CalMHSA
California Mental Health Services Authority

California Mental Health Services Authority
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA 95670
Office: 916.859.4800
Fax: 916.859.4805
www.calmhsa.org

Date: March 15, 2016

To: Napa County

From: CalMHSA JPA Administrative Manager

RE: FY 14/15 LPS MOU

CalMHSA has received the MOU copies from the Department of State Hospitals in their final executed form. The DSH is to retain one of these copies for their own files, and CalMHSA shall keep another. The remaining copy, attached to this cover letter, is for your own county files.

Any questions, concerns, or requests regarding the completed MOU contained herein may be addressed to Laura Li at (916) 859-4818, or laurali@calmhsa.org.

Thank you.

napa - original

Napa County Agreement No. 8459

STATE OF CALIFORNIA — DEPARTMENT OF STATE HOSPITALS EDMUND G. BROWN JR., GOVERNOR

OFFICE OF ADMINISTRATION
1600 Ninth Street, Room 150
Sacramento, CA 95814

FULLY EXECUTED

Purchase of State Hospital Beds

Memorandum of Understanding

California Department of State Hospitals
and
The California Mental Health Services Authority (CalMHSA) and Participating Counties

I. RECITALS

A. The parties to this Memorandum of Understanding ("MOU") are the California Department of State Hospitals ("DSH"), the California Mental Health Services Authority ("CalMHSA") as administrative agent for participating Counties, and each participating County which has executed this MOU ("County") as indicated in Exhibit 1. "MOU" shall be deemed to include Exhibits 1-4, attached hereto.

B. The DSH has jurisdiction over all state hospitals ("Hospitals") which provide services to persons with mental disorders, in accordance with Welfare and Institutions Code Section 4100 et seq. All Hospitals shall comply with the responsibilities noted for DSH in this MOU. A description of services provided by the DSH shall be included in Exhibit 2.

C. Welfare and Institutions Code section 4330 requires counties to reimburse DSH for its use of Hospital beds and services provided pursuant to the Lanterman-Petris-Short Act ("LPS", Welfare and Institutions Code section 5000 et seq.) in accordance with annual MOUs between DSH and each county acting singly or in combination with other counties, pursuant to Welfare and Institutions Code section 4331.

D. CalMHSA is a joint powers authority pursuant to Government Code section 6500 (Joint Exercise of Powers Act) of counties and cities with mental health programs. CalMHSA was requested by its members to negotiate a joint agreement with DSH and serve as liaison agency for matters of compliance with terms and conditions.

E. The parties are independent agents. 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. Notwithstanding the

independence of the parties, all patient services must be integrated and coordinated across levels of care for continuity of care.

II. TERMS AND CONDITIONS

A. The term of this MOU is July 1, 2014 through June 30, 2016 ("FY 14-15/FY 15-16").

B. County Referred Patient ("Patient")

1. County shall screen, determine the appropriateness of, and authorize all referrals for admission of Patients to the Hospital. The County shall, at the time of admission, provide admission authorization and identify the preferred Hospital and bed type to which a Patient is being referred, and identify the estimated length of stay for each Patient. However, the Hospital's Medical Director or designee shall make the determination of the appropriateness of a Patient for admission to the preferred Hospital and assign the Patient to the appropriate level of care and treatment unit.

2. If Medical Director or designee's assessment determines the Patient shall not be admitted to the preferred Hospital, the preferred Hospital will notify the County and the DSH – Sacramento Patient Management Unit (PMU) for review and consideration of placement within an alternative appropriate DSH facility.

3. The County shall name a point-of-contact and provide assistance to the Hospital treatment staff in the screening of Patients to initiate, develop and finalize discharge planning and necessary follow-up services for the Patients. Either party may initiate this process by contacting the other party.

C. Description of Provided Hospital Services

1. The DSH defines bed types and uses in accordance with the following California Department of Public Health hospital licensing definitions. These definitions shall apply to the MOU:

2. Acute Psychiatric Hospital (APH) Acute psychiatric hospital means a hospital having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care for mentally disordered, incompetent or other Patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. An acute psychiatric hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients.

3. Intermediate Care Facility (ICF) Intermediate care facility is a health facility, or a distinct part of a hospital or skilled nursing facility which provides

inpatient care to patients who have need for skilled nursing supervision and need supportive care, but do not require continuous nursing care.

