mental Health and Substance Abuse Services to Children, Youth, Families, Adults or Older Adults**

If applicable each program shall report to CBHS Administrative Staff on innovative and/or best practices being used by the program including available outcome data.

Data Source:
Program Self Report.

Program Review Measurement:
Objective will be evaluated quarterly during the 12-month period from July 1, 2010 to June 30, 2011. Only the summaries from the two first quarterly meetings held by March 2011 will be included in the program review.

1. **Program Name: Early Childhood Mental Health**
   Program Address: 1010 Gough Street
   City, State, Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 931-3773

2. **Nature of Document**

   X New ☐ Renewal ☐ Modification

3. **Goal Statement**

The program goals are:

(1) To increase the emotional and social well-being of the young child
(2) Enhance childcare staff/family daycare providers training and efficacy in dealing with children and their parents.
(3) Assist in improving child care center practices to respond more effectively to children's developmental and mental health need
(4) Improve families' well-being and capability to deal with life problems thus improving the children's prognosis in overcoming behavioral and emotional problems.
(5) To provide early childhood mental health consultation in a Family Resource Center utilizing the principles of family support in addressing the multifaceted needs of families

4. **Target Population:**

Subsection (1) HAS/DCYFFunding Source:
Services will be provided to children 0-5 and their families in the eight sites listed below:

Site Name	Classrooms	Children Served	Staff Served	Hours Per Week	Consultant
Family Developmental Center	7.0	136.0	30.0	8.0	R.Johnson
Lee Woodward Counseling Center	1.0	5.0	3.0	4.0	C.McBride
McLaren Children's Center	1.0	25	7.0	3.0	R. Johnson
John Muir Preschool	1.0	12.0	2.0	4.0	C. McBride
Nihonmachi Little Friends – Bush St.	1.0	48.0	9.0	5.0	C. McBride
Nihonmachi Little Friends – Sutter St.	1.0	36.0	7.0	4.0	C.McBride
San Miguel Children's Center	4.0	96.0	25.0	6.0	C. McBride
YMCA Stonestown Preschool	2.0	35.0	5.0	4.0	C.McBride

Subsection (2) First Five Enhancements Funding Source:
Services will be provided to children 0-5 and their families in the two sites listed below:

Site Name	Classrooms	Children Served	Staff Served	Hours Per Week	Consultant
John McLaren Preschool For All	1.0	24	3.0	4.0	R. Johnson
SFUSD Redding Preschool For All	1.0	30	3.0	4.0	C. McBride

Subsection (3) First Five Youth Family Resource Center Funding Source:
Services will be provided to children 0-5 years old and their parents/caregivers as listed below:

Site Name	Classrooms	Children Served	Staff Served	Hours Per Week	Consultant
Young Family Resource Center – TAPP Program	1.0	TBA	TBA	4.0	R. Johnson

1. **Modality(ies)/Interventions**

All ECMHCI contractors are required to establish a Site Agreement (SA) with each respective site served (childcare, shelter, permanent supportive housing, family resource centers, etc., at the beginning of each fiscal or academic year, whichever is most appropriate. Each Site Agreement should include the following information:

- Site information to which the SA applies
- The term of the SA
- Number of on-site consultation hours per week
- Agreed upon services that the consultant will provide
- Agreed upon client/site roles and responsibilities
- Agreed upon day and time for regular group consultation meeting
- Schedule of planned review of SA document
- Signature lines for Consultant, Site Director/Manager, Contractor Program Director

Once the SA is completed and signed by all parties, a copy of the document will be sent to the ECMHCI Program Director, Rhea H. Bailey, at CBHS. The SA must be received by CBHS no later than November 15th of each year.

Standards of Practice (SOP) – The ECMH Program will establish Site Agreements (SA) with each respective site served at the beginning of each fiscal or academic year, whichever is most appropriate as mandated in the contract.
The Program Director will be responsible for implementing and monitoring compliance with the directives.

Modalities

- **Consultation – Individual:** Discussions with a staff member on an individual basis about a child or a group of children, including possible strategies for intervention. It can also include discussions with a staff member on an individual basis about mental health and child development in general.
- **Consultation -Group:** Talking/working with a group of three or more providers at the same time about their interactions with a particular child, group of children and/or families.
- **Consultation – Class/Child Observation:** Observing a child or group of children within a defined setting.
- **Training/Parent Support Group:** Providing structured, formal in-service training to a group of four or more individuals comprised of staff/teachers, parents, and/or family care providers on a specific topic. Can also include leading a parent support group or conducting a parent training class.
- **Direct Services – Individual:** Activities directed to a child, parent, or caregiver. Activities may include, but are not limited individual child interventions, collaterals with parents/caregivers, developmental assessment, referrals to other agencies. Can also include talking to a parent/caregiver about their child and any concerns they may have about their child's development.
- **Direct Services – Group:** Conducting therapeutic playgroups/play therapy/socialization groups involving at least three children.

Standards of Practice (SOP) –All ECMHCI contractors must incorporate the following standards of practice into each of their scopes of work:

NOTE: The standards of practice for consultation services that are detailed below are only applicable to early care and education, family child care, and shelter programs, and are NOT directly applicable to services provided to permanent supportive housing facilities and family resources centers.

Program Consultation

Center and/or classroom focused (including children's programming in shelter settings), benefits all children by addressing issues impacting the quality of care.

Frequency of Activities

Activity	Children's Programs w/in Shelters	Small Child Care Center 12-24 children	Medium Child Care Center 25-50 children	Large Child Care Center > 50 children
Program Observation	Initially upon entering the site and 2 to 3 times a year per classroom equaling 4 to 6 hours per year	Initially upon entering the site and 2 to 3 times a year per classroom equaling 4 to 6 hours per year	Initially upon entering the site and 2 to 4 times a year per classroom equaling 6 to 10 hours per year	Initially upon entering the site and 2 to 4 times a year per classroom equaling 10 to 20 hours per year
Meeting with Director	Monthly 1 hour per month	Monthly 1 hour per month	Monthly 1 to 2 hours per month	Monthly 2 to 3 hours per month
Meeting with Staff	Bi-monthly with all staff members (usually by classroom) 2 hours a month	Bi-monthly with all staff members (usually by classroom) 2 hours a month	Bi-monthly with all staff members (usually by classroom) 2 to 4 hours a month	Bi-monthly with all staff members (usually by classroom) 4 to 6 hours a month
Trainings	As needed and as stipulated in the MOU between the site and the service providing agency	As needed and as stipulated in the MOU between the site and the service providing agency	Same as small center	Same as small center

Case Consultation
Child focused, benefits an individual child by addressing developmental, behavioral, socio-emotional questions or concerns with teachers and/or staff.

Frequency of Activities

	Children's Programs w/in Shelters	Small Center 12-24 children	Medium Center 25-50 children	Large Center > 50 children
Activity				
Child Observation	2 to 4 times initially for each child and as needed. Recommended 4 to 10 hours per child per year.	2 to 4 times initially for each child and as needed. Recommended 4 to 10 hours per child per year.	Same as for small center	Same as for small center
Meeting with Director	Once per month per child who is the focus of case consultation.	Once per month per child who is the focus of case consultation.	Same as for small center	Same as for small center
Meeting with Staff	Once per month per child for duration of case consultation.	Once per month per child for duration of case consultation.	Same as for small center.	Same as for small center.
Meeting with Parents	3 to 5 times per child	3 to 5 times per child	Same as for small center.	Same as for small center.

- Direct treatment services occur within the child care center and/or shelter as allowed by the established MOU and are provided as needed to specific children and family members. All services to children are contingent upon written consent from parents or legal guardians.
- Provided by mental health consultants who are licensed or license-eligible.
- All direct treatment service providers, consultants, receive ongoing clinical supervision.

- Assessments for direct treatment service eligibility can include screenings for special needs, domestic violence in the family, possible referral for special education screenings, and alcohol or other substance use in the family.

- All direct treatment providers follow federal HIPPA regulations pertaining to the provisions of services and the maintenance of records.

In addition, to those listed above in the SOPs, please specify additional modality (ies) of service/interventions to be provided in the program. If applicable, define billable service unit(s) or deliverables.

- **Outreach and Linkage:** Providing activities related to program development, staff supervision, staff development/training and other administrative functions.

- **Evaluation Activities:** Providing activities related to conducting evaluation of Project or High Quality Child Care Mental Health Consultation initiative.

2. Methodology

Inherent within the ECMH Program are the core values of Family Service Agency of San Francisco. The services provided are welcoming family-oriented, strength-based, team implemented, culturally relevant, recovery oriented and advancing in the field. More specifically, the ECMH Program integrates delivery of consultation, training and , when pertinent, direct service into a seamless system of services that reflects CBHS mandates while remaining sensitive to community attitudes and with cultural values.

The service delivery is based upon the integration of a model of relationship focused consultation (Mental Health Consultation in Child Care, Kadija Johnston/Charles Brinamen) and one that focuses on promoting social-emotional development, providing support for children's appropriate behavior and preventing challenging behaviors (Teaching Pyramid). The services consist of 80% consultation and 20% direct services and are provided at the sites. Services are delivered as determined, agreed upon and scheduled in the Site Agreements.

The activities provided include the modalities of consultation, training, direct service, if pertinent, outreach, linkage and evaluation. Generally, the activities are as follows:

Consultation: Classroom management staff support around communication, psycho education, strategies for behavioral interventions with children, team meetings, classroom intervention

Class/Child Observation: Observation, assessment using ASQ, Desired Results

Training: Parent education, staff training re: psycho educational issues, implementation of the Teaching Pyramid

Direct Service: Conflict-resolution skill building, classroom interventions

Outreach, Linkage, Referral: Collaboration, linkages to resources

Services are conducted by licensed and/or license-eligible staff. All staff is required to read Mental Health Consultation in Childcare and be informed of the Teaching Pyramid model. The model for supervision focuses on reinforcing the concepts of consultation and its implementation at the Sites. Supervision occurs weekly, both individually and in group. Direct feedback and guidance is provided, interaction is encouraged and training is ongoing

3. **Objectives and Measurements**

A. Performance/Outcome Objectives

1. Understanding emotional and development needs
   A minimum of 75% of staff at each site receiving consultation services will report that meeting with a consultant increased their understanding of a child's emotional and developmental needs, helping them to more effectively respond to the child's behavior.

2. Communication with parents
   A minimum of 75% of staff at each site receiving consultation services will report that consultation helped them learn to communicate more effectively with parents of children where there were concerns about the child's behavior.

3. Response to children's behavior.
   A minimum of 75% of staff at each site receiving consultation services will report that the consultant helped them to respond more effectively to children's behavior.

4. Overall satisfaction
   Of those staff who received consultation and responded to the survey, a minimum of 75% will report that they are satisfied with the services they've received from the consultant.

5. Responsiveness to Needs
   Of those parents who themselves or their children received direct services from the early childhood mental health consultant, a minimum of 75% will report that the consultant was attentive and responsive to their needs.

6. Linkage to Resources
   Of those parents who themselves or their children received direct services from the early childhood mental health consultant, a minimum of 75% will report that consultant assisted them in linking to needed resources.

7. Understanding of Child's Behavior

Of those parents who themselves or their children received direct services from the early childhood mental health consultant, a minimum of 75% will report that they have a better understanding of their child's behavior.

8. (Improvement of Child's Behavior

Of those parents who themselves or their children received direct service from the early childhood mental health consultant, a minimum of 75% will report that their child's behavior has improved.

DATA SOURCE: Early Childhood Mental Health Consultation Initiative provider and parent surveys to be administered by CBHS during the third quarter of Fiscal Year 2010-2011 and will be used in the Program Monitoring Report for 2010-2011.

B. CBHS Compliance Objectives

D.4b. Applicable to: All Early Childhood Mental Health Consultation Initiative Contractors

Early Childhood Mental Health Consultation Initiative contractors shall comply with outcome data collection requirements.
Data source: Program Evaluation Unit Compliance Records and Charting Requirements for the Provision of Direct Services
Program Review Measurement: Objective will be evaluated based on 6-month period from July 1, 2010 to December 31, 2011.

C.6a. Applicable to: All Early Childhood Mental Health Consultation Initiative Contractors

Early Childhood Mental Health Consultation Initiative contractors shall comply with satisfaction data requirements.
Data source: Surveys distributed and submitted to CBHS.
Program Review Measurement: Objective will be evaluated based on 12-month period from July 1, 2010 to June 30, 2011.

C. CBHS Privacy Objectives

1. DPH Privacy Policy is integrated in the program's governing policies and procedures regarding patient privacy and confidentiality.
Required Documentation: Program has approved and implemented policies and procedures that abide by the rules outlined in the DPH Privacy Policy. Copies of these policies are available to patients/clients.

2. All staff who handles patients health information are trained and annually updated in the program's privacy policies and procedures.

Required Documentation: Program has written documentation that staff members have received appropriate training in patient privacy and confidentiality.

3. A Privacy Notice that meets the requirements of the FEDERAL Privacy Rule (HIPAA) written and provided to all patients/clients in their threshold language. If the document is not available in the patient's/client's relevant language, verbal transition is provided.

Required Documentation: Program has evidence in patients'/clients' charts or electronic files that they were "noticed" in their relevant language either in writing or verbally.
A summary of the Privacy Notice is posted and visible in registration and common areas of treatment facility.
Requirement Documentation: Program has the DPH Summary of Privacy Notice posted in the appropriate threshold languages in patient/client common areas.

4. Each disclosure of a patient's/client's health information for purposes other than treatment, payment or operations is documented.
   Required Documentation: Program has a HIPAA complaint log form that is used by all relevant staff.
5. Authorization for disclosure of patient's/client's health information is obtained prior to release to providers outside the DPH Safety Net, including early childhood mental health consultants.
   Requirement Documentation: Program has evidence that HIPAA-compliant "Authorization to Release Protected Health Information" forms are used.

Start-up and Process Objectives:

Entering a new site, consultation services to the Young Family Resource Center

1) A consideration of the site's philosophy, its organizational structure roles and relationships and staff perceptions will be maintained.
   The consultant will assume the consultative stance including mutuality of endeavor.

2) The needs of the site will be assessed.
   The consultant will develop a trusting relationship, wondering instead of knowing and create a context for site staff to identify areas of need.

3) The services provided will e in accordance with the Principles of Family Support as defined by Family Support America.
   The consultant will be knowledgeable and adhere to the principles of Family Support.

