SIGNATURE DOCUMENT FOR
DEPARTMENT OF STATE HEALTH SERVICES
CONTRACT NO.
UNDER THE
MENTAL HEALTH COORDINATED SPECIALTY CARE GRANT PROGRAM

I. PURPOSE

The Department of State Health Services ("System Agency"), and Dallas County Mental Health Mental Retardation Center DBA Metrocare Services ("Grantee") (each a "Party" and collectively the "Parties") enter into the following grant contract to provide funding for Mental Health Coordinated Specialty Care (the "Contract").

II. LEGAL AUTHORITY

This Contract is authorized by and in compliance with the provisions of Local Political Subdivisions, which includes but is not limited to Cities, Counties, School Districts, Local Health Departments – Texas Government Code Chapter 791.

II. DURATION

The Contract is effective on October 1, 2016 and terminates on August 31, 2017, unless renewed or terminated pursuant to the terms and conditions of the Contract. The System Agency, at its own discretion, may extend this Contract subject to terms and conditions mutually agreeable to both Parties.

III. BUDGET

The total amount of this Contract will not exceed **SEVEN HUNDRED SEVENTY NINE THOUSAND ONE HUNDRED SIXTY SEVEN DOLLARS ($779,167.00).** All expenditures under the Contract will be in accordance with **ATTACHMENT B, BUDGET**.

IV. CONTRACT REPRESENTATIVES

The following will act as the Representative authorized to administer activities under this Contract on behalf of their respective Party.

System Agency
Department of State Health Services
Mental Health Contracts Management Unit, MC 2058
909 W. 45th St., Building 552
Austin, TX 78751
Attention: Elizabeth Wyatt
Elizabeth.wyatt@dshs.state.tx.us

Grantee
Dallas County MHMR Center DBA Metrocare Services
1380 River Bend
Dallas, TX 75247
Attention: John Burruss, MD
John.burruss@metrocareservices.org

V. LEGAL NOTICES

Any legal notice required under this Contract shall be deemed delivered when deposited by the System Agency either in the United States mail, postage paid, certified, return receipt requested; or with a common carrier, overnight, signature required, to the appropriate address below:

System Agency
Department of State Health Services
Attention: Lisa Hernandez
1100 W. 49th Street, MC 1911
Austin, TX 78756

Grantee
Dallas County MHMR Center DBA Metrocare Services
1380 River Bend
Dallas, TX 75247
Attention: John Burruss, MD
John.burruss@metrocareservices.org

Notice given by Grantee will be deemed effective when received by the System Agency. Either Party may change its address for notice by written notice to the other Party.

VI. ADDITIONAL GRANT INFORMATION

Federal Award Identification Number (FAIN): SM010051-16
Federal Award Date: 12/02/2015
Name of Federal Awarding Agency: Department of Health and Human Services Substance Abuse and Mental Health Services Administration
CFDA Name and Number: 93.958- Block Grants for Community Mental Health Services
Awarding Official Contact Information: Wendy Pang
Grants Management Officer
Division of Grants Management
DUNS: 076708494

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE FOR SYSTEM AGENCY CONTRACT NO.

Health & Human Services Commission

By: _____
Sonja Gaines
Associate Commissioner
Behavioral Health & IDD Services

Date: 12/14/16

GRANTEE

John Burruss, MD / Linda Thompson, COO

John Burruss, M.D.
Chief Executive Officer
Date of execution: 11/23/2016

THE FOLLOWING ATTACHMENTS TO SYSTEM AGENCY CONTRACT NO. ARE HEREBY INCORPORATED BY REFERENCE:

ATTACHMENT A -	STATEMENT OF WORK
ATTACHMENT A-1	COORDINATED SPECIALTY CARE IMPLEMENTATION MANUAL
ATTACHMENT A-2	CLINICAL ELIGIBILITY EARLY ONSET PROGRAM
ATTACHMENT A-3	UNIFORM ASSESSMENT INSTRUCTIONS
ATTACHMENT A-4	COORDINATED SPECIALTY CARE OUTREACH AND RECRUITMENT MANUAL
ATTACHMENT A-5	LEVEL OF CARE ADULT EARLY ONSET SERVICE ARRAY
ATTACHMENT A-6	LEVEL OF CARE CHILD EARLY ONSET SERVICE ARRAY
ATTACHMENT A-7	ACUTE CARE MEDICAL HISTORY FORM
ATTACHMENT A-8	EARLY ONSET REPORTING FORM
ATTACHMENT A-9	EARLY ONSET DATA DEFINITIONS
ATTACHMENT A-10	SECURITY ADMINISTRATOR ATTESTATION AND AUTHORIZED USERS LIST
ATTACHMENT B -	BUDGET
ATTACHMENT C -	UNIFORM TERMS AND CONDITIONS
ATTACHMENT D -	GENERAL AFFIRMATIONS
ATTACHMENT E -	SUPPLEMENTAL & SPECIAL CONDITIONS
ATTACHMENT F -	FEDERAL ASSURANCES AND CERTIFICATIONS
ATTACHMENT G -	DATA USE AGREEMENT

ATTACHMENTS FOLLOW

ATTACHMENT A
STATEMENT OF WORK

I. GRANTEE RESPONSIBILITIES

A. GOALS

Grantee shall:

1. Implement a Coordinated Specialty Care (CSC) program for early psychosis identification and service provision in accordance with the Coordinated Specialty Care Implementation Manual, Attachment A-1.
2. Fulfill the roles as identified in Attachment A-1 by establishing a dedicated First Episode Psychosis (FEP) team. In addition to the roles identified in Attachment A-1 , contactor shall provide a peer provider in accordance with the standards defined in Texas Administrative Code, Title 25, Part 1, Chapter 416, Subchapter A, Mental Health Rehabilitative Services;
3. Adhere to fidelity standards as set forth in Attachment A-1 in provision of these services or as otherwise specified by Department of State Health Services (DSHS).
4. Provide an average of 5 hours of services per individual per month for the first 12 months the individual is enrolled in the program. The clock starts at the time the individual is enrolled in the program and applies to the first 12 months the individual is receiving services even if the 12 months is not contiguous.
5. Create an implementation plan that includes the aforementioned items in this subsection, as well as the following:
    a. Dedicated team members names, position, credentials and percentage of Full Time Equivalent(FTE) if not full time;
    b. How staff vacancies will be addressed during the course of this project;
    c. Implementation timeline specifying benchmarks for the following:
        i. Date the dedicated team will be in place and trained to provide the services; and
        ii. When services will begin for the CSC enrolled individuals.
    d. Timeline for internal fidelity reviews;
    e. Training as outlined in Section II,D.; and
    f. Written plan of action to include:
        i. a minimum of 3 strategies that will be implemented to provide service delivery; and
        ii. barriers that may prevent the Grantee from meeting the target and strategies that will be used to address these barriers; and
        iii. Strategies for providing community outreach and engagement.
6. Grantee shall notify DSHS of any staffing changes.

B. TARGET POPULATION

Grantee shall provide CSC services for individuals ranging in age from 15-30 that meet the diagnostic criteria. Individual must meet the specified age requirements, as outlined in this subsection of the Contract to be enrolled in this program. Grantee shall serve individuals who are in the early stages of a primary psychotic disorder listed in Clinical Eligibility Early Onset Program, Attachment A-2.

ATTACHMENT A
STATEMENT OF WORK

C. STAFFING

Grantee shall fulfill the following minimum requirements:

1. The Grantee shall only staff this project with personnel essential to the execution of the set forth curriculum. Staff roles per team would be those identified in Attachment A-1 including the following; 1 Full Time Team Lead who is an Licensed Professional of the Healing Arts (LPHA), 1 Full Time Individual Supported Employment/Supported Education Specialist (SEE), 1 0.5-1.0 Full time Skills Trainer, and 0.2 Full Time Psychiatrist, Psychiatric Advanced Practice Nurse, or Physician Assistant. In addition, Grantee shall employ a Full Time Peer Specialist for adults age 18-30 and Family Partner services shall be available for enrolled individuals under 18. Depending on caseload, some of these roles may be combined when appropriate.
2. In the event team personnel exit their position, Grantee shall ensure that their duties are executed fully by available qualified staff until vacancy is filled. Grantee shall make every attempt to fill the vacancy within 30 days. The Grantee shall not alter this project due to staff vacancies.

D. TRAINING & EVIDENCE-BASED CURRICULUM

Grantee shall utilize evidence-based practices in the provision of services to persons meeting criteria for the CSC program as specified below.

