INTEROFFICE MEMO

DATE: June 21, 2012 **PHONE:** 382-3088

FROM: SHARON NEVINS, DEPUTY DIRECTOR
DEPARTMENT OF BEHAVIORAL HEALTH

TO: MEMBERS
BEHAVIORAL HEALTH COMMISSION

SUBJECT: ACTION ITEM FOR JULY 5, 2012 BEHAVIORAL HEALTH COMMISSION MEETING

Greetings Commissioners!
Attached, for your review, is an action item for the July 5, 2012, Behavioral Health Commission meeting. Historically, the members of the Commission have reviewed the Agreement with the California Department of Mental Health for State psychiatric inpatient hospital beds prior to approval by the Board of Supervisors. This Agreement will go before the Board on July 26, 2012. Below is a summary of the attached document.

AGREEMENT WITH THE CALIFORNIA DEPARTMENT OF MENTAL HEALTH FOR STATE PSYCHIATRIC INPATIENT HOSPITAL BEDS (Agreement No. 11-79036-000)

BACKGROUND INFORMATION

This item will allow the Department of Behavioral Health (DBH) to contract with the California Department of Mental Health (State) to provide state hospital level services in an amount not to exceed $2,589,036 for the period of July 1, 2011 through June 30, 2012. DBH anticipates that approximately 42 unduplicated patients will be served during 2011-12 at an annual cost of $61,644 per client. Each patient's length of stay varies and is dictated by the severity of the patient's mental illness. Sections 4330 through 4335 of the California Welfare and Institutions Code (WIC) require State and the County of San Bernardino (County) to contract for the utilization and reimbursement of state hospital beds.

DBH is responsible for providing mental health, alcohol, and substance abuse services to County residents who are experiencing major mental illness, substance abuse, and other addictions. An integral part of the service delivery system consists of providing psychiatric inpatient state hospital services to the seriously and persistently mentally ill population.

DBH operates a continuum of care system that consists of County operated clinics and contracted service providers delivering a variety of mental health treatment services within each geographic region of the County. The state hospital psychiatric unit allows DBH to accommodate seriously and persistently mentally ill patients at an appropriate level of care in a psychiatric inpatient state hospital setting. Annually, DBH notifies the State of the number of state hospital beds anticipated to be used by the County during the upcoming fiscal year. This request serves as the County's bed agreement, until it is replaced by the State Hospital Bed Purchase Contract which is usually received toward the end of the fiscal year. Pursuant to WIC Section 4331, contracts must specify the number of beds to be provided, rate(s) of reimbursement, services requested by the County, procedures for admission and discharge, and any other pertinent terms as agreed to by the State and County.

The highest level of care is the state hospital psychiatric unit; the next highest level of treatment is provided through the Institute of Mental Disease (IMD). Patients in need of a lower level of care are placed in board and care facilities. Programs at each facility depend on the patient's level of care, specific patient needs, and condition under which the patient is admitted. State hospitals provide services to patients who are committed pursuant to sections of the Penal Code and WIC or who are found to be incompetent to stand trial.

County residents in need of State Hospital level of services are primarily admitted to Metropolitan State Hospital (Metro) in Norwalk and Patton State Hospital (Patton) in San Bernardino. Metro, also a skilled nursing facility (SNF), specializes in acute care (severe symptoms that last for a short period of time), sub-acute care (recent onset, somewhat rapid symptoms lasting less than 3 months), and psychiatric rehabilitation. Patton provides state-of-the-art sub-acute mental health care and treatment to forensic and civilly committed patients in need of a structured, secure environment.

RECOMMENDATION

Review Agreement (State Agreement No. 11-79036-000) with the California Department of Mental Health for hospital beds and inpatient health care and support services provided to adults and children with psychiatric disabilities, in the amount of $ 2,589,036, for the period July 1, 2011 through June 30, 2012.

Should you have any questions, please contact my office at 909-382-3088. Thank you for advocating for quality behavioral health services provided to the residents of San Bernardino County.

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213 (Rev 06/03)

AGREEMENT NUMBER
11-79036-000
REGISTRATION NUMBER

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME
California Department of Mental Health

CONTRACTOR'S NAME
San Bernardino County Behavioral Health

2. The term of this Agreement is: July 1, 2011 through June 30, 2012

3. The maximum amount of this Agreement is: $2,589,036.00 Payable by the County to the State
Two Million Five Hundred and Eighty-Nine Thousand Thirty-Six Dollars and Zero Cents

4. The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement.

Exhibit A – Scope of Work	17 pages
Exhibit B – Budget Detail and Payment Provisions	1 page
Exhibit B – Attachment	2 pages
Exhibit C* – General Terms and Conditions	GTC-610

Check mark one item below as Exhibit D:

X	Exhibit - D Special Terms and Conditions (Attached hereto as part of this agreement)	2 pages
	Exhibit - D* Special Terms and Conditions	

Items shown with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto. These documents can be viewed at www.ols.dgs.ca.gov/Standard+Language

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR		***California Department of General Services Use Only***
CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)* San Bernardino County Behavioral Health		
BY *(Authorized Signature)*	DATE SIGNED *(Do not type)*	
PRINTED NAME AND TITLE OF PERSON SIGNING		
ADDRESS 268 West Hospitality Lane, Suite 400 San Bernardino, CA 92415		
STATE OF CALIFORNIA		
AGENCY NAME California Department of Mental Health		
BY *(Authorized Signature)*	DATE SIGNED *(Do not type)*	
PRINTED NAME AND TITLE OF PERSON SIGNING Kathryn Radtkey-Gaither, Chief Deputy Director		☒ Exempt per: WIC 4331(a)
ADDRESS 1600 9th Street, Room 101, Sacramento, CA 95814		

DMH USE ONLY
☐ State Master ☐ Contractor ☐ Contract Manager ☐ Accounting ☐ State Controller

EXHIBIT A
STATE HOSPITAL BED PURCHASE AND USAGE

RELATIONSHIP OF THE PARTIES

The California Department of Mental Health, hereafter referred to as the "DMH" and the County hereafter referred to as "Contractor" are, and shall at all times be deemed to be, independent agencies. Each party to this contract shall be wholly responsible for the manner in which it performs the services required of it by the terms of this contract. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The DMH, and its agents and employees, shall not be entitled to any rights or privileges of Contractor employees and shall not be considered in any manner to be Contractor employees. The Contractor, its agents and employees, shall not be entitled to any rights or privileges of state employees and shall not be considered in any manner to be state employees.