9. Continuous Quality Improvement

All CQI Sections should include the following HIPAA language verbatim; the language has not changed since FY05-06:

"With the implementation of HIPAA requirements, a DPH Privacy Policy was developed and contractors were trained during FY 03-04. Effective July 1, 2004, contractors were subject to audits to determine their compliance with the DPH Privacy Policy using the six compliance standards listed below. Audit findings and corrective actions (if any) identified in FY 04-05 (July 1, 2004 – June 30, 2005) will be considered informational, to establish a baseline for the following year. Beginning FY 05-06 (July 1, 2005 – June 30, 2006), findings of compliance or non-compliance and corrective actions (if any) will be integrated into the contractor's monitoring report. (The following items should be incorporated in the contract narrative.)

Item #1: DPH Privacy Policy is integrated in the program's governing policies and procedures regarding patient privacy and confidentiality.
As Measured by: Evidence that the policy and procedures that abides by the rules outlined in the DPH Privacy Policy have been adopted, approved and implemented.

Item #2: All staff who handle patient health information are trained (including new hires) and annually updated in the program's privacy/confidentiality policies and procedures.
As Measured by: Documentation exists showing individuals were trained.

Item #3: A Privacy Notice that meets the requirements of the Federal Privacy Rule (HIPAA) is written and provided to all patients/clients served in their threshold and other languages. If document is not available in the patient's/client's relevant language, verbal translation is provided.
As Measured by: Evidence in patient's/client's chart or electronic file that patient was "noticed." (Examples in English, Cantonese, Vietnamese, Tagalog, Spanish, and Russian will be provided.)

Item #4: A Summary of the above Privacy Notice is posted and visible in registration and common areas of treatment facility.
As Measured by: Presence and visibility of posting in said areas. (Examples in English, Cantonese, Vietnamese, Tagalog, Spanish, and Russian will be provided.)

Item #5: Each disclosure of a patient's/client's health information for purposes other than treatment, payment, or operations is documented.
As Measured by: Documentation exists.

Item #6: Authorization for disclosure of a patient's/client's health information is obtained prior to release (1) to providers outside the DPH Safety Net or (2) from a substance abuse program.
As Measured by: An authorization form that meets the requirements of the Federal Privacy Rule (HIPAA) is signed and in patient's/client's chart/file."

1. Program Name: FSA Teen Resourced to Achieve Positive Practices (T-RAPP)
   Program Address: 1010 Gough Street,San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 931-3773

2. Nature of Document

   x New ☐ Renewal ☐ Modification

3. School-Based Community Challenge Grant (CCG) Services

   During Fiscal Year 2010-2011, the Contractor's Teen Resources to Achieve Positive Practices (T-RAPP) program will support the Health Education Department at Balboa High Teen Health Center and at various designated San Francisco Unified School District (SFUSD) middle and high school sites utilizing of teen parent peer educators to provide health informational presentations and relate projects.

   Data Source:
   The Coordinator of the San Francisco Department of Health Services (SFDPH) Primary Care Youth Programs will work with the designated Contractor T-RAPP Program Manager to develop procedures for the implementation of the health education sessions and related activities on behalf of the SDDPH CCG program (known as the "Community Link Program"). The Contractor will provide classroom presentations, including question and answer periods, to approximately 250 students attending Balboa Teen Health Center and other designated SFUSD schools. The Coordinator of the San Francisco Department of Health Services (SFDPH) Primary Care Youth Programs will report out to staff at the end of the contract period regarding completion status for this objective.

   Designated Contact: Coordinator, SFDPH Primary Care Youth Programs.

1. **Program Name: MHSA Prevention and Recovery in Early Psychosis**
Program Address: 1010 Gough, San Francisco
City, State, and Zip Code: San Francisco, CA 94109
Telephone: (415) 474-7310
Facsimile: (415) 931-0972

2. **Nature of Document (check one)**

X New ☐ **Renewal** ☐ **Modification**

3. **Goal Statement**

Three of San Francisco's leading mental health organizations, FSA, UCSF and MHA collaborate with the goal of diagnosing psychosis early and intervening vigorously with the aim of stably remitting the disease and allowing the client to resume a happy, stable, and productive life.

4. **Target Population**

The target population for the PREP Program will be youth and young adults ages 12 - 26 who have had their first major psychotic episode within the previous two years or who, on the basis of the PREP diagnostic interview, are at high risk for having their first episode within two years. Based upon our past experience, we expect that the largest share of clients will be between the ages of 16 and 24.

PREP will operate citywide. Due to the nature of psychosis—which strikes without regard to income or socioeconomic status—we expect a distribution of cases that approximates the demographic distribution of youth and young adults in San Francisco, but with a somewhat greater proportion of low-income youth and families. The table below provides an estimate of ethnic distribution

White	30%	African American	20%	Asian	25%
Latino	20%	Native American	2%	Multiracial	3%

5. **Modality(ies)/Interventions**

PREP will continue to provide a comprehensive, systemic approach to this problem. The PREP Program will provide the best in evidence-based treatment and support for youth and families. Although each intervention has been research tested in one or more locations, this will be the first center in the United States where this treatment array has been offered as an integrated package. We believe that by intervening early with a comprehensive treatment package, we can make dramatic progress in remitting or preventing the disease. Core services will include:

Algorithm based medication management. For the first phase of this project, Dr. Demian Rose, our Medical Director, has adapted the Texas Medication Algorithm to focus specifically on medication for young adults in the early stages of psychosis.

Cognitive Rehabilitation: PREP Team member, Dr. Sophia Vinogradov, working with nationally renowned brain plasticity researcher, Dr. Michael Merzenich, has developed a computer-based cognitive rehabilitation program specifically designed to address the cognitive deficits engendered by psychosis. Evidence-based individual therapy, as appropriate, based on Cognitive Behavioral therapy (CBT) for early psychosis which teaches techniques for specific symptom clusters (positive symptoms, negative symptoms, depression, skills for emotion regulation, etc).

Multifamily groups: We will provide all groups for the families of young adults suffering from psychosis, even when the primary client chooses not to participate in treatment.

Strength-based care management: Intensive care management will ensure that the broad spectrum of clients and family needs are addressed.

Neuropsychiatric and other advanced diagnostic services will be available as needed at 30% time.

6. Methodology.

A. Program's outreach, recruitment, promotion, and advertisement.

Under the lead of the Mental Health Association, PREP will outreach across all of SF's diverse communities to provide outreach and education on the PREP program, behavioral health, stigma, wellness, and signs of early psychosis. The goal of outreach will be to create awareness, reduce stigma, and recognize signs of early psychosis and to educate about the PREP program. Extensive outreach will continue to be conducted across San Francisco in settings where youth and their families typically spend time (e.g., neighborhood centers, schools, churches, after-school organized sports activities, libraries and shopping centers). Outreach methods will also include social media venues such as Twitter, Facebook, YouTube, Google Video and other online methods. Special efforts will be taken to engage and reach out to traditionally underserved population groups through our partnerships with Sojourner Truth and Larkin Street – reaching out to those who would not typically receive or who would experience a delay in services due to such factors as limited access, stigma, poverty, and cultural and linguistic barriers.

Individuals receive a telephone screening. Those who are clearly not appropriate for, or in need of, early psychosis services will be assisted to locate needed services. Those who are appropriate for assessment will receive an appointment within seven working days of first contact. PREP will provide a comprehensive diagnostic assessment for each youth referred. The diagnostic approach will be based upon the SIPS (Structured Interview for Prodromal Symptoms) and the Structured Interview for DSM-IV (SCID) but will be extended by a strength-based care management assessment, and will assess for such frequent collateral issues as depression, trauma, substance abuse, and affective dysregulation. The assessment will be provided at whatever location is most convenient and comfortable for the youth and family to encourage service engagement.

B. Program's service delivery model.

Care Management and Treatment: The PREP Program will provide the best in evidence-based treatment and support for youth and families. We have carefully designed this treatment array and selected the particular treatments because each has a strong evidence base for promoting positive outcomes for people suffering from early psychosis. Collectively, they address the spectrum of impacts caused by psychosis. Core services will include:

Algorithm-Based Medication Management.

Cognitive Rehabilitation:

Evidence-Based Individual Therapy,

Multifamily Groups

Strength-Based Care Management:

Neuropsychological Assessments

Each client is served based on their individual need and willingness to participate, however the Multifamily group is a one-year commitment. The other services will be provided at whatever location is most convenient and comfortable for the youth and family to encourage service engagement. The length of stay is based on outcome data that is shared continuously with the client and their families, with a maximum of up two years for prodromal clients/families and up to two years for recent-onset clients /families.

C. Program's exit criteria and process.

PREP clients include the primary client and their families – and there are different exit criteria based on the service modalities employed in the treatment. When families are involved in the multi-family group therapy, there is a pre-agreement that the families stay in treatment for a full year and the primary client is assessed on-going during and after care at the end of the group's duration. These groups are closed, meaning that family's travel together through the course of treatment, thus educating one another on lessons learned in the process. Not all PREP clients participate in the multi-family group therapy – therefore other services provided are offered intensively, often weekly with client centered treatment plans which are reviewed during the course of treatment and measured against an array of baseline measure taken during the assessment using the SIPS (Structured Interview for Prodromal Symptoms) or QSANS and QSAPS. Treatment ideally aims to integrate clients to a functioning status, either working or in school, and transitions from the program to other forms of care, or back to the community – complete with a contingency plan. All discharge planning will be collaborated upon between FSA staff and clients together with their families' total participation whenever possible. Discharge is often determined by intervention outcomes – which are assessed from a client, family can clinician perspective using established measures that are currently being used to evaluate the impact of early psychosis and other services at FSA.

D. Program's staffing.

Felton Institute Director: PREP sits under the Felton Institute at FSA. Felton Institute Director is also adjunct faculty for the UCSF CARTA Project.

Medical Director and Psychiatrist: Will serve as 25% time Medical Director and psychiatrist on the PREP Project.

UCSF Site CBT Trainer: Will be responsible for CBT Supervision and overall operations assessment aspects of this project.

Mental Health Association of San Francisco. Will guide and over see the community outreach portion of this proposal.

Clinical Director of PREP at FSA will be the overall Project Coordinator, Program Director and Clinical supervisor at FSA

Full-time Therapist at FSA, will run MFGT and provide care management when needed

Half-time Therapist at FSA, will run MFGT and provide care management when needed

Medication support at FSA under the supervision of the medical director.

Outreach Worker at Larkin Street; Liaison for PREP-Larkin Street Clients

Part Time Therapist at Sojourner Truth and care manager, especially for kids coming from the Foster Care system; will run MFG

Neuro-psychologist on contract as needed.

A Employment/Education Specialist - half time to support clients returning to work and school and a full time bi-lingual (Cantonese or Spanish) Therapist/Care Manager who will also be able to run groups, will be hired.

7. Objectives and Measurements

FSA will comply with all applicable DPH Standardized Appendix a, fiscal year 2010 – 2011 Performance Objective, including the following:

Objective 1: Provide 2,000 hours of treatment services annually.

- Staffing: Staff from FSA, Sojourner Truth and Larkin Street will be involved in delivering treatment services.
- Data collection tools: At all agencies, service hours are entered directly into the electronic record system (CIRCE) by service providers.
- Data: Service provision data is recorded in terms of hours of type of service provided.
- Frequency: Data collection will ongoing. Data will be summarized and discussed monthly.
- Data reporting: data is pulled from CIRCE and reviewed by the Executive committee monthly, reported to CBHS annually.

Objective 2: Consumers will show clinically and statistically meaningful reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services from baseline to 12 months, as measured from consumer and clinician perspectives using standardized measures.

- Staffing: Clinicians and consumers will provide outcome ratings. PREP support staff will insure that outcome ratings are completed on schedule.
- Data collection tools: Clinicians will rate consumers' symptoms, functioning and engagement in services using several standardized measures:

  1. Quick Scale for the Assessment of Negative Symptoms (QSANS)--

     Negative symptoms of psychosis

  2. Quick Scale for the Assessment of Positive Symptoms (QSAPS)--

     Negative symptoms of psychosis

  3. Global Functioning Scale: Role--

     Overall role functioning

  4. Global Functioning Scale: Social--

     Overall social functioning

  5. Working Alliance Inventory (WAI)--

     Quality of consumer-clinician working relationship from clinician's perspective

Objective 3: Consumers will rate their own quality of life, symptoms, engagement in and satisfaction with services using several standardized measures:

a) WHOQOL-Bref-- Quality of Life

b) Patient Health Questionnaire Depression Scale (PHQ9)--Depression symptoms

c) Patient Health Questionnaire Anxiety Scale-- Anxiety symptoms

d) Working Alliance Inventory (WAI)--Quality of consumer-clinician working relationship from consumer's perspective

- Data: All of the above measures provide quantitative scores at the item and scale level.
- Frequency: Outcome data will be collected quarterly, regardless of consumer's participation in services.
- Data reporting: PREP support staff will receive completed outcome evaluations and enter them into an electronic database. The evaluator, will compile and analyze the data. Results will be

presented to the Research and Evaluation Committee, and the PREP executive Committee to guide service planning and delivery.

Objective 4: Participants in Multifamily Groups will achieve practically and statistically meaningful reductions in familial criticism and improvements in family functioning, as well as increases in knowledge about psychosis from baseline to 12 months, as measured by established self-report and clinician interview measures.

- Staffing: Consumer and family participants in the multifamily groups will provide self-report ratings using standardized measures, as described below. Clinicians leading the multifamily groups, with the assistance of PREP support staff, will insure that ratings are completed on schedule.

- Data collection tools:

  1. The self-report Knowledge about Schizophrenia Questionnaire (KASQ) will be used to assess consumer and family member knowledge about psychosis and schizophrenia.

  2. The interview-based Structured Assessment of Insight (SAI-E) will be used to assess consumers' social problem solving skills and the self-report Expressed Emotion scale will be used to assess familial warmth and criticism from the consumer perspective.

  3. The self-report Family Questionnaire and Caregivers Experience Scale will be used to assess caregiver burden from the family member perspective. Family members will also complete the Expressed Emotion scale to assess their levels of warmth and criticism towards the consumer.

- Data: All of the above measures provide quantitative scores at the item and scale level.

- Frequency: Data collection is linked to the structure of the Multifamily Group treatment. Knowledge about psychosis is assessed prior to the start of the treatment and at the conclusion of the 12 month treatment. All other outcomes are measured at the start of treatment and 6 and 12 months later.