1. Grantee shall ensure that the CSC team is trained in the provision of the following evidence-based practices in accordance with Texas Resilience and Recovery standards:
   a. Individual Placement & Supports Supported Employment;
   b. Supported Education;
   c. Illness Management & Recovery;
   d. Cognitive Behavioral Therapy;
   e. Trauma Focused Cognitive Behavioral Therapy;
   f. Preparing Adolescents for Young Adulthood;
   g. Family Psycho-education; and
   h. Other Substance Abuse Mental Health Services Administration (SAMHSA) evidence-based practices deemed appropriate by DSHS for the CSC program.
2. Contractor shall ensure all staff on the CSC teams are trained in the CSC model. Training may be conducted by an in-house team member with at least one year of experience providing the CSC model to enrolled CSC clients. If a qualified in-house team member is not available, training shall be conducted by a third=party trainer with a minimum of 3 years' experience conducting training for the CSC program. The CSC training shall comprise of:
   a. General CSC training for all team members
      i. Introduction to Coordinated Specialty Care
      ii. Shared Decision Making
      iii. Psychopharmacology of FEP
      iv. Working with Families in FEP

v. Supported Employment and Education in FEP
vi. The Primary Clinician Role: Psychotherapy, Support and Case Management
vii. Skills Building and Substance Abuse Treatment

b. Role Specific Trainings:
i. The role of the Psychiatrist, Psychiatric Advanced Nurse Practitioner, or Psychiatric Physician Assistant in CSC and psychopharmacology of FEP
ii. The role of the Team Lead and Psychotherapist in FEP
iii. The role of the Supported Employment/Education specialist in FEP
iv. The role of Case Management/Psychosocial Rehabilitation/Skills Training in FEP
v. The role of the peer specialist in FEP

3. Contractor shall maintain records of the CSC teams' training in any Evidence-Based Practices and CSC training.

E. RECRUITING, ADMITTING AND OUTREACH

1. Within 60 days of contract execution, Grantee shall achieve and maintain a caseload of no more than 30 enrolled individuals per CSC team.
2. Grantee shall serve a minimum of 20 individuals.
3. Grantee shall complete the Adults Uniform Assessment or Child Uniform Assessment at intake within 7 calendar days of referral.
4. Grantee shall complete update assessments as indicated in Uniform Assessment Instructions, Attachment A-3. Enrolled individuals shall receive assessments in accordance with standards as set forth in the Texas Administrative Code, Title 25, Part 1, Chap. 416, Subchapter A, Mental Health Rehabilitative Services.
5. Grantee shall maintain and make available to DSHS a recruitment plan utilizing Coordinated Specialty Care Outreach and Recruitment Manual, Attachment A-4, which shall include:
   a. Written Policies and Procedures that will ensure that the caseload is maintained at a minimum of 20 and maximum of 30 per team for the duration of the Contract and outline the admission criteria;
   b. Outreach activities that include community education on early psychosis events, networking with hospitals and coordination with other satellite facilities to identify candidates for this CSC program.
6. Grantee shall serve individuals in the community as defined by Level of Care Adult Early Onset Service Array, Attachment A-5 and Level of Care Child Early Onset Service Array, Attachment A-6.
7. Grantee shall develop rapport and provide education about medication options and best practices for medication treatment for FEP so that enrolled individuals are willing to try antipsychotic medications.
8. Grantee's psychiatrist, psychiatric advanced practice nurse, or physician assistant and the enrolled individual shall review medication effectiveness and side effects at least quarterly and as clinically indicated. Grantee shall record symptoms and side effects

in a manner that facilitates monitoring changes over time.

9. Grantee shall transition the enrolled individual from the CSC Program to the most appropriate level of care if the enrolled individual becomes ineligible for this program after admission.
10. Grantee shall maintain the following information regarding enrolled individuals' primary care medical history and make available to DSHS upon request. In regards to item e., the requirement is to make appropriate referrals and facilitate the person keeping the appointments to the extent possible:
    a. Individual's Name;
    b. CSC Program Admission Date;
    c. Primary Care Referral/Linkage Date;
    d. First Appointment with Primary Care Physician Date; and
    e. Subsequent Primary Care and Specialty Care Appointment Dates. An example of this form is Acute Care Medical History Form, Attachment A-7.