SCOPE OF WORK

I. PURPOSE AND DESCRIPTION OF SERVICES

A. Facilities, Payments and Services

Section 4330 of the California Welfare and Institutions Code (WIC) requires counties to reimburse the DMH for use of state hospital beds/services provided pursuant to Part 1 (commencing with Section 5000) of Division 5 of the WIC. The Contractor shall compensate the DMH and the DMH agrees to provide the services, including staffing, facilities, equipment and supplies in accordance with the provisions of Exhibit B of this Standard Agreement, hereafter referred to as the "Agreement."

The DMH has jurisdiction over Atascadero, Metropolitan, Napa and Patton State Hospitals, hereafter referred to as the "Hospitals," which provide services to persons with mental disorders, in accordance with the WIC Section 4100 et seq. The DMH shall operate the Hospitals continuously throughout the term of this contract with at least the minimum number and type of staff which meet applicable state and federal regulations and which are necessary for the provisions of the services hereunder. Contractor reimbursements shall be made in accordance with Exhibit B of this Agreement.

B. Records and Services

1. The Contractor may review the quantity and quality of services provided pursuant to this Agreement, including the following:

a. Medical and other records of Contractor patients. A copy of the review report, if any, shall be provided to the hospital.

b. Hospital procedures for utilization review and quality assurance (QA) activities and related committee minutes and records, except for privileged communications and documents.

c. Periodic meetings regarding the quantity and quality of services are encouraged with the hospital Medical Director, or designee.

C. Contractor Responsibility

1. The Contractor shall screen, determine the appropriateness of, and authorize all referrals for admission of Contractor patients to the Hospitals. The Contractor shall, at the time of admission, provide admission authorization, identify the program to which a patient is being referred, and identify the estimated length of stay for each Contractor patient. However, the hospital Medical Director or designee shall make the determination of the appropriateness of a Contractor referred patient for admission to a hospital and assign the patient to the appropriate level of care and treatment unit.

2. The Contractor shall provide such assistance as is necessary to assist the hospital treatment staff to initiate, develop and finalize discharge planning and necessary follow-up services.

3. The Contractor shall provide such assistance as is necessary to assist in the screening of Contractor patients for alternative placements, and shall facilitate such placements.

4. The Contractor shall provide case management services, as defined in I (Coordination of Treatment/Case Management) of Exhibit A.

D. Description of Covered Hospital Services

1. The DMH shall provide Lanterman-Petris-Short (LPS) hospital services only to those persons referred by the Contractor specifically for services under this Agreement, including those admitted pursuant to Sections 1370.01 of the Penal Code (PC) and Murphy Conservatorship (Section 5008(h)(1)(B) of the WIC). When patients, committed pursuant to provisions of the PC are converted to LPS billing status they shall become the financial responsibility of the Contractor of first admission and part of that Contractor's LPS dedicated bed capacity as described in G (Admission and Discharge Procedures) of Exhibit A.

   Former inmates of the California Department of Corrections and Rehabilitation (CDCR) who convert to Murphy Conservatees following concurrent Incompetent to Stand Trial (IST) commitments shall, at the expiration of their CDCR commitment, be the responsibility of the Contractor that sent the inmate to prison.

The Contractor Mental Health Director, or designee, shall be involved in the conversion process and the conversion shall be made in accordance with the provisions of R (Notices), item 4 of Exhibit A and the provisions of Divisions 5 and 6 of WIC.

The following services are provided:

Psychiatric and Ancillary Services-

The DMH shall provide inpatient psychiatric health care and support services, including appropriate care and treatment to Contractor patients who suffer from mental, emotional or behavioral disorders and who have been referred to the Hospitals by the Contractor.

The DMH shall not refuse to admit patients referred from the Contractor when the Contractor has a bed available within its dedicated capacity and the patient, in the judgment of the hospital Medical Director or designee, meets the established criteria for admission, and any other provisions contained in this Agreement.

The Hospitals shall provide psychiatric treatment and other services in accordance with all applicable laws and regulations, including, but not limited to, Title 22 and Title 9 of the California Code of Regulations (CCR).

The Hospitals shall provide all ancillary services necessary for the evaluation and treatment of psychiatric conditions. To the extent possible, medical procedures performed prior to a patient's admission to the hospital shall not be duplicated.

2. Expert Testimony

The DMH and the Contractor shall provide or cause to be provided expert witness testimony by appropriate mental health professionals in legal proceedings required for the institutionalization, admission, or treatment of Contractor patients. These proceedings may include, but not be limited to, writs of habeas corpus, capacity hearings (Reise) as provided in Section 5332 et seq. of the WIC, conservatorship, probable cause hearings, court-ordered evaluation and appeal and post-certification proceedings.

3. Health Care Services

The DMH shall provide or cause to be provided any health care services, including physician or other professional services, required by Contractor patients served pursuant to this Agreement. In cases where non-emergent or elective medical/surgical care is recommended by hospital medical staff and where the cost for such care is likely to exceed $5,000, the hospital Medical Director shall confer with the Contractor's Medical Director, or designee, regarding the provision of service, including the option that, at the Contractor's discretion, the Contractor may make arrangements for the provision of such service.

4. Electro-Convulsive Therapy

   The Hospitals may cause to be provided Electro-Convulsive Therapy, herein referred to as "ECT," in accordance with applicable laws, regulations, and established state policy.