- Data reporting: PREP support staff will receive completed outcome evaluations and enter them into an electronic database. The evaluator, will compile and analyze the data. Results will be presented to the Research and Evaluation Committee and the PREP executive committee to guide service planning and delivery.

Other Objectives and Measurements

Training Objectives for Early Psychosis

Objective 1. Trainees will show statistically and practically significant increases in core clinical and scientific knowledge about early psychosis from baseline to the end of training, and on each individual training module, as measured by a standardized multiple choice knowledge test.

- Staff: UCSF and select staff from partner agencies and outside trainers will provide the training. Program assistant will administer and collect the knowledge surveys from trainees anonymously. All PREP staff at FSA, Sojourner Truth, Larkin Street and MHA who provides direct or indirect services will complete the training.

- Data Collection Tools: A multiple choice knowledge test is used to assess trainee knowledge. Data is collected and entered by the program assistants or by trainees as they complete the web-based version.
- Data: Performance is calculated as total number and percentage of questions correct. Data is analyzed by the evaluator and staff on the Research & Evaluation Committee.
- Frequency: Data is collected pre- and post- training for each trainee. Data is analyzed after each round of training.
- Data Reporting: Data is reported to the PREP Research, Training and Executive committees after each round of training, and to CBHS annually.

Objective 2. Trainees will show high levels of satisfaction with Early Psychosis training on the Satisfaction Survey.

- Staff: All trainees will complete Satisfaction surveys.
- Data Collection Tools: A standardized satisfaction survey is administered as a paper-and-pencil measure or a web-based survey at the end of each training module.
- Data: Satisfaction is rated on a scale of 1 to 5. Data is collected and entered by the program assistant or by trainees as they complete the web-based version. Data is analyzed by Dr. Shumway and staff on the Research & Evaluation Committee.
- Frequency: Data is collected following each training session and analyzed immediately so that multi-session trainings can be optimized during delivery.
- Data Reporting: Data is reported to the PREP Research, Training and Executive committees after each round of training, and to CBHS annually.

Objective 3. Trainees will demonstrate increased knowledge of the principles of cognitive-behavioral therapy for early psychosis (CBTp) as assessed by a standardized survey of knowledge and confidence administered following training and will demonstrate clinical competence in cognitive-behavioral therapy for early psychosis (CBTp) by demonstrating appropriate use of CBT techniques by 6 months as assessed by a standardized rating of competence completed by the supervisor.

- Staff: UCSF and FSA staff will provide the CBT training. All PREP staff that provides CBTp will complete the training. Trainees complete the knowledge and confidence survey and CBTp supervisor completes the supervisor ratings based on evaluation of videotapes of 25% of clinician's sessions.
- Data Collection Tools: The knowledge and confidence survey and the supervisor ratings are standardized paper-and-pencil measures.
- Data: Program assistant will enter checklist data. Data is analyzed by Dr. Shumway and staff on the Research & Evaluation Committee.

- Frequency: Trainees will submit at least 1 recorded client session to the supervisor for evaluation every four weeks for the first 6 months. Data is analyzed quarterly.

- Data Reporting: Data is reported to the PREP Research, Training and Executive committees after each round of analysis and to CBHS annually.

Objective 4. Trainees will demonstrate increased knowledge of evidence-based medication management medication management for early psychosis as measured by a multiple choice knowledge test and will demonstrate clinical competence by demonstrating adherence to the evidence-based PREP Antipsychotic Medication Algorithm, assessed by review of client records by the supervisor.

- Staff: The PREP medical Director will provide the medication management training. All PREP staff that provides medication services will complete the training and complete the self-report knowledge test. Medical Director assesses algorithm adherence.

- Data Collection Tools: The knowledge test is a self-report multiple-choice survey. Trainees enter information about algorithm use in chart notes.

- Data: The knowledge test is completed before and after training and is entered by a program assistant. Data on algorithm adherence is recorded by the Medical Director upon review of chart notes, and is entered by the program assistant. Data is analyzed by Dr. Shumway and staff on the Research & Evaluation Committee.

- Frequency: Knowledge test data are analyzed following training. Algorithm adherence is assessed by the Medical Director at least quarterly and data is analyzed quarterly.

- Data Reporting: Data is reported to the PREP Research, Training and Executive committees after each round of analysis and to CBHS annually.

Objective 5. Trainees will demonstrate clinical competence in diagnostic assessment of psychosis and risk for psychosis by achieving at least .80 agreements with expert raters on standardized interview measures.

- Staff: UCSF and FSA staff will provide the training and supervision of diagnostic assessment. All clinicians conducting diagnostic assessments will complete the training. The Assessment supervisor collects clinician symptom ratings and diagnoses. Program assistant will enter rating data.

- Data Collection Tools: Trainees provide symptom ratings and diagnoses on the interview measure at the end of each interview.

- Data: Inter-rater reliability is measured as agreement with expert ratings (intra-class correlation). Data is analyzed by the evaluator and staff on the Research & Evaluation Committee.

- Frequency: Data is collected and analyzed at the end of each training round.

- Data Reporting: Data is reported to the PREP Research, Training and Executive committees after each round of analysis and to CBHS annually.

Objective 6. Trainees will demonstrate clinical competence in multifamily group (MFG) therapy for early psychosis by demonstrating adherence to the MFG model as assessed by the PIER Program in monthly phone supervision.

- Staff: PIER program staff provides the training. All clinicians serving as co-leaders in MFG will attend the training. Supervisor checklists are completed by PIER staff and shared with the PREP research committee.
- Data Collection Tools: Supervisor checklists for MFG are rated based on videotaped sessions and monthly phone supervision.
- Data: Adherence to MFG model is rated as number of intervention elements conducted appropriately per session. Data is analyzed by the evaluator and staff on the Research & Evaluation Committee.
- Frequency: Supervisor checklists are completed monthly shared with PREP and analyzed quarterly.
- Data Reporting: Data is reported to the PREP Research, Training and Executive committees after each round of analysis and to CBHS annually.

Outreach Objectives

Objective 1: Provide 2,000 hours of outreach and education services about early psychosis to a diverse array of stakeholders, including health and mental health care providers, schools, community organizations and at-risk youth.

- Staffing: Staff from all PREP partners will be involved in conducting outreach and will keep detailed records of outreach activities. The evaluator, Dr. Shumway, will monitor data collection.
- Data collection tools: All partners will use standardized outreach activity logs to record outreach activities to individuals and groups. When possible, for example in large group presentations, we will collect data from individuals using paper-and-pencil surveys.
- Data: Outreach activity logs will enumerate of type and length of contacts as well as the number and type of stakeholders involved. Paper-and-pencil surveys be based on surveys used successfully in FSA Felton Institute trainings and will be tailored to the presentation context to measure participant demographics, knowledge gained, and satisfaction with the presentation, as appropriate to the target population. Logs of calls to the PREP referral line will include information on caller zip code, race/ethnicity of individuals referred for service, and information on referral source and route.
- Frequency: Data collection will ongoing in the context of outreach activities. Data will be summarized and discussed [quarterly].
- Data reporting: The evaluator, Dr. Shumway, will compile and analyze the data. Results will be presented to the PREP Outreach Committee to guide implementation and planning of outreach activities.

Objective 2: Revise and distribute printed informational materials targeted to varied stakeholder groups, including at-risk youth, community members and service providers.

- Staffing: PREP staff will develop a series of new materials. All PREP partners will be involved in distributing materials and will keep records of distribution using standardized logs, led by the Mental Health Association of San Francisco. The evaluator, Dr. Shumway, will monitor data collection.
- Data collection tools: All partners will use standardized logs to record distribution of printed materials.
- Data: Printed material distribution logs will enumerate the date of distribution, the number of copies distributed and the target populations(s) to whom materials were distributed.
- Frequency: Data collection will be ongoing in the context of outreach activities. Data will be summarized and discussed [quarterly].
- Data reporting: The evaluator, will compile and analyze the data. Results will be presented to the PREP Outreach Committee to guide development and distribution of printed materials.

Objective 3: Increase community awareness of early psychosis and its treatment through a public education campaign using the PREP web site, social media, and traditional media outlets.

- Staffing: Staff from [x] and [y] will be involved in delivering aspects of the public education campaign. Automated monitoring is in place for web-based aspects of the campaign. Partner agencies will keep standardized logs of traditional media outreach efforts. The evaluator, will monitor data collection.
- Data collection tools: Detailed monitoring of activity on the PREP web-site (www.prepwellness.org) is conducted using the Google Analytics software. Automated tools are also in place to monitor social media activity on Facebook, Twitter and YouTube. Partners will use standardized logs to record traditional media outreach efforts.
- Data: Data on traffic on the PREP website will include numbers of total visitors, unique visitors, new visitors, hits per page, hits per content area, bounce rates by page and content area. Data on activity on the PREP Facebook page will include 150 + numbers of posts.]. Data on Twitter activity will include 100 + numbers of tweets, [retweets] and followers. Data on videos posted on YouTube will include information pertinent to magnetizing youth with early psychosis concerns.
- Frequency: Data collection will be ongoing. Data will be aggregated by the week or month to examine change over time and response to particular outreach efforts and summarized and discussed quarterly.
- Data reporting: The evaluator, will compile and analyze the data. Results will be presented to the PREP Outreach Committee to guide implementation and planning of the public education campaign.

8. Continuous Quality Improvement

FSA will collaborate with CBHS and MHSA staff to develop and implement an evaluation plan. FSA will assign staff to participate in collaborative program development, planning and training efforts as requested by CHS or MHSA. Any evaluation components will be designed to be used for continuous quality improvement. Frequent, regular analysis and review of data collected from both trainees and supervisors will be used to insure and improve the quality and effectiveness of training activities.
FSA will collect and report quarterly on the number of individuals served through funded activities.
HIPAA Compliance: FSA will integrate DPH Privacy Policy in its governing policies and procedures regarding patient privacy and confidentiality. The Executive Director will ensure that the applicable policy and procedures as outlines in the DPH Privacy Policy have been adopted, approved and implemented.
Electronic Record keeping and Data Collection Requirements: FSA will provide evidence of sufficient computing resources for staff to support direct real time data entry and documentation in current billing and interim clinical applications and in the new Billing Information System (BIS) that provide for work flow management, data collecting and documentation.

1. **Program Name: MHSA Felton Institute Trainings in Older Adult Behavioral Health Screening**
   Program Address: 1010 Gough, San Francisco
   City, State, and Zip Code: San Francisco, CA 94109
   Telephone: (415) 474-7310
   Facsimile: (415) 931-0972

2. **Nature of Document** (check one)

   x New ☐ Renewal ☐ Modification

3. **Goal Statement**

   The Older Adult Screening training in Partnership with the Over 60 Project (Dr. Patricia Areán) and the Felton Institute will provide training for case workers and interns who serve older adults in the Project Impact model, addressing issues of depression, substance abuse, generalized anxiety, and social isolation. The training will provide an overview of the collaborative care team, medication management, Behavioral Activation, stepped care management, Problem Solving Therapy, and SBIRT.

4. **Target Population**

   Our target training population for the Older Adult training is a cadre of dedicated and enthusiastic clinical staff at IOA for the Project Impact model, within the care provider community. The target population for the Older Adult Behavioral Health Screening and Response are all clinicians and interns who work with the older adult population in San Francisco primary care clinics.

5. **Modality(ies)/Interventions**

   For the Older Adult Behavioral Health Screening and Response Project the training elements are:
   1. A one-hour introductory training for staff of clinics and senior centers, to introduce the IMPACT model and discuss what staff might expect from its implementation in their site.
   2. All care managers and interns will receive a three-day course in Collaborative Care, including training in use of the PHQ-9, GAD-7, CAGE, and PIRS, suicide risk assessment, working with a collaborative care team, medication management, Behavioral Activation, SBIRT, PST and stepped care management. Drs. Arean, Satterfield and Unutzer, experts in the IMPACT model, will lead the workshop.
   3. All permanent care managers and selected interns will be trained in Problem Solving Therapy, an EBP that is particularly appropriate for brief depression-focused therapy with Seniors, and Screening, Brief Intervention and Referral to Treatment for substance abuse (SBIRT), a substance abuse model that was designed for primary care medicine and ineffective in the treatment and prevention of substance abuse /dependence in older adults .

6. **Methodology**

Each module will include the following four assessments:
1. Prior experience survey. Prior to the start of each training module, trainees will complete a brief survey about

their prior experience with the module's content area. This information will allow trainers to tailor their presentations to match trainees' existing knowledge and expertise.

2. Ongoing evaluation. During each module, trainees will be anonymously surveyed about how the training is going, whether specific topics should be covered in more or less detail, and whether review of previously presented topics would be useful.
3. Knowledge and competency assessment. At the end of each module, trainees will complete a knowledge and competency assessment. Trainees who demonstrate mastery of less than 80% of the content will meet individually with the trainer to discuss problematic areas and will complete the assessment again.
4. Module evaluation. At the end of each module, trainees will complete an anonymous evaluation of the training provided in the module.

Trainee checklist. As part of ongoing supervision, trainees will complete a structured checklist for selected clients, indicating the extent to which they used and understood specific intervention components.

Supervisors checklist. As part of ongoing supervision, supervisors will rate trainees performance with selected clients, indicating the extent to which trainees used and understood specific intervention components.

Supervision survey. Trainees will complete monthly anonymous surveys of supervision content and quality so that supervision can be modified to meet trainees' changing needs.

Data collection is on going, with evaluations completed at the end of each module. Trainees enter data directly using web-based survey tools, making data readily available for immediate analysis.

Felton Institute's staff of 2.7 FTE and contracted faculty come from a variety of backgrounds and with a variety of training experiences, including federally funded research, graduate medical education, program administration, community and university clinics, family practice centers, and substance abuse treatment centers. Together, they have decades of experience living and working in the diverse landscape of San Francisco
Melissa Moore, Ph.D. – Felton Institute Director: Dr. Moore will oversee the content and collaborations of these trainings with faculty and University partners
Teri Hedman, BA – Felton Institute Research and Program Manager: Ms. Hedman will coordinate the details and logistics of all FI trainings
Stephan Georgiou, Felton Institute Program Coordinator: Mr. Georgiou began as an intern and was recently hired to assist in program coordinator.

Web-based survey tools will be used to collect structured evaluation and quality improvement data. All evaluation and assessment tools will be based on tools that have been used successfully in prior Felton Institute training activities. An online discussion board will be available so that trainees can ask questions and exchange information with the trainers and each other between sessions.