F. DATA SUBMISSION & REPORTING

1. Grantee shall report service delivery using procedure codes data in the current version of Mental Health Service Array (Info_Mental_Health_Service_Array_ Combined), which can be found in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) www2.mhmr.state.tx.us/applications/datawarehouse which is incorporated by reference, in the CA General Warehouse Information, Specifications subfolder. Grantee shall submit data via Clinical Management for Behavioral Health Services (CMBHS) https://www.cmbhs.dshs.state.tx.us/cmbhs/WebPages/Contract.aspx which is incorporated by reference, or submit batch data if applicable, in accordance with Attachment A-5 and Attachment A-6.
2. Grantee shall submit performance measures quarterly using Early Onset Reporting Form, Attachment A-8 on the following dates of each fiscal year:
    a. September 1;
    b. December 1;
    c. March 1; and
    d. June 1.
3. DSHS will gather outcome and target data from MBOW on a quarterly basis and cross reference it with Grantee's quarterly data submission. Questionable data or data discrepancies will be resolved using the data shown in MBOW, as MBOW will be the official source.
4. Grantee shall use Early Onset Data Definitions, Attachment A-9, as guidance for data reporting in Attachment A-8.

G. SERVICE PROVISION

1. All enrolled individuals interested shall have access to Individual Placement and Support Services (IPS) regardless of readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation.
2. IPS specialists help enrolled individuals pursue permanent competitive jobs and academic opportunities in mainstream, integrated educational settings. Acceptable

jobs include seasonal jobs and temporary jobs that are part of the community's regular labor market.

3. There shall be an active 24/7 crisis response system available for individuals enrolled in the CSC program. It is recommended, although not required, that individuals enrolled in the program have cell phone access to team members on an ongoing basis.
4. All enrolled individuals shall be assessed by Grantee for suicide risk and safety plans shall be formulated and implemented for those determined to be at risk. Grantee shall be consistent in its use of risk assessment tools. Safety plans shall be available to DSHS upon request.
5. Team shall discuss with each enrolled individual their preferences for family involvement, as part of the intake and assessment process, to incorporate as part of the recovery plan. Team shall reassess these preferences periodically.
6. Individual length of stay in CSC program for any enrolled individual shall not exceed 36 months.

H. CLINICAL MANAGEMENT FOR BEHAVIORAL HEALTH SERVICES (CMBHS)

1. Grantee shall ensure that it has appropriate Internet access and an adequate number of computers of sufficient capabilities to use CMBHS. If Grantee purchases equipment with DSHS funds, the equipment shall be inventoried, maintained in working order, and secured.
2. Grantee shall notify DSHS immediately if a security violation is detected, or if Grantee has any reason to suspect that the security or integrity of CMBHS data has been or may be compromised in any way. Grantee is required to update records on a daily basis to reflect any changes in account status.
3. Grantee shall ensure that adequate internal controls, security, and oversight are established for the approval and electronic transfer of information regarding payments and reporting requirements. Grantee shall ensure that the electronic payment requests and reports transmitted contain true, accurate, and complete information.
4. DSHS may limit or deny access to CMBHS by Grantee at any time in DSHS's sole discretion.
5. Grantee shall use the following CMBHS components/functionality, in accordance with DSHS's instructions:
   a. Staff Member;
   b. User Profiles;
   c. Assign Roles; and
   d. Client Profile.
6. Grantee's network monitoring shall include troubleshooting or assistance with Grantee-owned Wide Area Networks (WANs), Local Area Networks (LANs), router switches, network hubs or other equipment and Internet Service Provider (ISP). Grantee shall maintain responsibility for local procedures to end-users and be responsible for data backup, restore, and contingency planning functions for all local data. Grantee shall:
   a. Create, delete, and modify end-user LAN-based accounts;
   b. Change/reset user local passwords as necessary;
   c. Administer security additions/changes and deletions for CMBHS;

d. Install, maintain, monitor, and support Grantee Local Access Networks (LANs) and Wide Area Networks (WANs); and
e. Select, purchase service from, and monitor performance of ISP.