5. Transportation

   The Contractor is responsible for transportation to and from the Hospitals, including court appearances, Contractor-based medical appointments or services, and pre-placement visits and final placements. The Contractor is also responsible for transportation between Hospitals when the Contractor initiates the transfer. The hospitals are responsible for other transportation between the Hospitals and transportation to and from local medical appointments or services.

E. Standards of Care

1. Staffing

   a. The Hospitals shall staff each hospital unit which provides services under this Agreement in accordance with acceptable standards of clinical practice, applicable state staffing standards and any applicable court orders or consent decrees. The DMH shall provide administrative and clerical staff to support the staffing specified and the services provided hereunder.

   b. The Hospitals shall make a good faith effort to provide sufficient bilingual staff with experience in a multicultural community sufficient to meet the needs of patients treated pursuant to this Agreement.

2. Licensure

   The Hospitals shall comply with all applicable federal and state laws, licensing regulations and shall provide services in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment. The Hospitals, which are accredited, shall make a good faith effort to remain accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) throughout the term of this Agreement.

3. Patient Rights

   a. The Hospitals shall in all respects comply with federal and state requirements regarding patient rights in accordance with Sections 5325 and 5325.1 of the WIC and Sections 862 through 868 of Title 9 of the CCR. The Hospitals shall include ECT reporting, as required by law, in its quarterly "Electro-Convulsive Therapy" report submitted to the DMH.

   b. The Hospitals shall follow established procedures for resolving patient complaints. Patient complaints relating to violations of their rights during their

hospitalization shall be handled and resolved by the DMH Contract Advocate, Disability Rights California. Patient rights issues pertaining to matters outside the jurisdiction of the Hospitals, shall be the responsibility of the Contractor patients' rights advocate. Issues relating to the denial of patients' rights pursuant to Section 5325 of the WIC, shall be reported quarterly to the DMH, as required by law, on the DMH "Denial of Rights" form.

4. Informed Consent

The Hospitals shall comply with applicable law relating to informed consent.

F. Planning

The Contractor may participate in regional committees of the CMHDA Long Term Care Committee. Staff from the DMH Division of Administration and staff from the Hospitals used by regional members shall meet with the regional committee at the chairperson's request to discuss program, staffing, and capacity changes. These types of issues may also be discussed between the DMH and the counties as part of the agenda of the CMHDA Long Term Care Committee and when appropriate with the CMHDA Executive Board.

G. Admission and Discharge Procedures

1. Admission Procedures

a. The Contractor shall be directly involved in referring Contractor patients for admission to the Hospitals, discharge planning, and the actual discharge process. When an individual committed pursuant to provisions of the PC is converted to an LPS commitment, the Contractor Mental Health Director, or designee, shall be involved as provided in this Agreement and in accordance with the provisions of Divisions 5 and 6 of the WIC.

b. If the Contractor is below dedicated capacity, it shall have immediate access to a bed for any Contractor patient who is determined by the hospital Medical Director, or designee, to be clinically appropriate for the available bed/service. Admission shall be accomplished in accordance with hospital admitting procedures and admission hours. The Hospitals shall make a good faith effort to flexibly accommodate patients referred for admission in a manner which maximizes access to appropriate hospital beds and services.

c. If the Contractor is at or above its dedicated capacity, the Contractor may arrange a bed exchange with another Contractor, which is below its dedicated capacity. At the time of admission the hospital shall be provided written authorization from both the referring Contractor and the Contractor whose bed will be used. Copies shall also be provided to the Department's Deputy Director of Administration.

d. If, for any reason, a Contractor patient is in a bed that is inappropriate to that patient's needs, the attending clinician shall develop, in consultation with the

treatment team and the Contractor, except when the urgency of the patient's situation precludes such consultation, a plan for transfer of the patient to an appropriate unit in accordance with the treatment plan.

e. All denials of admission shall be in writing with an explanation for the denial. Denials shall not occur if the patient meets the admission criteria and the Contractor has dedicated capacity available, or has obtained authorization from another Contractor to use its available dedicated capacity. A denial of admission may be appealed as provided in G3a (Appeal Procedures-Admissions), found within this section.

2. Discharge Procedures

a. Discharge planning shall begin at admission.

b. The development of a discharge plan and the setting of an estimated discharge date shall be done jointly by the treatment team and the Contractor's designated case manager. The treatment plan shall identify the discharge plan.

c. A hospital shall discharge a patient at the Contractor's request or in accordance with the approved discharge plan except: (1) if at the time the discharge is to occur, the hospital's Medical Director, or designee, determines that the patient's condition and the circumstances of the discharge would pose an imminent danger to the safety of the patient or others; or, (2) when a duly appointed conservator refuses to approve the patient's discharge or placement. A denial of discharge may be appealed as provided in G.3.b. (Discharges), found within this section.

3. Appeal Procedures

a. Admissions

When agreement cannot be reached between the Contractor staff and the hospital admitting staff regarding whether a patient meets or does not meet the admission criteria for the bed(s) available, the following appeal process shall be followed. When the Contractor staff feel that impasse has been reached and further discussions would not be productive, the denial of admission may be appealed, along with all available data and analysis to the hospital Medical Director and the Contractor Mental Health Director. Such appeals may be made immediately by telephone. If the hospital Medical Director and the Contractor Mental Health Director are unable to achieve agreement, the case may be referred to the Deputy Director of Administration within two (2) working days. The Deputy Director shall discuss the case with the Contractor Mental Health Director and may obtain additional consultation. The Deputy Director shall render a final decision within two (2) working days after receiving the documented basis on which the appeal is based.

b. Discharges

When the hospital Medical Director, or designee, determines that discharge cannot occur in accordance with the approved plan or upon the request of the Contractor, he/she will contact the Contractor Mental Health Director or designee immediately to review the case and shall make every effort to resolve the issues preventing the discharge. If this process does not result in agreement, the case may be referred to the Deputy Director, Administration, by the Contractor Mental Health Director within one (1) working day of the hospital's denial. The Deputy Director after consultation with the Contractor Mental Health Director and others shall make the final decision within two (2) working days of receiving the documentation of the basis of the disagreement regarding discharge, and communicate this decision to the Contractor Mental Health Director and the hospital Medical Director by telephone followed by written confirmation.