7. Performance/Outcome Objectives

FSA will comply with all applicable DPH Standardized Appendix a, fiscal year 2010-11 Performance Objective, including the following:

Training Outcomes for the Older Adult Behavioral Health Screening and Response Project are:

1. All clinic and center staff will become familiar with the basics of the model, its rationale, and the benefit for their clients, and their role in the program's implementation.
2. Care managers/interns will become proficient in providing the elements of the IMPACT model.
3. All permanent care managers and a selection of interns will become certified providers in the practice of Problem Solving Therapy and SBIRT.

In the end, by completion of the Trainings, all care workers and interns who have completed the curriculum and returned to their workplace under the coaching component of this training project will demonstrate competency in the various training elements as measured by CQI client and supervisor evaluations. The certification process in PST and SBIRT ensures that the care managers are providing these services to and above standard expectations.

8. Continuous Quality Improvement

Describe your program's CQI activities to enhance, improve and monitor the quality of services delivered. The CQI section must include a guarantee of compliance with Health Commission, Local, State, Federal and/or Funding Source policies and requirements such as Harm Reduction, Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, and Client Satisfaction.

FSA will collaborate with CBHS and MHSA staff to develop and implement an evaluation plan. FSA will assign staff to participate in collaborative program development, planning and training efforts as requested by CHS or MHSA.

All of the evaluation components described above are designed to be used for continuous quality improvement. Frequent, regular analysis and review of data collected from both trainees and supervisors will be used to insure and improve the quality and effectiveness of training activities.

FSA will collect and report quarterly on the number of individuals served through funded activities.

HIPAA Compliance: FSA will integrate DPH Privacy Policy in its governing policies and procedures regarding patient privacy and confidentiality. The Executive Director will ensure that the applicable policy and procedures as outlines in the DPH Privacy Policy have been adopted, approved and implemented.

Electronic Record keeping and Data Collection Requirements: FSA will provide evidence of sufficient computing resources for staff to support direct real time data entry and documentation in current billing and interim clinical applications and in the new Billing Information System (BIS) that provide for work flow management, data collecting and documentation.

Appendix B
Calculation of Charges

1. **Method of Payment**

A. Invoices furnished by CONTRACTOR under this Agreement must be in a form acceptable to the Contract Administrator and the CONTROLLER and must include the Contract Progress Payment Authorization number or Contract Purchase Number. All amounts paid by CITY to CONTRACTOR shall be subject to audit by CITY. The CITY shall make monthly payments as described below. Such payments shall not exceed those amounts stated in and shall be in accordance with the provisions of Section 5, COMPENSATION, of this Agreement.

Compensation for all SERVICES provided by CONTRACTOR shall be paid in the following manner. For the purposes of this Section, "General Fund" shall mean all those funds which are not Work Order or Grant funds. "General Fund Appendices" shall mean all those appendices which include General Fund monies.

(1) Fee For Service (Monthly Reimbursement by Certified Units at Budgeted Unit Rates)

CONTRACTOR shall submit monthly invoices in the format attached, Appendix F, and in a form acceptable to the Contract Administrator, by the fifteenth (15th) calendar day of each month, based upon the number of units of service that were delivered in the preceding month. All deliverables associated with the SERVICES defined in Appendix A times the unit rate as shown in the appendices cited in this paragraph shall be reported on the invoice(s) each month. All charges incurred under this Agreement shall be due and payable only after SERVICES have been rendered and in no case in advance of such SERVICES.

(2) Cost Reimbursement (Monthly Reimbursement for Actual Expenditures within Budget):

CONTRACTOR shall submit monthly invoices in the format attached, Appendix F, and in a form acceptable to the Contract Administrator, by the fifteenth (15th) calendar day of each month for reimbursement of the actual costs for SERVICES of the preceding month. All costs associated with the SERVICES shall be reported on the invoice each month. All costs incurred under this Agreement shall be due and payable only after SERVICES have been rendered and in no case in advance of such SERVICES.

B. Final Closing Invoice

(1) Fee For Service Reimbursement:

A final closing invoice, clearly marked "FINAL," shall be submitted no later than forty-five (45) calendar days following the closing date of each fiscal year of the Agreement, and shall include only those SERVICES rendered during the referenced period of performance. If SERVICES are not invoiced during this period, all unexpended funding set aside for this Agreement will revert to CITY. CITY'S final reimbursement to the CONTRACTOR at the close of the Agreement period shall be adjusted to conform to actual units certified multiplied by the unit rates identified in Appendix B attached hereto, and shall not exceed the total amount authorized and certified for this Agreement.

(2) Cost Reimbursement:

A final closing invoice, clearly marked "FINAL," shall be submitted no later than forty-five (45) calendar days following the closing date of each fiscal year of the Agreement, and shall include only those costs incurred during the referenced period of performance. If costs are not invoiced during this period, all unexpended funding set aside for this Agreement will revert to CITY.

C. Payment shall be made by the CITY to CONTRACTOR at the address specified in the section entitled "Notices to Parties."

D. Upon **the effective date** of this Agreement, contingent upon prior approval by the CITY'S Department of Public Health **of an invoice or claim submitted by Contractor, and** of each year's revised Appendix A (Description of Services) and each year's revised Appendix B (Program Budget and Cost Reporting Data Collection Form), and within each fiscal year, the CITY agrees to make an initial payment to CONTRACTOR not to exceed twenty-five per cent (25%) of the General Fund portion of the CONTRACTOR'S allocation for the applicable fiscal year.

CONTRACTOR agrees that within that fiscal year, this initial payment shall be recovered by the CITY through a reduction to monthly payments to CONTRACTOR during the period of October 1 through March 31 of the applicable fiscal year, unless and until CONTRACTOR chooses to return to the CITY all or part of the initial payment for that fiscal year. The amount of the initial payment recovered each month shall be calculated by dividing the total initial payment for the fiscal year by the total number of months for recovery. Any termination of this Agreement, whether for cause or for convenience, will result in the total outstanding amount of the initial payment for that fiscal year being due and payable to the CITY within thirty (30) calendar days following written notice of termination from the CITY.

2. Program Budgets and Final Invoice

A. Program Budgets are listed below and are attached hereto.

Budget Summary
CRDC B1 – B11

Appendix B-1	Older Adult IFSO
Appendix B-2	Older Adult Peer-Based Wellness And Recovery Center
Appendix B-3a	Community After Care Program
Appendix B-3b	Adult Care Management (ACM)
Appendix B-3c	Adult Full Service Partnership
Appendix B-4	Transitional –Age Youth Full Service Partnership
Appendix B-5	Administrative Service Organization
Appendix B-6	Full Circle Family Program (FCFP)
Appendix B-7	FCFP /Early Periodic Screening, Diagnosis and treatment (EPSDT) Program
Appendix B-8	Early Childhood Mental Health Initiative
Appendix B-9	Youth Striving for Excellence – Teen Resource to Achieve Positive Practice (TRAPP)
Appendix B-10	Prevention and Recovery in Early Intervention (PREP) Project
Appendix B-11	Felton Institute – Training in Older Adult Behavioral Health Screening

B. Compensation

Compensation shall be made in monthly payments on or before the 30th day after the DIRECTOR, in his or her sole discretion, has approved the invoice submitted by CONTRACTOR. The breakdown of costs and sources of revenue associated with this Agreement appears in Appendix B, Cost Reporting/Data Collection (CR/DC) and Program Budget, attached hereto and incorporated by reference as though fully set forth herein. The maximum dollar obligation of the CITY under the terms of this Agreement shall not exceed **Forty Five Million Four Hundred Eighty Three Thousand One Hundred Forty Dollars ($45,483,140)** for the period of **July 1, 2010 through December 31, 2015.**

CONTRACTOR understands that, of this maximum dollar obligation, **$4,873,193** is included as a contingency amount and is neither to be used in Appendix B, Budget, or available to CONTRACTOR without a modification to this Agreement executed in the same manner as this Agreement or a revision to Appendix B, Budget, which has been approved by the Director of Health. CONTRACTOR further understands that no payment of any portion of this contingency amount will be made unless and until such modification or budget revision has been fully approved and executed in accordance with applicable CITY and Department of Public Health laws, regulations and policies/procedures and certification as to the availability of funds by the Controller. CONTRACTOR agrees to fully comply with these laws, regulations, and policies/procedures.

(1) For each fiscal year of the term of this Agreement, CONTRACTOR shall submit for approval of the CITY's Department of Public Health a revised Appendix A, Description of Services, and a revised Appendix B, Program Budget and Cost Reporting Data Collection form, based on the CITY's allocation of funding for SERVICES for the appropriate fiscal year. CONTRACTOR shall create these Appendices in compliance with the instructions of the Department of Public Health. These Appendices shall apply only to the fiscal year for which they were created. These Appendices shall become part of this Agreement only upon approval by the CITY.

(2) CONTRACTOR understands that, of the maximum dollar obligation stated above, the total amount to be used in Appendix B, Budget and available to CONTRACTOR for the entire term of the contract is as follows, not withstanding that for each fiscal year, the amount to be used in Appendix B, Budget and available to CONTRACTOR for that fiscal year shall conform with the Appendix A, Description of Services, and a Appendix B, Program Budget and Cost Reporting Data Collection form, as approved by the CITY's Department of Public Health based on the CITY's allocation of funding for SERVICES for that fiscal year.

July 1, 2010 through December 31, 2010	**$3,412,014 (BPHM07000084)**
July 1, 2010 through June 30, 2011	**$4,114,657**
July 1, 2011 through June 30, 2012	**$7,428,328**
July 1, 2012 through June 30, 2013	**$7,329,985**
July 1, 2013 through June 30, 2014	**$7,329,985**
July 1, 2014 through June 30, 2015	**$7,329,985**
July 1, 2015 through December 31, 2015	**$3,664,993**
Total of July 1, 2010 through December 31, 2015	**$40,609,947**

(3) CONTRACTOR understands that the CITY may need to adjust sources of revenue and agrees that these needed adjustments will become part of this Agreement by written modification to CONTRACTOR. In event that such reimbursement is terminated or reduced, this Agreement shall be terminated or proportionately reduced accordingly. In no event will CONTRACTOR be entitled to compensation in excess of these amounts for these periods without there first being a modification of the Agreement or a revision to Appendix B, Budget, as provided for in this section of this Agreement.

(4) CONTRACTOR further understands that, **$3,412,014** of the period from July 1, 2010 through December 31, 2010 in the Contract Number BPHM07000084 is included with this Agreement. Upon execution of this Agreement, all the terms under this Agreement will supersede the Contract Number. BPHM07000084 for the Fiscal Year 2010-11.

C. CONTRACTOR agrees to comply with its Budget as shown in Appendix B in the provision of SERVICES. Changes to the budget that do not increase or reduce the maximum dollar obligation of the CITY are subject to the provisions of the Department of Public Health Policy/Procedure Regarding Contract Budget Changes. CONTRACTOR agrees to comply fully with that policy/procedure.

D. No costs or charges shall be incurred under this Agreement nor shall any payments become due to CONTRACTOR until reports, SERVICES, or both, required under this Agreement are received from CONTRACTOR and approved by the DIRECTOR as being in accordance with this Agreement. CITY may withhold payment to CONTRACTOR in any instance in which CONTRACTOR has failed or refused to satisfy any material obligation provided for under this Agreement.

E. In no event shall the CITY be liable for interest or late charges for any late payments.

F. CONTRACTOR understands and agrees that should the CITY'S maximum dollar obligation under this Agreement include State or Federal Medi-Cal revenues, CONTRACTOR shall expend such revenues in the provision of SERVICES to Medi-Cal eligible clients in accordance with CITY, State, and Federal Medi-Cal regulations. Should CONTRACTOR fail to expend budgeted Medi-Cal revenues herein, the CITY'S maximum dollar obligation to CONTRACTOR shall be proportionally reduced in the amount of such unexpended revenues. In no event shall State/Federal Medi-Cal revenues be used for clients who do not qualify for Medi-Cal reimbursement.

DPH 1: Department of Public Health Contract Budget Summary

CONTRACT TYPE - This contract is: Renewal					Page:	1
If modification, Effective Date of Mod.:	# of Mod:		VENDOR ID (DPH USE ONLY):			
LEGAL ENTITY NUMBER: 00237					Date:	9/24/2010
LEGAL ENTITY/CONTRACTOR NAME: Family Service Agency of San Francisco						
APPENDIX NUMBER	B-1a	B-1b	B-1c		B-2	
PROVIDER NUMBER	3822	3822	8990		3822	
PROVIDER NAME:	Family Serice	Family Serice	Geriatric Srvs West		Family Serice	
REPORTING UNIT NUMBER:	38223	3822G3	89903			
PROGRAM NAME:	Geriatric Gough OP / ICM / Community Integration	Older Adult FSP	Geriatric West		Senior Drop-In Center	TOTAL
CBHS FUNDING TERM:	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11		7/1/10 - 6/30/11	
FUNDING USES:						
SALARIES & EMPLOYEE BENEFITS	781,904	528,416	628,485		102,516	2,041,301
OPERATING EXPENSE	294,843	164,771	225,224		63,018	747,856
CAPITAL OUTLAY (COST $5,000 AND OVER)						0
SUBTOTAL DIRECT COSTS	1,076,747	693,187	853,689		165,534	2,789,157
INDIRECT COST AMOUNT	129,209	83,183	102,443		19,866	334,701
INDIRECT %	12%	12%	12%		12%	
TOTAL FUNDING USES:	1,205,956	776,370	956,132		185,400	3,123,858
CBHS MENTAL HEALTH FUNDING SOURCES						
FEDERAL REVENUES - click below						
SDMC Regular FFP (50%)	444,034	102,289	352,620			898,943
ARRA SDMC FFP (11.59)	102,928	23,711	81,738			208,377
STATE REVENUES - click below						-
MHSA		650,370			185,400	835,770
EPSDT State Match						-
GRANTS - click below						-
						-
State Office of Family Planning						-
PRIOR YEAR ROLL OVER - click below						-
MHSA						-
WORK ORDERS - click below						-
Dept of Children, Youth & Families						-
HSA (Human Svcs Agency)						-
First Five (SF Children & Family Commission) - PFA						-
First Five (SF Children & Family Commission) - FRC						-
3RD PARTY PAYOR REVENUES - click below						-
MediCare	18,740		13,330			32,070
State M-Managed Care						-
Family Mosaic Capitated Medi-Cal						-
REALIGNMENT FUNDS	248,993		197,732			446,725
COUNTY GENERAL FUND	391,261		310,712			701,973
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	1,205,956	776,370	956,132		185,400	3,123,858
CBHS SUBSTANCE ABUSE FUNDING SOURCES:						
FEDERAL REVENUES - click below						
						-
STATE REVENUES - click below						-
						-
GRANTS/PROJECTS - click below						-
						-
Please enter other funding source here if not in pull down						-
WORK ORDERS - click below						-
						-
Please enter other funding source here if not in pull down						-
3RD PARTY PAYOR REVENUES - click below						-
						-
Please enter other funding source here if not in pull down						-
COUNTY GENERAL FUND						-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES						
TOTAL DPH REVENUES	1,205,956	776,370	956,132		185,400	3,123,858
NON-DPH REVENUES - click below						
TOTAL NON-DPH REVENUES	0	0	0		0	0
TOTAL REVENUES (DPH AND NON-DPH)	1,205,956	776,370	956,132		185,400	3,123,858
Prepared by/Phone #: Michael Gaston 415-474-7310 x 487						