4. Skilled Nursing Facility (SNF) Skilled nursing facility is a health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hours inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

5. As the Hospitals' bed capacity permits, the DSH shall provide inpatient psychiatric health care and treatment, including outside medical health care and treatment, ancillary care and treatment, and/or support services, to those Patients referred by the County for LPS services, including those admitted pursuant to Penal Code Section 1370.01 and Welfare and Institutions Code Section 5008, subdivision (h)(1)(B) (Murphy Conservatorships). A summary of services provided to LPS Patients and the definition of care is detailed in Exhibit 2.

6. The DSH and the County shall provide or cause to be provided, expert witness testimony by appropriate mental health professionals in legal proceedings required for the commitment, admission, or treatment of the Patients.

7. The County is responsible for transportation to and from the Hospitals in the following circumstances: court appearances, County-initiated medical appointments or services, and pre-placement visits and final placements. The County is also responsible for transportation between Hospitals when the County initiates the transfer. The DSH is responsible for all DSH-initiated transportation between the Hospitals and transportation to and from local medical appointments or services. The reimbursement rates in Exhibit 3, entitled "Statement of Annual Bed Rates and County Estimated Bed Need," include reimbursement for transportation that is the responsibility of DSH.

8. Hospitals shall be culturally-competent (including sign-language) in staff and resources to meet the needs of Patients treated pursuant to this MOU.

9. Multi-disciplinary treatment team composition will be provided as set forth in Exhibit 2.

D. Admission and Discharge Procedures

1. Hospital admissions, intra-hospital transfers, inter-hospital transfers, referrals to outside medical care, and discharges shall be in accordance with the admission and discharge criteria established by court order, statute, and the DSH. A complete admission package must be submitted with the referral, including all assessments available.

2. Patients converting from a Penal Code (PC) commitment to a civil commitment will become county-billable on the effective date of the civil

commitment. If determined clinically appropriate, Patients occupying a bed within the Hospital's secure treatment area will be placed in an LPS bed outside of the secure treatment area upon conversion from a PC to civil commitment. Or, if a bed outside of the security treatment area is not immediately available, the Patient will remain in the secure treatment area until transfer to an available LPS bed outside of the secure treatment occurs. All intra-hospital, and inter-hospital transfers shall be communicated to the County by the transferring Hospital Medical Director, and/or appropriate staff, prior to transfer taking place.

3. All denials of admission shall be in writing with an explanation for the denial. Any denial of admission shall be based on the lack of the Patient's admission criteria, the Hospital's lack of bed capacity, or an inability to provide appropriate treatment based on patient-specific treatment needs. A denial of admission may be appealed as provided in the next paragraph.

4. Appeal Process for Admissions. When agreement cannot be reached between the County 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; the case may be referred to the Hospital Medical Director and the County Medical Director, or designee, within two (2) working days. Such appeals may be made by telephone, and shall be followed up in writing; email being an acceptable option. If the Hospital Medical Director and the County Medical Director, or designee, are unable to achieve agreement, the case may be referred to the Hospital Executive Director and the County Mental Health Director, or designee, within two (2) working days. If the Hospital Executive Director and the County Mental Health Director, or designee, are unable to achieve agreement, the case may be referred to the DSH Deputy Directors of Clinical Operations and Strategic Planning and Implementation within two (2) working days. The DSH Deputy Directors of Clinical Operations and Strategic Planning and Implementation shall discuss the case with the Hospital Medical Director, or designee, and Executive Director and shall obtain additional consultation from the County Mental Health Director, or designee. The DSH shall render a final decision within two (2) working days after receiving the documented basis on which the appeal is based. Appeal resolution for cases involving complex factors may exceed the timelines referenced in section D4, above.

5. Discharge planning shall begin at admission. The Hospital shall discharge a Patient at the County'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 the next paragraph.