4. Penalties

   a. Should the DMH fail to process appeals from the Contractor relating to the denial of admissions or discharges within the timelines specified in the preceding G3a and G3b, the Contractor shall be allowed to use additional bed days equal to the number of days lost due to the DMH's failure to respond within the established time lines. The penalty days thus provided shall be in the cost center to which the patient in question was referred.

   b. If the decision on appeal is against the hospital, the Contractor is allowed to use additional bed days equal to the number of days lost due to the hospital's failure to admit or discharge the patient in accordance with the Contractor's request.

H. Prior Authorization

The Contractor shall, prior to admission, provide the hospitals with a completed Short-Doyle Authorization Form (MH 1570) and all applicable court commitment orders. An initial projected length of stay shall be identified by the Contractor and addressed in the patient's treatment plan and discharge plan.

I. Coordination of Treatment/Case Management

Client services must be integrated and coordinated across levels of care, and an active case management system is a critical factor in this continuity of care. Accordingly, the DMH and Contractor shall agree to the following case management system:

1. The Contractor shall develop an operational case management system for Contractor patients, and shall identify a case manager or case management team for each Contractor patient. The duties of the case manager shall include, but are not limited to:

   a. Providing available assessment information on patients admitted to the hospitals.

b. Participating in-person or by telephone in an initial meeting with the patient and the hospital treatment team within a reasonable time frame after admission, for purposes of participating in the development of a treatment plan and a discharge plan, and to determine the level of the case manager's involvement during the patient's hospitalization. The treatment plan shall form the basis for the treatment and services provided to the Contractor patient.

c. Meeting, in-person, with the Contractor patient and with the hospital treatment team on a regular basis, not to exceed 180 days between meetings, to provide direct input into the development and implementation of the patient's treatment plan.

d. Ensuring that appropriate alternative placement options are developed as a part of the discharge planning process, and working closely with the hospital treatment teams to assure that discharges take place when and in a manner agreed upon by the hospital Medical Director or designee, and the Contractor Mental Health Director or designee.

2. The Hospitals shall encourage and facilitate the involvement of the case managers in the treatment team process, by providing, among other services, notification of treatment plan conferences or 90-day reviews no less than two weeks prior to the date of the conference or review. The Hospitals shall identify an appropriate treatment team member to function as the primary contact for the case manager or the case management team.

3. A treatment plan shall be used for planning services for each Contractor patient, and it shall identify each goal and objective for the patient with projected time lines for their completion. Development of the treatment plan shall be the responsibility of the hospital with Contractor consultation as requested. The Contractor case manager shall review the treatment plan and indicate in writing his/her agreement or disagreement. The treatment plan shall be developed in accordance with the following requirements:

a. The plan shall address reasons for admission.

b. Patient treatment and stabilization directed toward expediting discharge shall be considered the desired outcome for all Contractor patients, and all interventions shall relate to achieving discharge.

c. Any special treatment needs shall be addressed in the treatment plan.

d. The Hospitals shall provide programs which assist patients in achieving the objective of returning to a level of community living (i.e., a facility offering a protective environment, a residential facility, a board and care facility, independent living, etc.).

e. The treatment plan shall identify responsibility for each item included in the plan.

f. The treatment plan shall not be changed solely based upon staffing changes within the Hospitals.

g. The Contractor case manager/case management team shall be consulted whenever substantial changes to a patient's treatment plan are under consideration.

4. The case manager shall be encouraged to participate in treatment team meetings, clinical reviews or utilization review meetings and in clinical rounds that relate to Contractor patients.

5. Primary criteria for continued treatment in the hospitals shall include, but not be limited to, the medical necessity of hospitalization within the state hospital setting, including LPS criteria, as reflected within the medical record. If the Contractor Director of Mental Health or designee concludes that a Contractor patient no longer meets these primary criteria, Contractor may direct the hospital to discharge the patient to a facility that Contractor determines to be more appropriate to the patient's treatment requirements. In such cases, discharge must occur within two (2) days of the date an alternative placement option is identified and available except as provided in G.2.c. (Admission and Discharge Procedures), of Exhibit A or otherwise required by law.

6. When agreement cannot be reached between case manager and the treatment team regarding treatment, transfer, and/or discharge planning, the issues shall be referred to the hospital's Medical Director and the Contractor Mental Health Director within three (3) days. On specific treatment issues the Medical Director's decision shall be final. Any agreement or program policy issues arising from discussions which are not resolved between the Medical Director and the Contractor Mental Health Director shall be referred to the Deputy Director of Administration within five (5) working days. The Deputy Director will review the case with the Contractor Mental Health Director. A response on the referred issue shall be communicated to the Contractor Mental Health Director within two (2) working days after the Chief receives the documented basis for the appeal.

J. Patient's Rights

The parties to this Agreement shall comply with applicable laws, regulations and state policies relating to patient's rights.

K. Bed Usage

1. During the 2011-12 fiscal year, the DMH shall provide, within the Hospitals, specific numbers of beds dedicated to the care of only those patients referred by the Contractor, including those admitted pursuant to Section 1370.01 of the PC and Murphy Conservatorships (Section 5008(h)(1)(B) of the WIC). The number and type of beds are specified in Exhibit B-Attachment.

2. For the purposes within this Agreement the term "dedicated beds" shall mean that the Hospitals shall ensure that the number of beds contracted for by a Contractor in a particular cost center category shall be available to the Contractor at all times for patients who are appropriate for the services and facilities included in that cost center at the hospital to which the patient is being referred. Hospital admissions, intra-hospital transfers, referrals to outside medical care, and discharges shall be in accordance with the admission criteria established by the DMH and Contractor, and the judgment of the hospital Medical Director or designee.