DPH 1: Department of Public Health Contract Budget Summary

CONTRACT TYPE - This contract is: Renewal					Page:	2
If modification, Effective Date of Mod.:	# of Mod:		VENDOR ID (DPH USE ONLY)			
LEGAL ENTITY NUMBER: 00337					Date:	9/24/2010
LEGAL ENTITY/CONTRACTOR NAME: Family Service Agency of San Francisco						
APPENDIX NUMBER	B-3a	B-3b	B-3c	B-4	B-5	
PROVIDER NUMBER	8977	3822	3822	3822	3822	
PROVIDER NAME:	Comm. Aftercare	Family Serice	Family Serice	Family Serice	Family Serice	
REPORTING UNIT NUMBER:	8977OP	3822OP	3822A3	3822T3		
PROGRAM NAME:	Community Aftercare	Adult Care Management	Adult FSP	Transitional Age Youth (TAY) FSP	POPS ASO	TOTAL
CBHS FUNDING TERM:	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	
FUNDING USES:						
SALARIES & EMPLOYEE BENEFITS	355,378	489,028	342,234	257,313	168,005	1,611,958
OPERATING EXPENSE	49,485	135,506	190,477	115,848	3,143	494,459
CAPITAL OUTLAY (COST $5,000 AND OVER)						0
SUBTOTAL DIRECT COSTS	404,863	624,534	532,711	373,161	171,148	2,106,417
INDIRECT COST AMOUNT	48,583	74,944	63,925	44,779	20,538	252,769
INDIRECT %	12%	12%	12%	12%	12%	
TOTAL FUNDING USES:	453,446	699,478	596,636	417,940	191,686	2,359,186
CBHS MENTAL HEALTH FUNDING SOURCES						
FEDERAL REVENUES - click below						
SDMC Regular FFP (50%)	198,008	277,850	60,886	44,857		581,601
ARRA SDMC FFP (11.59)	45,896	64,406	14,114	10,398		134,814
STATE REVENUES - click below						-
MHSA			521,636	362,685		884,321
EPSDT State Match						-
GRANTS - click below						-
						-
State Office of Family Planning						-
PRIOR YEAR ROLL OVER - click below						-
MHSA						-
WORK ORDERS - click below						-
Dept of Children, Youth & Families						-
HSA (Human Svcs Agency)						-
First Five (SF Children & Family Commission) - PFA						-
First Five (SF Children & Family Commission) - FRC						-
3RD PARTY PAYOR REVENUES - click below						-
MediCare						-
State M-Managed Care					160,801	160,801
Family Mosaic Capitated Medi-Cal						-
REALIGNMENT FUNDS	102,461	146,700				249,161
COUNTY GENERAL FUND	107,081	210,522			30,885	348,488
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	453,446	699,478	596,636	417,940	191,686	2,359,186
CBHS SUBSTANCE ABUSE FUNDING SOURCES:						
FEDERAL REVENUES - click below						
						-
STATE REVENUES - click below						-
						-
GRANTS/PROJECTS - click below						-
						-
Please enter other funding source here if not in pull down						-
WORK ORDERS - click below						-
						-
Please enter other funding source here if not in pull down						-
3RD PARTY PAYOR REVENUES - click below						-
						-
Please enter other funding source here if not in pull down						-
COUNTY GENERAL FUND						-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES						-
TOTAL DPH REVENUES	453,446	699,478	596,636	417,940	191,686	2,359,186
NON-DPH REVENUES - click below						
TOTAL NON-DPH REVENUES	0	0	0	0	0	0
TOTAL REVENUES (DPH AND NON-DPH)	453,446	699,478	596,636	417,940	191,686	2,359,186
Prepared by/Phone #: Michael Gaston 415-474-7310 x 487						

DPH 1: Department of Public Health Contract Budget Summary

CONTRACT TYPE - This contract is: **Renewal**					Page:	3
If modification, Effective Date of Mod.:	# of Mod:		VENDOR ID (DPH USE ONLY):			
LEGAL ENTITY NUMBER: 00337					Date:	9/24/2010
LEGAL ENTITY/CONTRACTOR NAME: Family Service Agency of San Francisco						
APPENDIX NUMBER	B-6	B-7	B-8a	B-8b	B-8c	
PROVIDER NUMBER	3822	3822	3822	3822	3822	
PROVIDER NAME:	Family Serice	Family Serice	Family Serice	Family Serice	Family Serice	
REPORTING UNIT NUMBER:	382201	382203				
PROGRAM NAME:	Full Circle Family Program OP	Full Circle Family Program EPSDT	Early Childhood MH HSA/DCYF	Early Childhood MH SFCFC - PFA	Early Childhood MH SFCFC - FRC	TOTAL
CBHS FUNDING TERM:	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	
FUNDING USES:						
SALARIES & EMPLOYEE BENEFITS	191,032	271,638	79,609	77,050	12,510	631,840
OPERATING EXPENSE	78,636	106,242	16,984	16,437	2,669	220,968
CAPITAL OUTLAY (COST $5,000 AND OVER)						0
SUBTOTAL DIRECT COSTS	269,668	377,880	96,594	93,487	15,179	852,808
INDIRECT COST AMOUNT	32,361	45,345	11,591	11,218	1,821	102,336
INDIRECT %	12%	12%	12%	12%	12%	
TOTAL FUNDING USES:	302,029	423,225	108,185	104,705	17,000	955,144
CBHS MENTAL HEALTH FUNDING SOURCES						
FEDERAL REVENUES - click below						
SDMC Regular FFP (50%)	75,800	211,610				287,410
ARRA SDMC FFP (11.59)	17,568	49,052				66,620
STATE REVENUES - click below						-
MHSA						-
EPSDT State Match		141,402				141,402
GRANTS - click below						-
						-
State Office of Family Planning						-
PRIOR YEAR ROLL OVER - click below						-
MHSA						-
WORK ORDERS - click below						-
Dept of Children, Youth & Families			45,090			45,090
HSA (Human Svcs Agency)			63,095			63,095
First Five (SF Children & Family Commission) - PFA				104,705		104,705
First Five (SF Children & Family Commission) - FRC					17,000	17,000
3RD PARTY PAYOR REVENUES - click below						-
MediCare						-
State M-Managed Care						-
Family Mosaic Capitated Medi-Cal	7,753					7,753
REALIGNMENT FUNDS	80,450					80,450
COUNTY GENERAL FUND	120,458	21,161				141,619
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	302,029	423,225	108,185	104,705	17,000	955,144
CBHS SUBSTANCE ABUSE FUNDING SOURCES						
FEDERAL REVENUES - click below						
						-
STATE REVENUES - click below						-
						-
GRANTS/PROJECTS - click below						-
						-
Please enter other funding source here if not in pull down						-
WORK ORDERS - click below						-
						-
Please enter other funding source here if not in pull down						-
3RD PARTY PAYOR REVENUES - click below						-
						-
Please enter other funding source here if not in pull down						-
COUNTY GENERAL FUND						-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES						-
TOTAL DPH REVENUES	302,029	423,225	108,185	104,705	17,000	955,144
NON-DPH REVENUES - click below						
TOTAL NON-DPH REVENUES	0	0	0	0	0	0
TOTAL REVENUES (DPH AND NON-DPH)	302,029	423,225	108,185	104,705	17,000	955,144
Prepared by/Phone #: Michael Gaston 415-474-7310 x 487						

DPH 1: Department of Public Health Contract Budget Summary

CONTRACT TYPE - This contract is: **Renewal**					Page:	4
If modification, Effective Date of Mod.:	# of Mod:			VENDOR ID (DPH USE ONLY)		
LEGAL ENTITY NUMBER: 00337					Date:	9/24/2010
LEGAL ENTITY/CONTRACTOR NAME: Family Service Agency of San Francisco						
APPENDIX NUMBER	B-9	B-10a	B-10b	B-11		
PROVIDER NUMBER	3822	3822	3822	3822		
PROVIDER NAME:	Family Serice	Family Serice	Family Serice	Family Serice		
REPORTING UNIT NUMBER:		382214	382214			
PROGRAM NAME:	Youth Striving For Excellance	Early Psychosis (PREP) Cost Reimbursement	Early Psychosis (PREP) Fee For Service	Training OA Behavioral Health Screening	**Page TOTAL**	**Contract TOTAL**
CBHS FUNDING TERM:	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11		
FUNDING USES:						
SALARIES & EMPLOYEE BENEFITS	0	328,545	78,672	4,219	411,336	4,696,435
OPERATING EXPENSE	4,465	511,692	32,872	11,495	560,524	2,023,807
CAPITAL OUTLAY (COST $5,000 AND OVER)					-	-
SUBTOTAL DIRECT COSTS	4,465	840,237	111,444	15,714	971,860	6,720,242
INDIRECT COST AMOUNT	535	100,829	13,373	1,886	116,623	806,429
INDIRECT %	12%	12%	12%	12%	0	
TOTAL FUNDING USES:	5,000	941,066	124,817	17,600	1,088,483	7,526,671
CBHS MENTAL HEALTH FUNDING SOURCES						
FEDERAL REVENUES - click below					-	-
SDMC Regular FFP (50%)			62,415		62,415	1,830,369
ARRA SDMC FFP (11.59)			14,468		14,468	424,279
STATE REVENUES - click below					-	-
MHSA		852,066	47,934	17,600	917,600	2,637,691
EPSDT State Match					-	141,402
GRANTS - click below					-	-
					-	-
State Office of Family Planning	5,000				5,000	5,000
PRIOR YEAR ROLL OVER - click below					-	-
MHSA		89,000			89,000	89,000
WORK ORDERS - click below					-	-
Dept of Children, Youth & Familes					-	45,090
HSA (Human Svcs Agency)					-	69,095
First Five (SF Children & Family Commission) - PFA					-	104,705
First Five (SF Children & Family Commission) - FRC					-	17,000
3RD PARTY PAYOR REVENUES - click below					-	-
MediCare					-	32,070
State M-Managed Care					-	160,801
Family Mosaic Capitated Medi-Cal					-	7,753
REALIGNMENT FUNDS					-	776,336
COUNTY GENERAL FUND					-	1,192,080
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	5,000	941,066	124,817	17,600	1,088,483	7,526,671
CBHS SUBSTANCE ABUSE FUNDING SOURCES:						
FEDERAL REVENUES - click below					-	-
					-	-
STATE REVENUES - click below					-	-
					-	-
GRANTS/PROJECTS - click below					-	-
					-	-
Please enter other funding source here if not in pull down					-	-
WORK ORDERS - click below					-	-
					-	-
Please enter other funding source here if not in pull down					-	-
3RD PARTY PAYOR REVENUES - click below					-	-
					-	-
Please enter other funding source here if not in pull down					-	-
COUNTY GENERAL FUND					-	-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES						
TOTAL DPH REVENUES	5,000	941,066	124,817	17,600	1,088,483	7,526,671
NON-DPH REVENUES - click below					-	-
					-	-
TOTAL NON-DPH REVENUES	0	0	0	0	-	-
TOTAL REVENUES (DPH AND NON-DPH)	5,000	941,066	124,817	17,600	1,088,483	7,526,671
Prepared by/Phone #: Michael Gaston 415-474-7310 x 487						

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENIDX #:	B-1a
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #:	3822
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page:	1
REPORTING UNIT NAME::	Geriatric Gough OP / ICM / Community Integration					Date:	9/24/2010
REPORTING UNIT:	38223	38223	38223	38223	38223		
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19		
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion		TOTAL
CBHS FUNDING TERM:	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011		
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	119,948	326,641	272,256	27,099	35,957		781,904
OPERATING EXPENSE	45,230	123,171	102,664	10,219	13,559		294,843
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	165,179	449,812	374,923	37,318	49,516	-	1,076,747
INDIRECT COST AMOUNT	19,821	53,977	44,991	4,478	5,942		129,209
TOTAL FUNDING USES:	185,000	503,789	419,913	41,796	55,458	-	1,205,956
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	71,401	194,437	162,065	16,131	-		444,034
ARRA SDMC FFP (11.59)	16,551	45,071	37,567	3,739	-		102,928
STATE REVENUES - click below							
MHSA							-
EPSDT State Match							
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Familes							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare	3,013	8,206	6,840	681	-		18,740
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS	38,197	104,017	86,699	8,630	11,450		248,993
COUNTY GENERAL FUND	55,838	152,058	126,742	12,615	44,008		391,261
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	185,000	503,789	419,913	41,796	55,458		1,205,956
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							-
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL DPH REVENUES	185,000	503,789	419,913	41,796	55,458	-	1,205,956
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	185,000	503,789	419,913	41,796	55,458	-	1,205,956
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]	92,039.82	193,764.94	87,300.02	10,800.00	585.00		
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80	0.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80	0.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91		
UNDUPLICATED CLIENTS	335	335	335	335	335		