6. Appeals of Discharges. When the Hospital Medical Director determines that a discharge cannot occur in accordance with the approved plan or upon the request of the County, he/she will contact the County Medical 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 Hospital Executive Director and the County Mental Health Director, or designee, by either the Hospital Medical Director, or designee, or the County Medical Director, or designee, within two (2) working days of the Hospital's denial. Such appeals may be made by telephone and shall be followed up in writing; email being an acceptable option. If the Hospital Executive Director and the County Mental Health Director, or designee, are unable to achieve agreement, the case may be referred to the DSH Deputy Directors of Clinical Operations and Strategic Planning and Implementation, within two (2) working days. The DSH Deputy Directors of Clinical Operations and Strategic Planning and Implementation shall discuss the case with the Hospital Medical Director and Executive Director and shall obtain additional consultation from the County Mental Health Director, or designee. The DSH shall make the final decision within two (2) working days of receiving the documentation of the basis of the disagreement regarding the discharge, and communicate this decision to the County Mental Health Director, or designee, and the Hospital Executive Director. Appeal resolution for cases involving complex factors may exceed the timelines referenced in section D6, above.

E. Bed Type Transfers

1. If, for any reason, a County Patient is in a bed that is inappropriate to that Patient's needs, the attending clinician shall develop, in consultation with the Hospital's treatment team and the County (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. This plan shall be developed and communicated to County within forty-eight (48) hours of any urgent transfer. The County may initiate a treatment team discussion with the attending Hospital clinician at any time County feels that a County Patient is in a bed that is inappropriate to the Patient's needs or does not accurately reflect the level of care the Patient requires (APH, ICF, or SNF).

2. The Hospital shall provide the County Point-of-Contact notice of transfers between bed types within two (2) working days of any such transfer.

3. Bed Types Appeals. When agreement cannot be reached between the County staff and the Hospital staff regarding the type of bed the Patient needs, the following appeal process shall be followed. When the County staff feels that an impasse has been reached and further discussions would not be productive, the bed type may be appealed, along with all available data and analysis, to the Hospital Medical Director and the County Medical Director, or designee, within two (2) working days. If the Hospital Medical Director and the County Medical Director, or designee, are unable to achieve agreement, the case may be referred to the Hospital Executive Director and the County Mental Health Director, or designee, within two (2) working days. Such appeals may be made by telephone and shall be followed up in writing; email being an acceptable option. If the Hospital Executive Director and the County Mental Health Director, or designee, are unable to achieve agreement, the

case may be referred to the DSH Deputy Directors of Clinical Operations and Strategic Planning and Implementation within two (2) working days. The DSH Deputy Directors of Clinical Operations and Strategic Planning and Implementation shall discuss the case with the Hospital Medical Director and Executive Director and shall obtain additional consultation from the County Mental Health Director, or designee, The DSH shall render a final decision within two (2) working days after receiving the documented basis on which the appeal is based. Appeal resolution for cases involving complex factors may exceed the timelines referenced in section E3, above.

F. Prior Authorization

1. The County shall, prior to admission, provide the Hospital with the complete medical records on file, the Short-Doyle Authorization Form, and all applicable court commitment orders for each Patient. The County shall identify an initial projected length of stay which the Hospital shall address in Patient's treatment plan and discharge plan.

G. Coordination of Treatment/Case Management

1. It is the intent of the Parties to this MOU to be collaborative in all matters and specifically in matters of Patient's care.

2. The County shall develop an operational case management system for Patients, and shall identify a case manager or case management team for each Patient. The case manager shall provide available assessment information on Patients admitted to the Hospital.

3. The Hospitals shall provide at least two weeks notification of treatment plan conferences or 90-day reviews. The Hospitals shall identify a treatment team member to function as the primary contact for the case manager or the case management team.

4. The County may direct the Hospital to discharge the Patient to a facility that the County determines to be more appropriate to the Patient's treatment requirements. The Hospital shall provide to County, within five-business days of request for copies of current medical records, copies of current medical records needed to assist in this process. In such cases, the Hospital shall discharge the Patient within two days of the date an alternative placement option is identified and available except if the discharge is contrary to the medical necessity of hospitalization or would pose an imminent danger to the safety of the Patient or others, or otherwise required by law.

5. When an agreement cannot be reached between the County and the DSH on clinical assessment, treatment or the Patient's acuity, the DSH Hospital Medical Director and County Medical Director shall confer for a resolution. If a resolution cannot be achieved, the issue will be elevated to the DSH Deputy Directors of Clinical Operations and Strategic Planning and Implementation to review the case and shall make every effort to resolve the issue. If a resolution is not achieved, the County may direct the Hospital to discharge

the Patient. In such an event, the DSH response will be handled in accordance with Section II, Admission and Discharge Procedures (D)(5-6).