3. The Contractor shall be considered to have exceeded its dedicated capacity on any given day on which more Contractor patients are assigned to a cost center than the Contractor has dedicated capacity in that cost center. The Contractor shall only be permitted to use beds in excess of its dedicated capacity when use does not result in denial of access of other counties to their dedicated capacity. The Contractor's use in excess of the Agreement amount shall be calculated as provided in Exhibit B-Attachment of this Agreement.

   The DMH shall review the Contractor's use of state hospital beds in accordance with this Agreement on a monthly basis to determine if the dollar value of the Contractor's use has exceeded the dollar value of the Contractor's contracted beds during the respective half year periods of this Agreement.

   Excess use shall be established when the net dollar value of the Contractor's actual use exceeds the contracted amount for the period under consideration. The Contractor shall be obligated to pay the contract amount for the period or the dollar value of the Contractor's actual use for the period whichever is greater.

   The Contractor's obligation shall not be reduced below the contract amount set forth in Exhibit B-Attachment.

4. If the Contractor does not contract for any state hospital beds, it may purchase access to a dedicated bed from other counties. Notwithstanding the fact that the Contractor does not purchase any state hospital dedicated bed, the Contractor shall be financially responsible for its use of state hospital resources resulting from, but not limited to, the conversion of PC commitments to Murphy Conservatorships (Section 5008(h)(1)(B) of the WIC).

5. There shall be no decrease in the number of beds provided by the DMH within the hospitals and within a cost center, unless this Agreement is amended by mutual agreement no later than January 1, 2012 (Section 4331(b)(3) of the WIC). There shall be no increase in the number of beds provided by the DMH within the hospitals and within a cost center, unless this Agreement is amended by mutual agreement (Section 4331(c) of the WIC).

6. When the Contractor has a patient at a hospital other than at its primary use LPS hospital, it shall use one of its vacant dedicated beds, in an equivalent cost center at its primary use LPS hospital, to cover the costs of that patient's care. If the Contractor has no available dedicated capacity, it shall obtain the required

capacity by purchasing it from a Contractor that has available capacity in the proper cost center, purchase the services from the DMH as provided in the preceding item 3 or by amending this Agreement as provided herein.

7. The DMH, in consultation with the agencies who refer patients to the Hospitals, may provide special programs for patients with unique needs, e.g., hearing impairment, Neurobehavioral problems, etc. The Contractor shall have access to these beds on a first come first served basis. If the Contractor's dedicated capacity for the cost center in which the specialty unit(s) reside is all in use or if the Contractor does not have any dedicated capacity in the cost center, the Contractor may use any other of its available dedicated capacity to support the admission to the specialty unit(s).

L. Utilization Review

1. The hospitals shall have an ongoing utilization review program which is designed to assure appropriate allocation of the hospitals' resources by striving to provide quality patient care in the most cost-effective manner. The utilization review program shall address over-utilization, under-utilization, and the scheduling or distribution of resources. Hospitals that provide services which are certified for participation in the federal Medicare or Medi-Cal programs shall meet any additional requirements imposed by those certification regulations.

2. Contractor representatives shall take part in the utilization review and performance improvement activities at the hospital program and unit level relating to Contractor patients. Contractor case manager participation in utilization review and discharge planning may include attendance at treatment team and program meetings. The Hospitals shall include the Contractor's monitoring of the quality and appropriateness of the care provided to Contractor patients. The Hospitals shall provide the Contractor with information regarding the schedule of hospital-wide and patient specific utilization review activities. The Hospitals shall also provide the Contractor, upon request, summary aggregate data regarding special incidents.

3. Utilization review activities shall address the appropriateness of hospital admissions and discharges, clinical treatment, length of stay and allocation of hospital resources to most effectively and efficiently meet patient care needs.

M. Performance Improvement

1. The Hospitals shall have ongoing Performance Improvement (PI) activities designed to objectively and systematically evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.

2. The Hospitals PI activities shall address all of the elements of QA which are required by applicable sections of the Title 22 of the CCR, Federal Medicare certification regulations, and the standards of JCAHO. The Hospitals shall

provide to the Contractor summary data relating to aggregate review of incident reports, reports of untoward events, and related trend analysis.

3. PI activities shall address the quality of records, including but not limited to, quality review studies and analysis, peer review and medication monitoring procedures, drug use studies, medical care evaluation and standards studies, profile analysis and clinical care standards addressing patient care.

4. In accordance with the provisions outlined in L (Utilization Review), item 2, Contractor representatives may take part in PI activities at the hospitals program and unit levels and in monitoring the quality and appropriateness of care provided to Contractor patients.

N. Exchange of Information

1. The parties shall make a good faith effort to exchange as much information as is possible, to the extent authorized by law. Such information may include, but not be limited to, medication history, physical health status and history, financial status, summary of course of treatment in the hospitals or at the county, summary of treatment needs, and discharge summary.

2. The exchange of information will apply only to patients referred by the Contractor who are to be hospitalized, are currently hospitalized, or have been discharged from the hospital. Requests for information regarding any other patient shall be accompanied by an authorization to release information signed by the patient.

O. Records

1. Patient Records

The Hospitals shall maintain adequate medical records on each individual patient. These medical records shall include legal status, diagnosis, psychiatric evaluation, medical history, individual treatment plan, records of patient interviews, progress notes, recommended continuing care plan, discharge summary and records of services provided by various professional and paraprofessional personnel in sufficient detail to permit an evaluation of services.

2. Financial Records

The DMH shall prepare and maintain accurate and complete financial records of the Hospitals' operating expenses and revenue. Such records shall reflect the actual cost of the type of service for which payment is claimed, on an accrual basis. Additionally, such records shall identify costs attributable to the Contractor LPS patients, versus other types of patients to whom the Hospitals provide services. Any apportionment of or distribution of costs, including indirect costs, to or between programs or cost centers of the hospitals shall be documented, and shall be made in accordance with generally accepted accounting principles and applicable laws, regulations and state policies. The patient eligibility determination and any fee charged to and collected from patients, together with a record of all billings rendered and revenues received from any source, on behalf of patients treated pursuant to this Agreement, must be reflected in the hospital financial records.