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENIDX #: B-1b	
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #: 3822	
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page: 2	
REPORTING UNIT NAME::	Older Adult FSP					Date:	9/24/2010
REPORTING UNIT:	3822G3	3822G3	3822G3	3822G3	3822G3	3822G3	
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19	60/72	
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion	CS-Client Flexible Support Exp	TOTAL
CBHS FUNDING TERM:	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	258,265	95,560	65,476	13,433	54,845	40,837	528,416
OPERATING EXPENSE	80,532	29,797	20,417	4,189	17,102	12,734	164,771
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	338,797	125,357	85,893	17,622	71,946	53,571	693,187
INDIRECT COST AMOUNT	40,656	15,043	10,307	2,115	8,634	6,429	83,183
TOTAL FUNDING USES:	379,453	140,400	96,200	19,737	80,580	60,000	776,370
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	61,048	22,588	15,477	3,175			102,289
ARRA SDMC FFP (11.59)	14,151	5,236	3,588	736			23,711
STATE REVENUES - click below							
MHSA	304,254	112,576	77,135	15,826	80,580	60,000	650,370
EPSDT State Match							
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Familes							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	379,453	140,400	96,200	19,737	80,580	60,000	776,370
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-						-
TOTAL DPH REVENUES	379,453	140,400	96,200	19,737	80,580	60,000	776,370
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	379,453	140,400	96,200	19,737	80,580	60,000	776,370
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]						60,000.00	
UNITS OF TIME[2]	188,782.59	54,000.00	20,000.00	5,100.00	850.00		
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80	1.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80	1.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.66	113.91	N/A	
UNDUPLICATED CLIENTS	50	50	50	50	50	50	

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Departme... of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENDIX #:	B-1c
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #:	8990
PROVIDER NAME:	Geriatrics Services West					Page:	3
REPORTING UNIT NAME::	**Gersitrics West**					Date:	9/24/2010
REPORTING UNIT:	89903	89903	89903	89903	89903		
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19		
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion		TOTAL
CBHS FUNDING TERM:	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011		
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	99,088	267,406	183,373	22,894	35,705		628,465
OPERATING EXPENSE	35,510	102,998	65,716	8,204	12,795		225,224
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	134,598	390,403	249,089	31,098	48,500	-	853,689
INDIRECT COST AMOUNT	16,152	46,848	29,891	3,732	5,820		102,443
TOTAL FUNDING USES:	150,750	437,252	278,980	34,830	54,320	-	956,132
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	58,945	170,971	109,085	13,619	-		352,620
ARRA SDMC FFP (11.59)	13,664	39,631	25,286	3,157	-		81,738
STATE REVENUES - click below							
MHSA							-
EPSDT State Match							
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Familes							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare	2,228	6,463	4,124	515	-		13,330
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS	31,176	90,425	57,694	7,203	11,234		197,732
COUNTY GENERAL FUND	44,737	129,761	82,791	10,336	43,086		310,712
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	150,750	437,252	278,980	34,830	54,320		956,132
CBHS SUBSTANCE ABUSE FUNDING SOURCES							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	150,750	437,252	278,980	34,830	54,320		956,132
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	150,750	437,252	278,980	34,830	54,320		956,132
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]	75,000.00	168,173.85	58,000.00	9,000.00	573.00		
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80	0.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80	0.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91		
UNDUPLICATED CLIENTS	220	220	220	220	220		

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11				APPENIDX #: B-2		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco				PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF				Page: 4		
REPORTING UNIT NAME::	**Senior Drop-In Center - Cost Reimbursement**				Date:	9/24/2010	
REPORTING UNIT:	3822SD						
MODE OF SVCS / SERVICE FUNCTION CODE							
SERVICE DESCRIPTION	Supplemental Support						TOTAL
CBHS FUNDING TERM:	2010-2011						
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	102,516						102,516
OPERATING EXPENSE	63,018						63,018
CAPITAL OUTLAY (COST $5,000 AND OVER)	-						-
SUBTOTAL DIRECT COSTS	165,534	-	-	-	-	-	165,534
INDIRECT COST AMOUNT	19,866						19,866
TOTAL FUNDING USES:	185,400	-	-	-	-	-	185,400
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)							-
ARRA SDMC FFP (11.59)							-
STATE REVENUES - click below							
MHSA	185,400						185,400
EPSDT State Match							-
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	185,400	-	-	-	-	-	185,400
CBHS SUBSTANCE ABUSE FUNDING SOURCES							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL DPH REVENUES	185,400						185,400
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	185,400	-	-	-	-	-	185,400
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]							
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	CR						
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	CR						
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)							
UNDUPLICATED CLIENTS	N/A						

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Departme... of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11				APPENIDX #: B-3a		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco				PROVIDER #: 8977		
PROVIDER NAME:	Community Aftercare Program - FSA				Page: 5		
REPORTING UNIT NAME::	Community Aftercare				Date:	9/24/2010	
REPORTING UNIT:	8977OP	8977OP	8977OP	8977OP	8977OP		
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19		
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion		TOTAL
CBHS FUNDING TERM:	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011		
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	189,035	110,343	36,189	6,066	13,745		355,378
OPERATING EXPENSE	26,322	15,365	5,039	845	1,914		49,485
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	215,358	125,707	41,228	6,911	15,659	-	404,863
INDIRECT COST AMOUNT	25,843	15,085	4,947	829	1,879		48,583
TOTAL FUNDING USES:	241,200	140,792	46,176	7,740	17,538	-	453,446
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	109,563	63,954	20,975	3,516			198,008
ARRA SDMC FFP (11.59)	25,396	14,824	4,862	815			45,896
STATE REVENUES - click below							
MHSA							-
EPSDT State Match							
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Familes							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS	54,502	31,813	10,434	1,749	3,963		102,461
COUNTY GENERAL FUND	51,739	30,201	9,905	1,660	13,575		107,081
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	241,200	140,792	46,176	7,740	17,538		453,446
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	241,200	140,792	46,176	7,740	17,538		453,446
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	241,200	140,792	46,176	7,740	17,538		453,446
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]	120,000.08	54,150.81	9,599.97	2,000.00	185.00		
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80	0.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80	0.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91		
UNDUPLICATED CLIENTS	250	250	250	250	250		

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENIDX #: B-3b	
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #: 3822	
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page: 6	
REPORTING UNIT NAME::	Adult Care Management					Date: 9/24/2010	
REPORTING UNIT:	3822OP	3822OP	3822OP	3822OP	3822OP		
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19		
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion		TOTAL
CBHS FUNDING TERM:	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011		
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	244,516	50,592	161,416	14,610	17,895		489,028
OPERATING EXPENSE	67,753	14,019	44,727	4,048	4,959		135,506
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	312,268	64,611	206,143	18,659	22,854	-	624,534
INDIRECT COST AMOUNT	37,472	7,753	24,737	2,239	2,742		74,944
TOTAL FUNDING USES:	349,740	72,364	230,880	20,898	25,596	-	699,478
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	144,202	29,837	95,185	8,617			277,850
ARRA SDMC FFP (11.59)	33,426	6,916	22,066	1,997			64,406
STATE REVENUES - click below							
MHSA							-
EPSDT State Match							
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Familes							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS	73,350	15,177	48,422	4,383	5,368		146,700
COUNTY GENERAL FUND	98,761	20,434	65,197	5,901	20,228		210,522
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	349,740	72,364	230,880	20,898	25,596		699,478
CBHS SUBSTANCE ABUSE FUNDING SOURCES							
FEDERAL REVENUES - click below							-
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	349,740	72,364	230,880	20,898	25,596		699,478
NON-DPH REVENUES - click below							
							-
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	349,740	72,364	230,880	20,898	25,596		699,478
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]	173,999.95	27,832.30	47,999.99	5,400.00	270.00		
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80	0.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80	0.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91		
UNDUPLICATED CLIENTS	108	108	108	108	108		

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENIDX #: B-3c	
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #: 3822	
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page: 7	
REPORTING UNIT NAME:	Adult FSP					Date: 9/24/2010	
REPORTING UNIT:	3822A3	3822A3	3822A3	3822A3	3822A3	3822A3	
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19	60/72	
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion	CS-Client Flexible Support Exp	TOTAL
CBHS FUNDING TERM:	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	194,120	54,485	24,831	4,795	29,636	34,416	342,234
OPERATING EXPENSE	108,041	30,297	13,820	2,669	16,494	19,155	190,477
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	302,162	84,782	38,652	7,464	46,130	53,571	532,711
INDIRECT COST AMOUNT	36,259	10,166	4,638	896	5,536	6,429	63,925
TOTAL FUNDING USES:	338,421	94,900	43,290	8,359	51,666	60,000	596,636
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	42,487	11,914	5,435	1,049			60,886
ARRA SDMC FFP (11.59)	9,849	2,762	1,260	243			14,114
STATE REVENUES - click below							
MHSA	286,084	80,224	36,595	7,066	51,666	60,000	521,636
EPSDT State Match							
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	338,421	94,900	43,290	8,359	51,666	60,000	596,636
CBHS SUBSTANCE ABUSE FUNDING SOURCES							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL DPH REVENUES	338,421	94,900	43,290	8,359	51,666	60,000	596,636
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	338,421	94,900	43,290	8,359	51,666	60,000	596,636
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]						60,000	
UNITS OF TIME[2]	168,368.56	36,500.00	9,000.00	2,160.00	545.00		
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80	1.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80	1.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91	N/A	
UNDUPLICATED CLIENTS	45	45	45	45	45	45	

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11				APPENIDX #: B-4		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco				PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF				Page: 8		
REPORTING UNIT NAME::	Transitional Age Youth (TAY) FSP				Date:	9/24/2010	
REPORTING UNIT:	3822T3	3822T3	3822T3	3822T3	3822T3	3822T3	
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19	60/72	
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion	CS-Client Flexible Support Exp	TOTAL
CBHS FUNDING TERM:	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	122,512	61,892	15,695	2,383	24,047	30,783	257,313
OPERATING EXPENSE	55,158	27,865	7,066	1,073	10,826	13,859	115,848
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	177,670	89,757	22,762	3,456	34,873	44,643	373,161
INDIRECT COST AMOUNT	21,320	10,771	2,731	415	4,185	5,357	44,779
TOTAL FUNDING USES:	198,990	100,528	25,493	3,871	39,058	50,000	417,940
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	27,141	13,711	3,477	528			44,857
ARRA SDMC FFP (11.59)	6,291	3,178	806	123			10,398
STATE REVENUES - click below							
MHSA	165,558	83,639	21,210	3,220	39,058	50,000	362,685
EPSDT State Match							
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	198,990	100,528	25,493	3,871	39,058	50,000	417,940
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	198,990	100,528	25,493	3,871	39,058	50,000	417,940
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	198,990	100,528	25,493	3,871	39,058	50,000	417,940
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]						50,000	
UNITS OF TIME[2]	99,000.00	38,664.62	5,300.00	1,000.26	412.00		
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80	1.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80	1.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91	N/A	
UNDUPLICATED CLIENTS	30	30	30	30	30	30	

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Departme of Public Heath Cost Reporting/Data Co tion (CRDC)

FISCAL YEAR:	2010-11				APPENIDX #: B-5		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco				PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF				Page: 9		
REPORTING UNIT NAME::	POPS / ASO - Cost Reimbursement				Date:	9/24/2010	
REPORTING UNIT:	N/A						
MODE OF SVCS / SERVICE FUNCTION CODE							
SERVICE DESCRIPTION	Support Services						TOTAL
CBHS FUNDING TERM:	2010 - 2011						
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	168,005						168,005
OPERATING EXPENSE	3,143						3,143
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	171,148	-	-	-	-	-	171,148
INDIRECT COST AMOUNT	20,538						20,538
TOTAL FUNDING USES:	191,686	-	-	-	-	-	191,686
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)							-
ARRA SDMC FFP (11.59)							-
STATE REVENUES - click below							
MHSA							-
EPSDT State Match							-
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care	160,801						160,801
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND	30,885						30,885
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	191,686						191,686
CBHS SUBSTANCE ABUSE FUNDING SOURCES							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	191,686						191,686
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	191,686						191,686
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]							
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	CR						
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	CR						
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)							
UNDUPLICATED CLIENTS	N/A						-

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11				APPENDIX #: B-6		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco				PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF				Page: 10		
REPORTING UNIT NAME::	Full Circle Family Program - OP				Date: 9/24/2010		
REPORTING UNIT:	382201	382201	382201	382201	382201		
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19		
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion		TOTAL
CBHS FUNDING TERM:	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011		
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	6,654	116,795	37,343	1,423	28,817		191,032
OPERATING EXPENSE	2,739	48,077	15,372	586	11,862		76,636
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	9,394	164,873	52,714	2,009	40,678	-	269,668
INDIRECT COST AMOUNT	1,127	19,785	6,326	241	4,881		32,361
TOTAL FUNDING USES:	10,521	184,658	59,040	2,250	45,560	-	302,029
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	2,480	50,620	22,140	560			75,800
ARRA SDMC FFP (11.59)	575	11,733	5,131	130			17,569
STATE REVENUES - click below							
MHSA							-
EPSDT State Match							-
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS	1,904	38,879	17,003	430	22,234		80,450
COUNTY GENERAL FUND	5,562	83,426	14,766	1,130	23,326		128,210
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	10,521	184,658	59,040	2,250	45,560		302,029
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-		-
TOTAL DPH REVENUES	10,521	184,658	59,040	2,250	45,560		302,029
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	10,521	184,658	59,040	2,250	45,560		302,029
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]					480.59		-
UNITS OF TIME[2]	5,234.33	71,022.31	12,274.43	581.40			
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80		
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80		
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91		
UNDUPLICATED CLIENTS	348	348	348	348	348		

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Departm. . of Public Heath Cost Reporting/Data C. ction (CRDC)

FISCAL YEAR:	2010-11					APPENIDX #: B-7	
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #: 3822	
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page: 11	
REPORTING UNIT NAME::	Full Circle Family Program - EPSDT					Date: 9/24/2010	
REPORTING UNIT:	382203	382203	382203	382203			
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79			
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP			TOTAL
CBHS FUNDING TERM:	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11	7/1/10 - 6/30/11			
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	10,063	228,958	29,637	2,981			271,638
OPERATING EXPENSE	3,936	89,549	11,592	1,166			106,242
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	13,998	318,507	41,229	4,146	-	-	377,880
INDIRECT COST AMOUNT	1,680	38,221	4,947	498			45,346
TOTAL FUNDING USES:	15,678	356,727	46,176	4,644	-	-	423,226
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	7,839	178,361	23,088	2,322			211,610
ARRA SDMC FFP (11.59)	1,817	41,345	5,352	538			49,052
STATE REVENUES - click below							
MHSA							-
EPSDT State Match	5,238	119,165	15,427	1,552			141,402
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Familes							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND	784	17,836	2,309	232			21,161
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	15,678	356,727	46,176	4,644			423,225
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	15,678	356,727	46,176	4,644			423,225
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	15,678	356,727	46,176	4,644			423,225
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]	7,800	137,203	9,600	1,200			
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87			
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87			
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.49	3.13	5.78	4.65			
UNDUPLICATED CLIENTS	348	348	348	348			