H. Patient's Rights and Confidentiality

1. The parties to this MOU shall comply with The Health Insurance Portability and Accountability Act (HIPAA) and all applicable state laws, regulations, and policies relating to the Patient's rights and confidentiality.

I. Bed Usage and Availability

1. Based upon Hospital bed capacity, during the 2014-15 and 2015-16 FYs, DSH shall provide mental health treatment to approximately 556 Patients under this MOU, including those whose PC commitments are expiring and will transfer to an LPS commitment, admitted under the LPS Act, including Murphy Conservatorships, and under PC Section 1370.01.

2. The County shall notify DSH, through CalMHSA, by January 31 of each year of this MOU, of its estimate of the number and type of beds that the County expects to use during the subsequent fiscal year for bed planning purposes. Counties contracting directly with the DSH may submit the Statement of Annual Bed Rates and County Bed Need directly to the DSH. However, the County is only obligated to pay for beds it uses. The DSH will update Exhibit 3 with the County's bed need estimate and submit it to the county.

3. This MOU constitutes specific approval of the Director of State Hospitals, as described in Welfare and Institutions Code section 4333, for the elimination of the County bed commitments, to facilitate the maximum flexibility contemplated by Section 4333, subdivision (f) which constitutes an innovative arrangement for delivery of Hospital services as stated in Welfare and Institutions Code section 4335.

4. The County is required to execute Exhibit 1 of this MOU in order to obtain beds. A County that has not previously executed a FY 2014-15/FY 15-16 Exhibit 1 shall, upon application for admission of a Patient from the County, commit to executing Exhibit 1 by providing a signed "Purchase Agreement of State Hospital Beds" (Exhibit 4) to demonstrate the County's intent to execute Exhibit 1, within 120 days of submitting the bed Purchase Agreement of State Hospital Beds.

5. Patients under the care of the DSH, referred to outside medical facilities, will remain the responsibility of the DSH unless the County initiates discharge, at which time the Patient and all costs become the responsibility of the County. During all offsite leave, Counties will continue to be charged at the daily bed rate. For all offsite leave of greater than 30 days, the DSH and the County may, at the request of either party, discuss appropriate care options for Patients.

J. Bed Payment

1. The current bed rates, historical bed usage and current estimated bed usage are reflected in Exhibit 3.

2. This MOU involves a minimum commitment of zero beds. The amount that the Controller is authorized to reimburse DSH from the mental health account of the County's Health and Welfare Trust Fund, pursuant to Welfare and Institutions Code section 17601, subdivision (b), is based on the amounts provided to the Controller per the County Actual Use statement reflecting actual bed usage by the County for the prior month.

3. ICF and Acute Rates – The established bed rate reflects a blended Acute and ICF rate based on the prior year's established bed rates. This rate shall be in effect until the DSH can provide actual cost information in compliance with Welfare and Institutions Code section 4330, subdivision (c). The DSH will review rates on an annual basis, based on actual expenditures at Hospitals that serve LPS patients.

4. SNF Rates – The rate established in the prior year will remain in effect through June 30, 2016. This rate shall be in effect until such time the DSH can provide actual cost information in compliance with WIC 4330, subd. (c). The DSH will review rates on an annual basis, based on actual expenditures at Hospitals that serve LPS patients.

5. The bed rates in this MOU represent the total amount due from the county for services provided in Section II, Terms and Conditions (C)(1-6, 8-9) by the DSH. These rates do not represent the total claimable amount for services provided to the patient. Patient will be responsible for any costs exceeding the bed rates described in this MOU.

K. Utilization Review – Hospital Operations

1. The Hospitals shall have ongoing utilization review activities which 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 the Patient's care needs. Such reviews shall be at a minimum of one time per year and include the County's participation. The DSH will provide written results of the utilization review, if available.