3. Retention of Records

a. All financial or patient records for patients who have not yet been discharged shall be retained until the patient has been discharged, at which time the record retention requirements in b through d below shall apply.

b. Financial records shall be retained by the DMH in accordance with the provisions of the State Administrative Manual, Section 1671. This section requires that most financial records, including CALSTARS reports, be kept for two (2) years. After the two (2) years they are to be kept until audited or an additional four (4) years, whichever occurs first. Contractor financial records relating to this Agreement shall be retained in accordance with applicable law, regulation, and Contractor policy.

c. Patient records for adults (age 18 and over) shall be retained by the DMH for a minimum of seven (7) years from the date of discharge.

d. Patient records of persons under the age of eighteen (18) years who have been discharged shall be retained for one (1) year past the person's eighteenth (18th) birthday, or for seven (7) years, whichever is greater.

e. Records which relate to litigation or settlement of claims arising out of the performance of this Agreement, or costs and expenses of this Agreement as to which exception has been taken by the parties to this Agreement, shall be retained by the parties until disposition of such appeals, litigation, claims, or exceptions are completed.

f. Except for records which relate to litigation or settlement of claims, the parties may, in fulfillment of their obligations to retain the financial and patient records as required by this Agreement, substitute photographs, micro-photographs, or other authentic reproductions of such records which are mutually acceptable to the parties, after the expiration and two (2) years following termination of

this Agreement, unless a shorter period is authorized, in writing, by the parties.

P. Revenue

The Contractor and the DMH agree to comply with all of the applicable provisions of Sections 7275 through 7278 of the WIC.

The DMH shall collect revenues from patients and/or responsible third parties, e.g., Medicare, Medi-Cal, and insurance companies, in accordance with the provisions of the above-cited sections of the WIC and related state laws, regulations and policies. When the Contractor acts as the conservator of the patient and has control of the patient's estate it shall, on behalf of the patient's estate, pay the DMH for state hospital care in the same way that it pays other financial obligations of the patient's estate.

Q. Inspections and Audits

1. Consistent with confidentiality provisions of Section 5328 of the WIC, any authorized representative of the Contractor shall have reasonable access to the books, documents and records, including medical and financial records and audit reports of the DMH for the purpose of conducting any budget or fiscal review, audit, evaluation, or examination during the periods of retention set forth under O (Records) of Exhibit A. The Contractor representative may at all reasonable times inspect or otherwise evaluate the services provided pursuant to this Agreement, and the premises in which they are provided. The Contractor Mental Health Department shall not duplicate investigations conducted by other responsible agencies or jurisdictions, e.g., State Department of Health Services (Hospital Licensing), Contractor Coroner's Office, District Attorney's Office, and other review or regulatory agencies. Practitioner specific peer review information and information relating to staff discipline is confidential and shall not be made available for review.

2. The Hospitals shall actively cooperate with any person specified in paragraph 1 above, in any evaluation or monitoring of the services provided pursuant to this Agreement, and shall provide the above-mentioned persons adequate space to conduct such evaluation or monitoring. As each of the Hospitals have contracts with several counties, the Executive Director of the Hospitals shall coordinate the access described in paragraph 1, above, in such a manner as to not disrupt the regular operations of the Hospitals.

R. Notices

1. The DMH has designated the Deputy Director of Administration to be its Project Coordinator for all issues relating to this Agreement. Except as otherwise provided herein, all communications concerning this Agreement shall be with the Project Coordinator. The Contractor has designated the following as its Project

Coordinator and except as otherwise provided herein, all communication concerning this Agreement shall be with the Contractor Project Coordinator:

CaSonya Thomas, MPA

2. The Hospitals shall notify the Contractor immediately by telephone or FAX, and in writing, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature which involves one of the Contractor patients. Such occurrences shall include, but are not limited to, homicide, suicide, accident, injury, battery, patient abuse, rape, significant loss or damage to patient property, and absence without leave.

3. The Hospitals shall notify the Contractor Mental Health Director or designee by telephone at the earliest possible time, but not later than three (3) working days after the treatment team determines that a patient on a PC commitment will likely require continued treatment and supervision under a Contractor LPS commitment after the patient's PC commitment expires. Such telephone notification shall be followed by a written notification to the Contractor Mental Health Director, or designee, which shall be submitted within ten (10) working days of the date the treatment team's determination that continued treatment and supervision should be recommended to the Contractor. The written notice must include the basis for the hospital's recommendation and the date on which the PC commitment will expire. (See the following item 5.)

   The above notices to the Contractor Mental Health Director, or designee, shall be given not less than thirty (30) days prior to the expiration of the PC commitment. If the hospital fails to notify the Contractor at least thirty (30) days prior to the expiration of the PC commitment, the Contractor's financial responsibility shall not commence until thirty (30) days after the hospital's telephone notification. However, if the DMH is given less than thirty (30) days to change a patient's commitment by court order, the DMH shall notify the Contractor of this change at the earliest possible time. In the event a court order provides the DMH less than thirty (30) days to notify the Contractor, the Contractor's financial responsibility shall commence on the day after the expiration of the PC commitment.

   The Contractor shall be responsible for making the decision regarding the establishment of any LPS commitment at the expiration of the PC commitment. The Contractor shall notify the hospital, in writing, at least fifteen (15) days prior to the expiration of a patient's PC commitment of its decision regarding the establishment of an LPS commitment and continued hospitalization. If the Contractor decides not to establish an LPS commitment or to remove the patient from the hospital, the Contractor shall be responsible to transport the patient from the hospital back to the Contractor or another treatment facility or residential placement. If the Contractor is given less than fifteen (15) days prior to the expiration of a patient's PC commitment to make its decision, the Contractor shall notify the DMH of its decision at the earliest possible time prior to expiration of the patient's PC commitment.