7. DSHS will provide support for CMBHS, including problem tracking and problem resolution. DSHS will provide telephone numbers for Grantees to access expert assistance for CMBHS related problem resolution. DSHS will provide initial CMBHS training. Grantee shall provide subsequent ongoing end-user training.
8. Grantee shall designate a Security Administrator and a back-up Security Administrator. The Security Administrator is required to implement and maintain a system for management of user accounts/user roles to ensure that all DSHS or HHSC database user accounts are current. Grantee shall develop and maintain a written security policy that ensures adequate system security and protection of confidential information. Grantee shall fulfill the following requirements:
   a. Grantee shall complete Security Administrator Attestation & Authorized Users List, Attachment A-10 confirming the Grantee has reviewed the names of agency employees who have access to DSHS database systems or HHSC database systems that may be used in conducting business with DSHS, and Grantee has removed access to users who are no longer authorized to access secure data. Grantee shall also use Attachment A-10 to provide to DSHS the name, phone number, and email address of the two administrators no later than 30 days following the execution of this Contract and every 6 months during the contract term. Information should be submitted electronically to the mhcontracts@dshs.state.tx.us email address, as well as to the assigned DSHS Contract Manager.
   b. Grantee shall use Attachment A-10 to notify DSHS within ten (10) business days of any change to the designated Security Administrator or the back-up Security Administrator.

II. PERFORMANCE MEASURES

A. Grantee shall submit an implementation plan as specified in Section I.A, within 30 days of Contract execution.
B. Grantee shall submit a FEP Staff Roster to include name, credentials, position, team role(s), phone number and email address within 30 days of contract execution and within 15 days of any changes in staffing.
C. Grantee shall maintain a caseload of a minimum of 20 and a maximum of 30 enrolled individuals per FEP team.
D. Grantee shall maintain a recruitment plan as specified in Section II, E and submit within 5 calendar days upon receipt of DSHS' request.
E. Grantee shall submit documentation of training subcontractor's experience and a copy of the executed subcontract with the training subcontractor within 30 days of execution of this contract.

The performance measures listed below (F-P) are included in the required quarterly reporting form, Attachment A-8.

F. Grantee's records shall document an average of 5 hours of services per enrolled individual per month for the first 12 months the individual is enrolled in the program
G. Grantee's records shall document a minimum of once weekly IPS supervision meetings conducted by the Team Lead to review individual situations, identify new strategies, and assist individuals in their work lives. Records shall document at least 1 such meeting per week.
H. Grantee's records shall document the Team Lead reviews current enrolled individual outcomes with IPS specialist. Team Lead and IPS specialist set goals to improve program performance at least quarterly, with a monthly review. Team maintains a list of performance goals and associated performance over time. Records shall document at least 2 such meetings per month.
I. Grantee's records shall document the provision of the follow-along supports by the IPS specialist as outlined by the IPS manual for Supported Employment. At least 80% of the enrolled individuals shall receive at least one visit between the time of job/academic start and end dates.
J. Grantee's records shall document that the focus of the IPS specialists exclusively focused on supported employment and supported education. Documentation indicates that no more than 10% of the IPS specialist's time is devoted to case management and crisis services, administrative duties, or other duties not directly related to employment or education.
K. Grantee shall ensure antipsychotic medication is prescribed for at least 60% of individuals enrolled at any given time.
L. Grantee shall ensure at least 75% of enrolled individuals have had at least one trial of an antipsychotic medication prescribed within the recommended dosage range for at least 4 weeks.
M. Grantee shall document that, in any given quarter, at least 50% of enrolled individuals have had one or more family members meet with a member of the CSC team at least once.
N. Grantee shall report enrolled individual's average length of stay with the CSC team. Mean length of stay for discharged individuals shall not exceed 30 months.
O. Grantee shall have at least 90% of the enrolled individuals participate in planning for discharge with the CSC team. Discharge planning begins at 90 days prior to discharge date.
P. Grantee shall ensure that at least 90% of discharged individuals attend their first appointment with a mental health and/or medical provider within 30 days of discharge.
Q. All reports, documentation, and other information required of Grantee shall be submitted electronically to mhcontracts@dshs.state.tx.us, as well as to the assigned DSHS Contract Manager. If DSHS determines Grantee needs to submit deliverables by mail or fax, Grantee shall send the required information to one of the following addresses:

U.S. Postal Mail

Department of State Health Services
Mental Health Contracts Management Unit (Mail Code 2058)
P. O. Box 149347

Austin, TX 78714-9347

Overnight Mail

Department of State Health Services
Mental Health Contracts Management Unit (Mail Code 2058)
909 West 45th Street, Bldg. 552
Austin, TX 78751
Fax: (512) 467-5476

III. INVOICE AND PAYMENT

A. Grantee shall establish and maintain an independent cost center that is accessible and identifies the source and application of funds provided under this Contract and original source documentation substantiating that costs are specifically and solely allocable to this Contract and are traceable from the transaction to the general ledger.