2. The County shall take part in the utilization review activities.

L. Records

1. Patient Records

    a. Hospitals shall maintain adequate medical records on each 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. These records shall be provided by various professional and paraprofessional personnel in sufficient detail to permit an evaluation of services.

b. The DSH will provide access to Patient medical records to Counties through the use of a secure file sharing technology determined by the DSH. To facilitate such access, the DSH will work with Counties to make sure that each County has an authorized person with sufficient training and credentials (i.e., user name and password) that the person will be able to access DSH Patient records on behalf of the County.

c. Upon request by the County for medical records of County's Patient, the DSH will ordinarily upload and make available to the County through a secure file sharing technology all current records of Patient within seven working days, provided, however, that if records of a Patient are unusually voluminous the DSH may give notice that more than seven working days will be needed.

d. Upon request by the County for physical access to medical records of County's Patient, the DSH will make available all current records of Patient for inspection at the facility where Patient resides, within a timeframe agreed upon by the DSH hospital representative and the County.

2. Financial Records

a. The DSH 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 County 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 MOU, shall be reflected in the Hospital's financial records.

3. Retention of Records

a. The Hospitals shall retain all financial and Patient records pursuant to the State and DSH record retention requirements.

M. Revenue

1. The DSH shall collect revenues from the Patients and/or responsible third parties (e.g., Medicare and/or insurance companies), in accordance with Welfare and Institutions Code sections 7275 through 7279, and related laws, regulations, and policies.

N. Inspections and Audits

1. Consistent with confidentiality provisions of Welfare and Institutions Code section 5328, any authorized representative of the County shall have access to the medical and financial records of the DSH for the purpose of conducting any fiscal review or audit during the Hospital's record retention period. The Hospital shall provide the County adequate space to conduct such review or audit. The County may, at reasonable times, inspect or otherwise evaluate services provided in the Hospitals; however, the County shall not disrupt the regular operations of the Hospitals.

2. The County shall not duplicate reviews conducted by other agencies (e.g., State Department of Public Health, County Coroner's Office, and District Attorney's Office), if the detailed review results, methods, and work papers of any such review are made available to the County and the County determines the review was sufficient for County purposes. Practitioner-specific peer review information and information relating to staff discipline is confidential and shall not be made available.

O. Notices

1. Except as otherwise provided herein, all communication concerning this MOU shall be as follows:

    a. Billing and general MOU provisions:

    Christian Jones, Associate Governmental Program Analyst
    CBBU@dsh.ca.gov
    (916) 651-8727

    b. Patient Placement and Appeals coordination:
    Candius Burgess, Chief – Patient Management Unit

    Candius.Burgess@dsh.ca.gov

    (916) 654-0090

The County has designated the following as its MOU coordinator:

Name: Doug Hawker

E-mail: doug.hawker@countyofnapa.org

Phone: 707-259-8662

2. The Hospitals shall notify the County by telephone (with subsequent written confirmation), encrypted email or FAX, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature which involves a Patient. 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 County by telephone at the earliest possible time, but not later than five (5) working days, after the treatment team determines that a Patient on a PC commitment will likely require continued treatment and supervision under a County-LPS commitment after the PC commitment expires. Within ten (10) working days of the date the treatment team's determination that continued treatment and supervision should be recommended to County, the Hospitals shall provide written notice to the County. The written notice shall include the basis for the Hospital's recommendation and the date on which the PC commitment will expire. The above notices to the County shall be given not less than thirty (30) days prior to the expiration of the PC commitment. If Hospital fails to notify the County at least thirty (30) days prior to the expiration of the PC commitment, the County's financial responsibility shall not commence until thirty (30) days after the Hospital's telephone notification. However, if the DSH is given less than thirty (30) days to change a Patient's commitment by court order, the DSH shall notify the County of this change at the earliest possible time. In the event a court order provides the DSH less than thirty (30) days to notify the County, the County's financial responsibility shall commence on the day after the expiration of the PC commitment.

4. The County shall be responsible for making the decision regarding the establishment of any LPS commitment at the expiration of the PC commitment. The County shall notify the Hospital, in writing, at least fifteen (15) days prior to the expiration of Patient's PC commitment, of its decision regarding the establishment of an LPS commitment and continued hospitalization. If the County is given less than fifteen (15) days prior to the expiration of a Patient's PC commitment to make its decision, the County shall notify the DSH of its decision at the earliest possible time prior to the expiration of the Patient's PC commitment.