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11						APPENDIX #: B-8a		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco						PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF						Page: 12		
REPORTING UNIT NAME::	EARLYCHILDHOOD MENTAL HEALTH - Dept of Children, Youth & Families						Date:	9/24/2010	
REPORTING UNIT:	3822	3822	3822	3822	3822	3822	3822	3822	
MODE OF SVCS / SERVICE FUNCTION CODE	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	
SERVICE DESCRIPTION	Outreach Svc/ Consultation Grp	Outreach Svc/ Consultation Indv	Outreach Svc / Class Observ	Outreach Svc / Training Grp	Outreach Svc / Direct Svc Grp	Outreach Svc / Direct Svc Indv	Outreach Svc / Linkage	Outreach Svc / Eval Services	TOTAL
CBHS FUNDING TERM:	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	
FUNDING USES:									
SALARIES & EMPLOYEE BENEFITS	7,984	6,653	4,490	5,781	2,617	3,985	1,631	39	33,180
OPERATING EXPENSE	1,703	1,419	956	1,233	558	850	348	8	7,079
CAPITAL OUTLAY (COST $5,000 AND OVER)									0
SUBTOTAL DIRECT COSTS	9,688	8,072	5,448	7,014	3,175	4,836	1,979	47	40,259
INDIRECT COST AMOUNT	1,163	969	654	842	381	580	237	6	4,831
TOTAL FUNDING USES:	10,850	9,041	6,102	7,856	3,556	5,416	2,216	53	45,090
CBHS MENTAL HEALTH FUNDING SOURCES									
FEDERAL REVENUES - click below									
SDMC Regular FFP (50%)									-
ARRA SDMC FFP (11.59)									-
STATE REVENUES - click below									
MHSA									-
EPSDT State Match									-
GRANTS - click below CFDA #:									
									-
State Office of Family Planning									-
PRIOR YEAR ROLL OVER - click below									
MHSA									-
WORK ORDERS - click below									
Dept of Children, Youth & Familes	10850	9,041	6,102	7,856	3,556	5,416	2,216	53	45,090
HSA (Human Svcs Agency)									-
First Five (SF Children & Family Commission) PFA									-
First Five (SF Children & Family Commission) FRC									-
3RD PARTY PAYOR REVENUES - click below									
MediCare									-
State M-Managed Care									-
Family Mosaic Capitated Medi-Cal									-
REALIGNMENT FUNDS									-
COUNTY GENERAL FUND									-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	10,850	9,041	6,102	7,856	3,556	5,416	2,216	53	45,090
CBHS SUBSTANCE ABUSE FUNDING SOURCES									
FEDERAL REVENUES - click below									
									-
STATE REVENUES - click below									
									-
GRANTS/PROJECTS - click below CFDA #:									
									-
WORK ORDERS - click below									
									-
3RD PARTY PAYOR REVENUES - click below									
									-
COUNTY GENERAL FUND									-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES									
TOTAL DPH REVENUES	10,850	9,041	6,102	7,856	3,556	5,416	2,216	53	45,090
NON-DPH REVENUES - click below									
TOTAL NON-DPH REVENUES	0	0	0	0	0	0	0	0	0
TOTAL REVENUES (DPH AND NON-DPH)	10,850	9,041	6,102	7,856	3,556	5,416	2,216	53	45,090
CBHS UNITS OF SVCS/TIME AND UNIT COST:									
UNITS OF SERVICE[1]									
UNITS OF TIME[2]	144.67	120.55	81.36	104.75	32.33	72.21	29.55	0.71	
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)									
UNDUPLICATED CLIENTS	88	88	88	88	88	88	88	88	

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Departm of Public Heath Cost Reporting/Data C ction (CRDC)

FISCAL YEAR:	2010-11						APPENIDX #: B-8a		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco						PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF						Page: 13		
REPORTING UNIT NAME::	EARLYCHILDHOOD MENTAL HEALTH - Human Services Agency						Date:	9/24/2010	
REPORTING UNIT:	3822	3822	3822	3822	3822	3822	3822	3822	
MODE OF SVCS / SERVICE FUNCTION CODE	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	
SERVICE DESCRIPTION	Outreach Svc/ Consultation Grp	Outreach Svc/ Consultation Indv	Outreach Svc / Class Observ	Outreach Svc / Training Grp	Outreach Svc / Direct Svc Grp	Outreach Svc / Direct Svc Indv	Outreach Svc / Linkage	Outreach Svc / Eval Services	TOTAL
CBHS FUNDING TERM:	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	
FUNDING USES:									
SALARIES & EMPLOYEE BENEFITS	11,196	9,227	7,593	6,876	3,651	5,598	2,215	74	46,429
OPERATING EXPENSE	2,389	1,969	1,620	1,467	779	1,194	473	16	9,906
CAPITAL OUTLAY (COST $5,000 AND OVER)									-
SUBTOTAL DIRECT COSTS	13,585	11,196	9,213	8,343	4,429	6,792	2,688	89	56,335
INDIRECT COST AMOUNT	1,630	1,343	1,106	1,001	532	815	323	11	6,760
TOTAL FUNDING USES:	15,215	12,539	10,319	9,344	4,961	7,607	3,010	100	63,095
CBHS MENTAL HEALTH FUNDING SOURCES									
FEDERAL REVENUES - click below									
SDMC Regular FFP (50%)									-
ARRA SDMC FFP (11.59)									-
STATE REVENUES - click below									
MHSA									-
EPSDT State Match									-
GRANTS - click below CFDA #:									
									-
State Office of Family Planning									-
PRIOR YEAR ROLL OVER - click below									
MHSA									-
WORK ORDERS - click below									
Dept of Children, Youth & Families									-
HSA (Human Svcs Agency)	15,215	12,539	10,319	9,344	4,961	7,607	3,010	100	63,095
First Five (SF Children & Family Commission) PFA									-
First Five (SF Children & Family Commission) FRC									-
3RD PARTY PAYOR REVENUES - click below									
MediCare									-
State M-Managed Care									-
Family Mosaic Capitated Medi-Cal									-
REALIGNMENT FUNDS									-
COUNTY GENERAL FUND									-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	15,215	12,539	10,319	9,344	4,961	7,607	3,010	100	63,095
CBHS SUBSTANCE ABUSE FUNDING SOURCES									
FEDERAL REVENUES - click below									
									-
STATE REVENUES - click below									
									-
GRANTS/PROJECTS - click below CFDA #:									
									-
WORK ORDERS - click below									
									-
3RD PARTY PAYOR REVENUES - click below									
									-
COUNTY GENERAL FUND									-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES									
TOTAL DPH REVENUES	15,215	12,539	10,319	9,344	4,961	7,607	3,010	100	63,095
NON-DPH REVENUES - click below									
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	15,215	12,539	10,319	9,344	4,961	7,607	3,010	100	63,095
CBHS UNITS OF SVCS/TIME AND UNIT COST:									
UNITS OF SERVICE[1]									
UNITS OF TIME[2]	202.87	167.19	137.59	124.59	45.10	101.43	40.13	1.33	
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)									
UNDUPLICATED CLIENTS	124	124	124	124	124	124	124	124	

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Departm...t of Public Heath Cost Reporting/Data Co...ection (CRDC)

FISCAL YEAR:	2010-11						APPENIDX #: B-8b		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco						PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF						Page: 14		
REPORTING UNIT NAME:	EARLYCHILDHOOD MENTAL HEALTH - Preschool For All						Date:	9/24/2010	
REPORTING UNIT:	3822	3822	3822	3822	3822	3822	3822	3822	
MODE OF SVCS / SERVICE FUNCTION CODE	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	
SERVICE DESCRIPTION	Outreach Svc/ Consultation Grp	Outreach Svc/ Consultation Indv	Outreach Svc / Class Observ	Outreach Svc / Training Grp	Outreach Svc / Direct Svc Grp	Outreach Svc / Direct Svc Indv	Outreach Svc / Linkage	Outreach Svc / Eval Services	TOTAL
CBHS FUNDING TERM:	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	-
FUNDING USES:									
SALARIES & EMPLOYEE BENEFITS	18,255	16,228	9,878	13,387	6,329	9,128	3,700	146	77,050
OPERATING EXPENSE	3,894	3,462	2,107	2,856	1,350	1,947	789	31	16,437
CAPITAL OUTLAY (COST $5,000 AND OVER)									-
SUBTOTAL DIRECT COSTS	22,149	19,689	11,986	16,243	7,679	11,075	4,489	177	93,487
INDIRECT COST AMOUNT	2,658	2,363	1,438	1,949	921	1,329	539	21	11,218
TOTAL FUNDING USES:	24,807	22,052	13,424	18,192	8,600	12,404	5,028	198	104,705
CBHS MENTAL HEALTH FUNDING SOURCES									
FEDERAL REVENUES - click below									
SDMC Regular FFP (50%)									-
ARRA SDMC FFP (11.59)									-
STATE REVENUES - click below									
MHSA									-
EPSDT State Match									-
GRANTS - click below **CFDA #:**									
									-
State Office of Family Planning									-
PRIOR YEAR ROLL OVER - click below									
MHSA									-
WORK ORDERS - click below									
Dept of Children, Youth & Familes									-
HSA (Human Svcs Agency)									-
First Five (SF Children & Family Commission) **PFA**	24,807	22,052	13,424	18,192	8,600	12,404	5,028	198	104,705
First Five (SF Children & Family Commission) **FRC**									-
3RD PARTY PAYOR REVENUES - click below									
MediCare									-
State M-Managed Care									-
Family Mosaic Capitated Medi-Cal									-
REALIGNMENT FUNDS									-
COUNTY GENERAL FUND									-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	24,807	22,052	13,424	18,192	8,600	12,404	5,028	198	104,705
CBHS SUBSTANCE ABUSE FUNDING SOURCES									
FEDERAL REVENUES - click below									
									-
STATE REVENUES - click below									
									-
GRANTS/PROJECTS - click below **CFDA #:**									
									-
WORK ORDERS - click below									
									-
3RD PARTY PAYOR REVENUES - click below									
									-
COUNTY GENERAL FUND									-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES									
TOTAL DPH REVENUES	24,807	22,052	13,424	18,192	8,600	12,404	5,028	198	104,705
NON-DPH REVENUES - click below									
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	24,807	22,052	13,424	18,192	8,600	12,404	5,028	198	104,705
CBHS UNITS OF SVCS/TIME AND UNIT COST:									
UNITS OF SERVICE[1]									
UNITS OF TIME[2]	330.76	294.03	178.99	242.56	78.18	165.39	67.04	2.64	
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)									
UNDUPLICATED CLIENTS	205	205	205	205	205	205	205	205	205

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11						APPENIDX #: B-8c		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco						PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF						Page: 15		
REPORTING UNIT NAME:	EARLYCHILDHOOD MENTAL HEALTH - Family Resource Center						Date:	9/24/2010	
REPORTING UNIT:	3822	3822	3822	3822	3822	3822	3822	3822	
MODE OF SVCS / SERVICE FUNCTION CODE	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	45/10-19	
SERVICE DESCRIPTION	Outreach Svc/ Consultation Grp	Outreach Svc/ Consultation Indv	Outreach Svc / Class Observ	Outreach Svc / Training Grp	Outreach Svc / Direct Svc Grp	Outreach Svc / Direct Svc Indv	Outreach Svc / Linkage	Outreach Svc / Eval Services	TOTAL
CBHS FUNDING TERM:	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	2010-2011	
FUNDING USES:									
SALARIES & EMPLOYEE BENEFITS	2,921	2,434	1,910	2,130	1,071	1,424	573	49	12,510
OPERATING EXPENSE	623	519	407	454	228	304	122	10	2,669
CAPITAL OUTLAY (COST $5,000 AND OVER)									-
SUBTOTAL DIRECT COSTS	3,544	2,954	2,317	2,584	1,299	1,728	695	59	15,179
INDIRECT COST AMOUNT	425	354	278	310	156	207	83	7	1,821
TOTAL FUNDING USES:	3,969	3,308	2,595	2,894	1,455	1,935	778	66	17,000
CBHS MENTAL HEALTH FUNDING SOURCES									
FEDERAL REVENUES - click below									
SDMC Regular FFP (50%)									-
ARRA SDMC FFP (11.59)									-
STATE REVENUES - click below									
MHSA									-
EPSDT State Match									-
GRANTS - click below CFDA #:									
									-
State Office of Family Planning									-
PRIOR YEAR ROLL OVER - click below									
MHSA									-
WORK ORDERS - click below									
Dept of Children, Youth & Families									-
HSA (Human Svcs Agency)									-
First Five (SF Children & Family Commission) PFA									-
First Five (SF Children & Family Commission) FRC	3,969	3,308	2,595	2,894	1,455	1,935	778	66	17,000
3RD PARTY PAYOR REVENUES - click below									
MediCare									-
State M-Managed Care									-
Family Mosaic Capitated Medi-Cal									-
REALIGNMENT FUNDS									-
COUNTY GENERAL FUND									-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	3,969	3,308	2,595	2,894	1,455	1,935	778	66	17,000
CBHS SUBSTANCE ABUSE FUNDING SOURCES									
FEDERAL REVENUES - click below									
									-
STATE REVENUES - click below									
									-
GRANTS/PROJECTS - click below CFDA #:									
									-
WORK ORDERS - click below									
									-
3RD PARTY PAYOR REVENUES - click below									
									-
COUNTY GENERAL FUND									-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-	-	-
TOTAL DPH REVENUES	3,969	3,308	2,595	2,894	1,455	1,935	778	66	17,000
NON-DPH REVENUES - click below									
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	3,969	3,308	2,595	2,894	1,455	1,935	778	66	17,000
CBHS UNITS OF SVCS/TIME AND UNIT COST:									
UNITS OF SERVICE[1]									
UNITS OF TIME[2]	52.92	44.11	34.60	38.59	13.23	25.80	10.37	0.88	
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	75.00	75.00	75.00	75.00	110.00	75.00	75.00	75.00	
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)									
UNDUPLICATED CLIENTS	33	33	33	33	33	33	33	33	