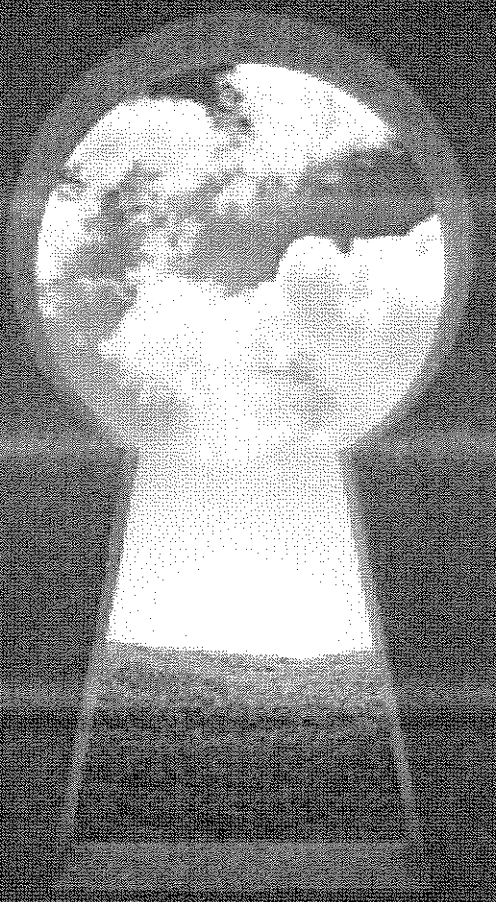
B. Grantee shall request payment using the State of Texas Purchase Voucher (Form B-13), which can be downloaded at http://www.dshs.state.tx.us/grants/forms.shtm which is incorporated by reference. When required by this Contract, supporting documentation for reimbursement of the services/deliverables shall also be submitted.

At a minimum, invoices shall include:
1. Name, address, and telephone number of Grantee;
2. DSHS Contract or Purchase Order Number;
3. Identification of service(s) provided;
4. Dates services were delivered;
5. Total invoice amount;
6. A copy of the General Ledger for the period which supports the budget items requesting reimbursement; and
7. Any additional supporting documentation which is required by this Contract or as requested by DSHS.

Grantee shall electronically submit all invoices with supporting documentation to the Claims Processing Unit at invoices@dshs.state.tx.us with a copy to mhcontracts@dshs.state.tx.us and to the assigned DSHS Contract Manager. Alternative submission arrangements must be approved by the assigned DSHS Contract Manager.

ATTACHMENT A
STATEMENT OF WORK

Coordinated Specialty Care for First Episode Psychosis



Manual II: Implementation

National Institute of Mental Health

RAISE
Recovery After an Initial Schizophrenia Episode
A Research Project of the NIMH

This manual was prepared under contract number HHSN271200900020C between the National Institute of Mental Health and the Research Foundation for Mental Hygiene. This project has been funded in whole or in part with Federal funds from the American Recovery and Reinvestment Act of 2009 and the National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services. Amy Goldstein, PhD., served as the Government Project Officer.

Disclaimer:
The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of HHS.

Contributors:
Melanie Bennett, Ph.D., University of Maryland School of Medicine, Baltimore, MD

Sarah Piscitelli, M.A., M.H.C., Research Foundation for Mental Hygiene, New York, NY

Howard Goldman, M.D., Ph.D., University of Maryland School of Medicine, Baltimore, MD

Susan Essock, Ph.D., New York State Psychiatric Institute, New York, NY: Department of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, NY

Lisa Dixon, M.D., M.P.H., New York State Psychiatric Institute, New York, NY; Columbia University Medical Center, NY

Table of Contents

I. Introduction

This manual is designed to guide implementation of a team-based program to serve individuals who are experiencing emerging psychosis within an existing mental health clinic (MHC). It provides information on administrative issues that must be discussed and resolved between the team and the clinic, such as hiring team members, managing team caseloads, providing services outside of the clinic setting, using the clinic's support staff for smooth team functioning, and sharing space and resources. Other critical implementation issues involve training and ongoing supervision of team members, ways to measure fidelity to the team model, and how to build supervision and fidelity assessment into ongoing practice within the clinic.