5. Regardless of whether the County served proper notice on the DSH regarding the expiration of a patient's commitment and any decision of the County regarding an LPS conservatorship, both parties shall follow a court order for

the transportation of the Patient to the County for the purpose of LPS proceedings.

6. The Hospital shall notify the County of the conversion of a Patient on LPS status to a PC commitment status that results in the DSH becoming financially responsible for the placement of the Patient. The Hospital shall notify the County, by telephone at the earliest possible time, but not later than five (5) working days after such conversion. Such telephone notification shall be followed by a written notification to the County, which shall be submitted no later than ten (10) working days after the Patient's conversion.

III. SPECIAL PROVISIONS

A. This MOU is subject to and is superseded by, any restrictions, limitations, or conditions enacted by the Legislature and contained in the Budget Act, or any statute or regulations enacted by the Legislature which may affect the provisions, terms, or funding of this MOU. The parties do not intend to amend or waive any statutory provision applicable to the use of state hospital beds by counties pursuant to Part 1 of Division 5 of the Welfare and Institutions Code, unless the subsection to be amended or waived is specifically identified in this MOU with a statement indicating the parties' intent to amend or waive the provision as thereinafter described. If statutory, regulatory, bed rate, or billing process changes occur during the term of this MOU, the parties may renegotiate the terms of this MOU affected by the statutory, regulatory, bed rate or billing process changes.

B. Should the DSH's ability to meet its obligations under the terms of this MOU be substantially impaired due to loss of a Hospital license, damage or malfunction of the Hospital, labor union strikes, or other cause beyond the control of the DSH, the parties may negotiate modifications to the terms of this MOU.

C. Mutual Indemnification

1. The County shall defend, indemnify, and hold the DSH and its agencies, their respective officers, employees and agents, harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the performance of this MOU but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of the County, its officers, agents, or employees.

2. The DSH shall defend, indemnify, and hold the County, its officers, employees, and agents, harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damage arising out of the performance of this MOU but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of the DSH and/or its agencies, their officers, agents, or employees.

D. The signatories below represent that they have the authority to sign this MOU on behalf of their respective agencies. Execution by a participating County of Exhibit 1 confirms the participating County agrees to the terms of this MOU and Exhibits 1-4. This MOU and its Exhibit 1 may be executed in counterparts.

E. This MOU, which includes Exhibits 1-4, comprises the entire agreement and understanding of the parties and supersedes any prior agreement or understanding.

F. This MOU which includes Exhibits 1-4 may be amended or modified only by a written amendment signed by the parties.

Maureen Bauman, President
CalMHSA

Date 2-26-16

Dawn DiBartolo, Chief
Acquisitions and Business Services Office
Department of State Hospitals

3/4/16

Date

EXHIBIT 1

Execution indicates that County is a participating County under the MOU.

_____ 1/26/16

Signature Date

Name Alfredo Pedroza Title Chairman of the Board of Supervisors

Napa County

APPROVED AS TO FORM
Napa County Counsel

By: _____

Date: 12/22/15

Doc Title: DSH MOU

ATTEST:
Clerk of the Board of Supervisors

By: _____

APPROVED 1/26/16
BOARD OF SUPERVISORS
COUNTY OF NAPA
GLADYS I. COIL
CLERK OF THE BOARD
BY _____ **Deputy**

EXHIBIT 2

LPS SERVICES SUMMARY

Licensure

The Hospitals comply with all applicable federal and state laws, licensing regulations and 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 throughout the term of the MOU.

The DSH provides the services to its LPS patients as follows:

Core Treatment Team and Nursing Care

The Hospitals provide Treatment Team services that are the core to a Patient's stabilization and recovery. The Treatment Team groups consist of the following individuals: Psychiatrist, Psychologists, Social Workers, Rehabilitation Therapists, and Nurses. These teams provide a highly-structured treatment for mental rehabilitation and re-socialization in preparation for an open treatment setting or community placement.

Treatment Team Ratios		
Treatment Team Member:	ICF Staffing Ratio:	Acute Care Staffing Ratio:
Psychiatrist	1:35	1:15
Psychologist	1:35	1:15
Social Worker	1:35	1:15
Rehabilitation Therapist	1:35	1:15
Registered Nurse	1:35	1:15

The Hospitals provide nursing care according to nursing licensing ratio requirements for state hospitals as follows:

Licensing Compliance Nursing Staff Ratios (Non-Treatment Team)		
Nursing Shift:	ICF Staffing Ratio:	Acute Care Staffing Ratio:
A.M. Shift	1:8	1:6
P.M. Shift	1:8	1:6
NOC Shift	1:16	1:12

The ratios provided above are the current staffing standards employed by the DSH. Each facility may adjust unit ratios as necessary for the continued treatment and safety of Patients and staff.