4. The Hospitals shall notify the Contractor Mental Health Director, or designee, of the conversion of a patient on LPS status to a PC commitment status that results in the DMH becoming financially responsible for the placement of the patient and removes the patient from the Contractor's dedicated capacity as defined in the preceding section K (Bed Usage). The Hospital shall notify the Contractor Mental Health Director, or designee, by telephone at the earliest possible time, but not later than three (3) working days after such conversion. Such telephone notification shall be followed by a written notification to the Contractor Mental Health Director, or designee, which shall be submitted no later than ten (10) working days after the patient's conversion.

5. For purposes of this Agreement, any notice to be provided by the Contractor to the DMH shall be given by the Contractor Mental Health Director or by other authorized representatives designated in writing by the Contractor.

S. Notification of Death

1. The Hospital shall notify the Contractor by telephone immediately upon becoming aware of the death of any person served hereunder, if the patient is an inpatient in the hospital or is on leave from the hospital but is still considered an inpatient at the time of death. However, such notice need only be given during normal business hours. In addition, the Hospitals shall use their best efforts to, within twenty-four (24) hours after such death, send a FAX written notification of death to the Contractor.

2. The telephone report and written notification of death shall contain the name of the deceased, the date and time of death, the nature and circumstances of the death, and the name of the hospital representative to be contacted for additional information regarding the patient's death.

II. SPECIFIC PROVISIONS

A. The DMH has designated the Deputy Director, Administration for all issues relating to this Agreement, to be its Project Coordinator. Except as otherwise provided herein, all communications concerning this Agreement shall be with the Project Coordinator.

B. No amendment or modification to the terms and conditions of this Agreement, whether written or verbal, shall be valid unless made in writing and formally executed by both parties.

Any amendments to this Agreement may include increases or decreases in the number of beds purchased within a cost center for the remainder of the current Agreement term. In the case of a decrease in the number of beds purchased within a cost center, the Contractor will remain responsible for the fixed costs of the beds which are eliminated pursuant to such Agreement amendment, unless the DMH contracts these beds to another entity, in which case the Contractor shall be absolved of all charges for such beds. In the case of an increase in the number of

beds purchased within a cost center, the purchase cost shall be the rate established for those beds for the current fiscal year.

C. The parties understand and agree that this Agreement shall not be terminated during its term. The provisions for altering this Agreement during its life are articulated in B, above.

   Section 4331 of the WIC defines the process to be followed in renewing the Contractor's contract for state hospital services. The parties understand that this annual renewal process is for the purpose of ensuring an orderly adjustment in the use of the Hospitals by Contractor.

D. Should the DMH's ability to meet its obligations under the terms of this Agreement be substantially impaired due to loss of license to operate, damage or malfunction of the physical facilities, labor unions, or other cause, the DMH and the Contractor shall negotiate modifications to the terms of this Agreement which ensure the safety and health of Contractor patients.

EXHIBIT B
STATE HOSPITAL BED PURCHASE AND USAGE

BUDGET DETAIL AND PAYMENT PROVISIONS

I. CONTRACT AMOUNT AND PAYMENT PROVISIONS

A. The amount payable by the Contractor to the DMH concerning all aspects of this Agreement shall be $2,589,036. The amount reflected here was computed based on the information contained in the Exhibit B-Attachment. The amount represents the application of the "State Hospital Rates for Fiscal Year 2011-12", as published in a letter from DMH to Local Mental Health Directors dated September 1, 2010, entitled "STATE HOSPITAL RATES AND PLANNING ASSUMPTIONS FOR FISCAL YEAR 2011-12" which by this reference is made a part hereof, to the Contractor's contracted beds.

B. Any Contractor bed use in excess of the contracted amount, as defined in Exhibit A (Bed Usage), during the 2011-12 fiscal year, shall be an additional cost to the Contractor and collected by adjusting the State Controller's Schedule "B" on a monthly basis.

C. To the degree that revenue projections are not realized, the Contractor shall be responsible for the cost of its state hospital use up to the FY 2011-12 rates to counties published in Enclosure A of the DMH letter referenced in A, above.

II. BUDGET CONTINGENCIES

A. This Agreement is subject to any restrictions, limitations, or conditions enacted by the Legislature and contained in the Budget Act or any statute enacted by the Legislature which may affect the provisions, terms, or funding of this Agreement in any manner. If statutory or regulatory changes occur during the term of this Agreement, both parties may renegotiate the terms of the Agreement affected by the statutory or regulatory changes.

B. This Agreement may be amended only in writing upon mutual consent of the parties. A duly authorized representative of each party shall execute such amendments.

EXHIBIT B-ATTACHMENT

SAN BERNARDINO COUNTY
STATE HOSPITAL COST COMPUTATION
July 1, 2011 through June 30, 2012

1. BEDS REQUESTED BY HOSPITAL, BY COST CENTER

July 1, 2011 to June 30, 2012 (366 days)

Cost Center	Napa	Metropolitan	Atascadero	Patton	Total
Continuing Medical Care (SNF)	0	3	0	0	3
ICF-Psychiatric Subacute	0	7	0	4	11
Total Beds Requested	**0**	**10**	**0**	**4**	**14**

2. COUNTY NET RATE FOR 2011-12

Cost Center	All Hospitals
Continuing Medical Care (SNF)	$512.78
ICF-Psychiatric Subacute	$503.23

3. TOTAL COMPUTED COSTS FOR CONTRACTED BEDS

Methodology: Multiply the county net rate times 366 to find the annualized cost for the cost center. Multiply the annualized cost times the number of beds requested in the cost center to find the annual total cost per cost center.

Cost Center	Napa	Metropolitan	Atascadero	Patton	Total
Continuing Medical Care (SNF)	$0	$563,032	$0	$0	$563,032
ICF-Psychiatric Subacute	$0	$1,289,275	$0	$736,729	$2,026,044
Total County Costs	**$0**	**$1,852,308**	**$0**	**$736,729**	**$2,589,036**

EXHIBIT B-ATTACHMENT

SAN BERNARDINO COUNTY
STATE HOSPITAL COST COMPUTATION
July 1, 2011 through June 30, 2012

4. NET UTILIZATION CALCULATION METHODOLOGY

For the 2011-12 State Hospital Bed Purchase and Usage Standard Agreement the following methodology will be used to calculate the County's use of state hospital resources, if any, in excess of the contract amount specified in this Agreement.