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENDIX #: B-9	
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #: 3822	
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page: 16	
REPORTING UNIT NAME:	Youth Striving For Excellence - Cost Reimbursement					Date: 9/24/2010	
REPORTING UNIT:	382214						
MODE OF SVCS / SERVICE FUNCTION CODE							
SERVICE DESCRIPTION	Health Education Services						TOTAL
CBHS FUNDING TERM:	7/1/10-6/30/11						
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	-						-
OPERATING EXPENSE	4,465						4,465
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	4,465	-	-	-	-	-	4,465
INDIRECT COST AMOUNT	535						535
TOTAL FUNDING USES:	5,000	-	-	-	-	-	5,000
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)							-
ARRA SDMC FFP (11.59)							-
STATE REVENUES - click below							
MHSA							-
EPSDT State Match							-
GRANTS - click below CFDA #:							
							-
State Office of Family Planning	5,000						5,000
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	5,000						5,000
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	5,000						5,000
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	5,000						5,000
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]							
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	CR						
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	CR						
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)							
UNDUPLICATED CLIENTS	N/A						

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENDIX #:	B-10a
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #:	3822
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page:	17
REPORTING UNIT NAME::	Prevention & Recovery in Early Psychosis (PREP) - Cost Reimbursement					Date:	9/24/2010
REPORTING UNIT:	382214						
MODE OF SVCS / SERVICE FUNCTION CODE							
SERVICE DESCRIPTION	Early Intervention						TOTAL
CBHS FUNDING TERM:	2010 - 2011						
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	328,545						328,545
OPERATING EXPENSE	511,692						511,692
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	840,237	-	-	-	-	-	840,237
INDIRECT COST AMOUNT	100,828						100,828
TOTAL FUNDING USES:	941,066	-	-	-	-	-	941,066
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)							-
ARRA SDMC FFP (11.59)							-
STATE REVENUES - click below							
MHSA	852,066						852,066
EPSDT State Match							-
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA	89,000						89,000
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	941,066	-	-	-	-	-	941,066
CBHS SUBSTANCE ABUSE FUNDING SOURCES							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-	-	-	-	-	-	-
TOTAL DPH REVENUES	941,066	-	-	-	-	-	941,066
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	941,066	-	-	-	-	-	941,066
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]							
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	CR						
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	CR						
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)							
UNDUPLICATED CLIENTS	N/A						

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11				APPENIDX #: B-10b		
LEGAL ENTITY NAME:	Family Service Agency of San Francisco				PROVIDER #: 3822		
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF				Page: 18		
REPORTING UNIT NAME::	Prevention & Recovery in Early Psychosis (PREP) - Fee For Service				Date: 9/24/2010		
REPORTING UNIT:	382214	382214	382214	382214	382214		
MODE OF SVCS / SERVICE FUNCTION CODE	15/01-09	15/10-59	15/60-69	15/70-79	45/10-19		
SERVICE DESCRIPTION	Case Mgt Brokerage	MH Svcs	Medication Support	Crisis Intervention-OP	MH Promotion		TOTAL
CBHS FUNDING TERM:	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011	2010 - 2011		
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	2,335	37,495	32,317	2,247	4,177		78,572
OPERATING EXPENSE	977	15,687	13,520	940	1,748		32,872
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	3,313	53,182	45,836	3,187	5,925	-	111,444
INDIRECT COST AMOUNT	398	6,382	5,501	382	711		13,373
TOTAL FUNDING USES:	3,710	59,564	51,338	3,569	6,636	-	124,817
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)	2,412	38,750	33,399	2,322	-		76,883
ARRA SDMC FFP (11.59)							-
STATE REVENUES - click below							
MHSA	1,298	20,814	17,939	1,247	6,636		47,934
EPSDT State Match							-
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Familes							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	3,710	59,564	51,338	3,569	6,636		124,817
CBHS SUBSTANCE ABUSE FUNDING SOURCES							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES							
TOTAL DPH REVENUES	3,710	59,564	51,338	3,569	6,636		124,817
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	3,710	59,564	51,338	3,569	6,636		124,817
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]					70		
UNITS OF TIME[2]	1,846	22,909	10,673	922			
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	2.01	2.60	4.81	3.87	94.80		
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	2.01	2.60	4.81	3.87	94.80		
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)	2.43	3.13	5.78	4.65	113.91		
UNDUPLICATED CLIENTS	150	150	150	150	150		

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

FISCAL YEAR:	2010-11					APPENIDX #: B-11	
LEGAL ENTITY NAME:	Family Service Agency of San Francisco					PROVIDER #: 3822	
PROVIDER NAME:	Family Service Agency Opt. Srvs of SF					Page: 19	
REPORTING UNIT NAME::	Older Adult Behavioral Health Screening / Training - Cost Reimbursement					Date: 9/24/2010	
REPORTING UNIT:	N/A						
MODE OF SVCS / SERVICE FUNCTION CODE							
SERVICE DESCRIPTION	Training Development						TOTAL
CBHS FUNDING TERM:	2010-2011						
FUNDING USES:							
SALARIES & EMPLOYEE BENEFITS	4,219						4,219
OPERATING EXPENSE	11,495						11,495
CAPITAL OUTLAY (COST $5,000 AND OVER)							-
SUBTOTAL DIRECT COSTS	15,714	-	-	-	-	-	15,714
INDIRECT COST AMOUNT	1,886						1,886
TOTAL FUNDING USES:	17,600	-	-	-	-	-	17,600
CBHS MENTAL HEALTH FUNDING SOURCES							
FEDERAL REVENUES - click below							
SDMC Regular FFP (50%)							-
ARRA SDMC FFP (11.59)							-
STATE REVENUES - click below							
MHSA	17,600						17,600
EPSDT State Match							-
GRANTS - click below CFDA #:							
							-
State Office of Family Planning							-
PRIOR YEAR ROLL OVER - click below							
MHSA							-
WORK ORDERS - click below							
Dept of Children, Youth & Families							-
HSA (Human Svcs Agency)							-
First Five (SF Children & Family Commission) PFA							-
First Five (SF Children & Family Commission) FRC							-
3RD PARTY PAYOR REVENUES - click below							
MediCare							-
State M-Managed Care							-
Family Mosaic Capitated Medi-Cal							-
REALIGNMENT FUNDS							-
COUNTY GENERAL FUND							-
TOTAL CBHS MENTAL HEALTH FUNDING SOURCES	17,600						17,600
CBHS SUBSTANCE ABUSE FUNDING SOURCES:							
FEDERAL REVENUES - click below							
							-
STATE REVENUES - click below							
							-
GRANTS/PROJECTS - click below CFDA #:							
							-
WORK ORDERS - click below							
							-
3RD PARTY PAYOR REVENUES - click below							
							-
COUNTY GENERAL FUND							-
TOTAL CBHS SUBSTANCE ABUSE FUNDING SOURCES	-						-
TOTAL DPH REVENUES	17,600	-	-	-	-	-	17,600
NON-DPH REVENUES - click below							
TOTAL NON-DPH REVENUES	-	-	-	-	-	-	-
TOTAL REVENUES (DPH AND NON-DPH)	17,600	-	-	-	-	-	17,600
CBHS UNITS OF SVCS/TIME AND UNIT COST:							
UNITS OF SERVICE[1]							
UNITS OF TIME[2]							
COST PER UNIT-CONTRACT RATE (DPH & NON-DPH REVENUES)	CR						
COST PER UNIT--DPH RATE (DPH REVENUES ONLY)	CR						
PUBLISHED RATE (MEDI-CAL PROVIDERS ONLY)							
UNDUPLICATED CLIENTS	N/A						

[1]Units of Service: Days, Client Day, Full Day/Half-Day

[2]Units of Time: MH Mode 15 = Minutes/MH Mode 10, SFC 20-25=Hours

Amendment of the Whole
in Committee. 12/1/10

FILE NO. 100927 RESOLUTION NO. 563-10

[Contract Approval - 18 Non-Profit Organizations and the University of California of San Francisco - Behavioral Health Services - $674,388,406]

Resolution retroactively approving $674,388,406 in contracts between the Department of Public Health and 18 non-profit organizations and the University of California at San Francisco, to provide behavioral health services for the period of July 1, 2010 through December 31, 2015.

WHEREAS, The Department of Public Health has been charged with providing needed behavioral health services to residents of San Francisco; and,

WHEREAS, The Department of Public Health has conducted Requests for Proposals or has obtained appropriate approvals for sole source contracts to provide these services; and

WHEREAS, The San Francisco Charter Chapter 9.118 requires contracts over $10 million to be approved by the Board of Supervisors; and

WHEREAS, Contracts with providers will exceed $10 million for a total of $674,388,406, as follows:

Alternative Family Services, $11,057,200;

Asian American Recovery Services, $11,025,858;

Baker Places, $69,445,722;

Bayview Hunters Point Foundation for Community Improvement, $27,451,857;

Central City Hospitality House, $15,923,347;

Community Awareness and Treatment Services (CATS), $12,464,714;

Community Vocational Enterprises (CVE), $9,705,509;

Conard House, $37,192,197;

Edgewood Center for Children and Families, $29,109,089;

Family Service Agency, $45,483,140;

Hyde Street Community Service, $17,162,210;

Instituto Familiar de la Raza, $14,219,161;

Progress Foundation, $92,018,333;

Richmond Area Multi-Services, $34,773,853;

San Francisco Study Center, $11,016,593;

Seneca Center, $63,495,327;

Walden House, $54,256,546;

Westside Community Mental Health Center, $43,683,160;

Regents of the University of California, $74,904,591; and

WHEREAS, The Department of Public Health estimates that the annual payment of some contracts may be increased over the original contract amount, as additional funds become available between July 2010 and the end of the contract term; now, be it

RESOLVED, That the Board of Supervisors hereby retroactively approves these contracts for the period of July 1, 2010, through December 31, 2015; and, be it

FURTHER RESOLVED, That the Board of Supervisors hereby authorizes the Director of the Department of Public Health and the Purchaser, on behalf of the City and County of San Francisco, to execute agreements with these contractors, as appropriate; and, be it

FURTHER RESOLVED, That the Board of Supervisors requires the Department of Public Health to submit a report each June with increases over the original contract amount, as additional funds become available during the term of contracts.

RECOMMENDED:

Mitchell Katz, M.D.
Director of Health

APPROVED:

Mark Morewitz, Secretary to the
Health Commission

City and County of San Francisco
Tails
Resolution

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

File Number: 100927 **Date Passed:** December 07, 2010

Resolution retroactively approving $674,388,406 in contracts between the Department of Public Health and 18 non-profit organizations and the University of California at San Francisco, to provide behavioral health services for the period of July 1, 2010, through December 31, 2015.

December 01, 2010 Budget and Finance Committee - AMENDED, AN AMENDMENT OF THE WHOLE BEARING NEW TITLE

December 01, 2010 Budget and Finance Committee - RECOMMENDED AS AMENDED

December 07, 2010 Board of Supervisors - ADOPTED

Ayes: 11 - Alioto-Pier, Avalos, Campos, Chiu, Chu, Daly, Dufty, Elsbernd, Mar, Maxwell and Mirkarimi

File No. 100927

I hereby certify that the foregoing Resolution was ADOPTED on 12/7/2010 by the Board of Supervisors of the City and County of San Francisco.

Angela Calvillo
Clerk of the Board

Mayor Gavin Newsom

December 8, 2010
Date Approved

October 05, 2015

Family Service Agency of San Francisco
$60,460,049

File No. 151036

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): Members, San Francisco Board of Supervisors	City elective office(s) held: Members, San Francisco Board of Supervisors

Contractor Information *(Please print clearly.)*	
Name of contractor: Family Service Agency of SF	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chie f financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. 1. Please see list of members of Board of Directors attached. 2. CEO: Al Gilbert; CFO: Marvin Davis; COO: N/A 3.Persons with more than 20% ownership: N/A 4. Subcontractors listed in contract: The Regents of the University of CA, Sojourner Truth Foster, and San Francisco Nurse Family Partnership. 5. Political committees sponsored or controlled by contractor: N/A	
Contractor address: 1010 Gough Street, San Francisco, CA 94109	
Date that contract was approved:	Amount of contract: Not to exceed $60,460,049
Describe the nature of the contract that was approved: Provide a comprehensive spectrum of mental health services.	
Comments:	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☑ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244, 1 Dr. Carlton B. Goodlett Pl., San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

_____ _____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____ _____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

Felton Institute/Family Service Agency of San Francisco
2015 - 2016 Board of Directors

Officers		
Michael N . Hofman, Chair Member si nce August 2013 Term expir es August 2016 Chair, Dev elopment Committee Executive Vice President **Janet Moyer Landscaping** 1031 Valencia Street San Francisco, CA 94110	**Terry M. Limpert, Vice Chair** Member since September 2004 Term expires September 2016 Member, Development Committee Senior Partner (Retired) **Mercer Delta Consulting, LLC**	**Elisabeth Madden, Secretary** Member since September 2008 Term expires September 2017 Member, HR Committee Partner **Lynch, Gilardi and Grummer** 170 Columbus Avenue, 5th floor San Francisco, CA 94111
Directors		
Zeena Altamimi Member si nce February 2014 Term expires February 2017 Member, Development Committee Self Employed, Marketing Executive	**H. Westley Clark** Member since April 2015 Term expires April 2018 Dean's Executive Professor of Public Health **Santa Clara University** 500 El Camino Real, Kena 110 Santa Clara, CA 95053	**Amelia Morris** Member since September 2014 Term expires September 2017 Member, Finance Committee Director **Brandes Investment Partners, L.P.** 11988 El Camino Real, Suite 600 P.O. Box 919048 San Diego, CA 92191-9048
Rowena L. Nery Member since February 2002 Term expires February 2016 Member, Finance Committee Lead Reviewer **APS Healthcare – California EQRO** 560 J Street, Suite 390 Sacramento, CA 95814	**Eric Severson** Member since September 2003 Term expires September 2015 Member, Governance Committee	**James (Will) Smiley** Member since September 2011 Term expires September 2017 Chair, Governance Committee Director, US Commercial, USMA and GPS Staffing **Genentech** 1 DNA Way, MS 31-4A South San Francisco, CA 94080
Matthew H. Snyder Member since February 2014 Term expires February 2017 Chair, Finance Committee Partner / Principal **Ernst & Young** 560 Mission Street San Francisco, CA 94105	**Amy Solliday** Member since September 2006 Term expires September 2015 Chair, HR Committee Vice President, Old Navy Store Operations **Old Navy Store** 550 Terry Francois Blvd. San Francisco, CA 94158	**Chris Thiele** Member since October 2014 Term expires October 2017 Member, HR Committee Director **McKesson** 1 Post Street, #1825 San Francisco, CA 94104

07/08/15