Skilled Nursing Facility services provide continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hours inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

Additional Treatment Services

Medical Services: Medical Clinics include Neurology, GYN, Ophthalmology, Optometry, Endocrinology, Cardiology, Podiatry, Dental and X-Ray services as well as referral services for Gastro-Intestinal care, Hematology, Nephrology, Surgery and related care for diseases of the liver (e.g., Hepatitis C). Full Acute Medical Care services are provided via contracts with community hospitals and/or a County Hospital.

Physical, Occupational and Speech Therapy (POST): Department provides physical rehabilitation services to all the patients at Napa State Hospital with the goal of assisting Patients to reach or maintain their highest level of functioning. The POST Team provides assessment services, treatment services and training to staff and Patients on the use and care of adaptive equipment that has been evaluated as appropriate for the Patient.

Individualized Active Recovery Services: Active Recovery Services focus on maximizing the functioning of persons with psychiatric disabilities and are provided both within the residential units and in the Treatment Mall. Treatment is geared to identify, support and build upon each person's strengths to achieve their maximum potential in meeting the person's hopes, dreams, treatment needs and life goals.

Active Recovery Services at the Hospitals:

- Are based on the specific needs of each patient.
- Are developed and delivered based on a philosophy of recovery.
- Provide a wide range of courses and activities designed to help patients develop the knowledge and skills that support recovery, and transition toward community living.
- Are organized to fully utilize staff resources and expertise.
- Provide a range of services that lead to a more normalized environment outside of the residential areas.
- Are facilitated by psychiatrists, psychologists, social workers, rehabilitation therapy staff, and nursing staff.

Industrial Therapy: Opportunities include dining room cleaning services, grounds maintenance, as well as other therapeutic services. Participants must demonstrate an appropriate level of behavior to ensure safety and security.

EXHIBIT 3

NAPA COUNTY
STATEMENT OF ANNUAL BED RATES
AND
COUNTY-ESTIMATED BED NEED
July 1, 2014 through June 30, 2015

1. STATE HOSPITAL BED RATE FOR FY 2014-15

Acute	$626
Intermediate Care Facility (ICF)	$626
Skilled Nursing Facility (SNF)	$775

2. BED USAGE BY ACUITY (IN BED DAYS)

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Estimated	*FY 2014-15 Annualized
Acute	711	986	4	1,460
ICF	425	482	0	0
SNF	405	283	1	365
Total	1,541	1,751	5	1,825

*FY 2014-15 Estimated number multiplied by 365 for total estimated bed need for entire FY.

EXHIBIT 4

Purchase Agreement of State Hospital Beds

Fiscal Year 2014-15 through Fiscal Year 2015-16

California Department of State Hospitals

By signing this Purchase Agreement, the County agrees to all recitals, terms and conditions, and special provisions between the County below and the Department of State Hospitals, (DSH) contained within the Fiscal Year (FY) 2014-15/FY 2015-16 Memorandum of Understanding (MOU) for the purchase of state hospital beds from the DSH. The DSH shall be reimbursed for use of state hospital beds by counties pursuant to Welfare and Institutions Code section 4330 et seq. Any County signing this form will be entitled to the same services contained in the FY 2014-15/FY 2015-16 MOU. The County will also abide by the same remunerative and legal policies contained within the FY 2014-15/FY 2015-16 MOU. The County agrees to sign Exhibit 1 of the MOU within the next 120 days. The DSH reserves the right to not accept patients from any county without a signed Exhibit 1.

Napa

County

William J. Carter

County Mental Health Director or Director designee – print

William J. Carter 2-11-16

County Mental Health Director or Director designee – sign/date

Dawn DiBartolo, Chief, DSH

Dawn DiBartolo, Acquisitions and Business Services Office – print

Dawn DiBartolo

Dawn DiBartolo, Acquisitions and Business Services Office – sign/date