A. Excess use will be calculated on a monthly basis. The State Controller will be directed to make an adjustment in the Schedule "B" for the county to reflect any excess use charge.

B. The total cost of the County's actual use in all cost centers at Napa, Metropolitan, Atascadero and Patton State Hospitals for each monthly period will be calculated. The County will be charged the contract amount or the actual cost of the County's state hospital use whichever is greater.

5. BASE CONTRACT AMOUNT

The total of item #3 on page 1 is $2,589,036. This amount appears in I A of Exhibit B.

EXHIBIT D
INTERAGENCY AGREEMENT
SPECIAL TERMS AND CONDITIONS

1. TERMINATION. Either party may terminate this Contract by giving 30 days written notice to the other party. The notice of termination shall specify the effective date of termination. Upon the Contractor's receipt of notice of termination from the Department of Mental Health (DMH), and except as otherwise directed in the notice, the Contractor shall:

a. Stop work on the date specified in the notice;

b. Place no further orders or enter into any further subcontracts for materials, services or facilities except as necessary to complete work under the Contract up to effective date of termination;

c. Terminate all orders and subcontracts;

d. Promptly take all other reasonable and feasible steps to minimize any additional cost, loss, or expenditure associated with work terminated, including, but not limited to reasonable settlement of all outstanding liability and claims arising out of termination of orders and subcontracts;

e. Deliver or make available to DMH all data, drawings, specifications, reports, estimates, summaries, and such other information and materials as may have been accumulated by the Contractor under this Contract, whether completed, partially completed, or in progress.

In the event of termination, an equitable adjustment in the price provided for this Contract shall be made. Such adjustment shall include reasonable compensation for all services rendered, materials supplies, and expenses incurred pursuant to this Contract prior to the effective date of termination.

2. DISPUTES. Any dispute concerning a question of fact arising under this contract that is not disposed of by agreement, shall be decided by the Deputy Director of Administration. All issues pertaining to this dispute will be submitted in written statements and addressed to the Deputy Director of Administration, Division of Administration, Department of Mental Health, 1600 Ninth Street, Room 150, Sacramento, CA 95814. Such written notice must contain the Contract Number. The Deputy Director's decision shall be final and binding to all parties. Within ten days of receipt of such notice, the Deputy Director, Division of Administration shall advise the Contractor of his/her findings. These findings do not preclude Contractor from any other resolution allowed by the laws of the State of California. Neither the pendency of a dispute nor its consideration by the Deputy Director of Administration will excuse the Contractor from full and timely performance in accordance with the terms of the contract.

3. CHANGES IN TIME FOR PERFORMANCE OF TASKS. The time for performance of the tasks and items within the budget, but not the total contract price, may be changed with the prior written approval of the Contract Manager. However, the date for completion of performance and the total contract price, as well as all other terms not specifically accepted may be altered only by formal amendment of this Contract.

4. APPROVAL OF PRODUCT. Each product to be approved under this Contract shall be approved by the Contract Manager. The Department of Mental Health's determination as to satisfactory work shall be final absent fraud or mistake.

5. CONTRACT IS COMPLETE. Other than as specified herein, no document or communication passing between the parties hereto shall be deemed a part of this Contract.

6. CAPTIONS. The clause headings appearing in this Contract have been inserted for the purpose of convenience and ready reference. They do no purport to and shall not be deemed to define, limit or extend the scope or intent of the clauses to which they pertain.

7. PUBLIC HEARINGS. If public hearings on the subject matter dealt with in this Contract are held within one year from the contract expiration date, Contractor will make available to testify the personnel assigned to this Contract at the hourly rates specified in the Contractor's proposed budget.

8. FORCE MAJEURE. No party to this contract shall be deemed to be in default in the performance of the terms of this Contract if either party is prevented from performing the terms of this Contract by causes beyond its control, including without being limited to: acts of God, interference, rulings or decision by municipal, Federal, State or other governmental agencies, boards or commissions; any laws and/or regulations of such municipal, State, Federal, or other governmental bodies; or any catastrophe resulting from flood, fire, explosion, or other causes beyond the control of the defaulting party. If any of the stated contingencies occur, the party delayed by force majeure shall immediately give the other parties written notice of the cause of delay. The party delayed by force majeure shall use reasonable diligence to correct the cause of the delay, if correctable, and if the condition that caused the delay is corrected, the party delayed shall immediately give the other parties written notice thereof and shall resume performance under this Contract.

9. SEVERABILITY. If any provision of this Contract is held invalid by a court of competent jurisdiction, such invalidity shall not affect any other provision of this Contract and remainder of this Contract shall remain in full force and effect. Therefore, the provisions of this Contract are and shall be deemed to be severable.

10. CLIENT CONFIDENTIALITY.

a. For contract involving clients and information regarding clients, the Contractor shall protect from unauthorized disclosure, names and other identifying information concerning persons receiving services pursuant to this contract, except for statistical information not identifying any client. Client is defined as "those persons receiving services pursuant to a DMH funded program." Contractor shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this contract.

b. Contractor shall promptly transmit to the DMH all requests for disclosure of such identifying information not emanating from the client.

c. Contractor shall not disclose, except as otherwise specifically permitted by this contract or authorized by the client, any such identifying information to anyone other than the DMH without prior written authorization from DMH.

d. For purposes of this section, identity shall include but not be limited to name, identifying number, symbol or other identifying piece of information assigned to the individual, such as a finger or voice print or a photograph which can be used to identify the individual person.

11. AUDITING. If the agreement is for funds in excess of $10,000, the agreement is subject to the examination and audit by the State Auditor for a period of three years after final payment under the agreement.