The recommendations and resources provided in this manual are derived from the experiences of the Recovery After an Initial Schizophrenia Episode Implementation and Evaluation Study (RAISE-IES). RAISE-IES was funded by the National Institute of Mental Health (NIMH) to develop tools that would support the implementation of Coordinated Specialty Care (CSC) programs designed to provide early intervention services for people with non-affective psychoses. The Connection Program represents an example of a CSC program recommended for first episode psychosis (FEP), and was the clinical intervention developed and evaluated in RAISE-IES. This manual is based on the experience of creating and implementing CSC programs in New York, New York and Baltimore, Maryland. Two Connection Teams were formed, one in each city. Per the CSC treatment model, and as will be further discussed throughout this manual, teams were comprised of a Team Leader, a Team Psychiatrist, an Individualized Placement and Support (IPS) Specialist, and a Recovery Coach. Throughout this document, we may refer to these team members in our examples of implementation. Keep in mind that teams in other locations, under different circumstances, may have different staffing configurations. These particular titles and associated training plans may not apply. They can, however, serve as useful guides for how to construct new programs.

Experience with creating and implementing these two Connection Teams illustrates the many opportunities that arise from embedding such a team within a larger MHC in terms of administration, resource sharing, and collaborations among staff members. The manual is intended to convey general concepts, providing examples from two program implementations: The RAISE Connection Program and OnTrackNY. OnTrackNY represents an extension and adaptation of RAISE Connection and is also a CSC model currently being implemented in four locations throughout New York.

II. Administrative Issues in Implementation

Section Tools

- ✓ ***Appendix 1: Getting Started Checklist***
- ✓ ***Appendix 2: RAISE Connection Program Eligibility Criteria***
- ✓ ***Appendix 3: Sample Job Descriptions for Team Hires***

This section describes a number of issues that need to be considered when implementing a team-based CSC program that serves individuals who are experiencing emerging psychosis. A checklist of these issues is provided in *Appendix 1*.

A. Program Structure and Services

An early consideration is the operational location of the team—will the team-based program operate and reside within an existing and established MHC, or will it be established as a separate organization and/or in a separate location? Advantages of the former include the opportunity for efficiencies within a shared infrastructure. Advantages of the latter include the possible opportunity to be more flexible and less stigmatizing for individuals who might avoid community mental health programs entirely. A related question is whether there will be a single team that functions on its own or a collection of teams that network to provide services to a broader area. In the case of related or collaborating teams, some efforts (e.g., training, developing an outreach and referral network, and performing outreach and recruitment) may be performed centrally to share costs. The single vs. multiple team issue will also influence the development of a referral network. Establishing a network for a single team will generally require efforts targeted to a specific area and/or set of referral sources, whereas creating a network of referral sources for a linked set of teams would require strategies to blanket outreach across large areas.

B. Geographic Boundaries

Two important issues related to geographic boundaries are population density and service boundaries. A population base of about 550,000 will have enough incident FEP cases to keep one FEP team filled at capacity given the team size and service durations proposed here, even with fairly conservative estimates about the number of such individuals who are identified and agree to be served.[1] The report by Humensky et al.[1] includes an interactive spreadsheet tool to estimate the number of teams that a given area can support and the associated cost given user-specified values for relevant variables (e.g., fraction of incident cases approached). When deciding whether the population density is sufficient to support one or more teams, the service boundaries need to be determined for each team operating in the area. Since part of the team's mission is to provide at least some services in the field, it is important to consider setting service boundaries that are reachable and will not require excessive time for travel when team members provide services in the community. Availability of public transportation is an important

[1] Humensky JL, Dixon LB, Essock SE. An interactive tool to estimate costs and resources for a first episode psychosis initiative in New York State. *Psychiatric Services*, 2013; 64 (9):832–834.

consideration, as is how accustomed to travel the potential population is. If the program will provide supported education or employment, the Individual Placement and Support (IPS) Specialist will make visits to community locations that need to be within reach of the young people and families served. As a rule of thumb, new teams should consider accepting clients living one-half hour from the clinic if education and employment services are offered. Without education and employment services, consider accepting clients no more than 45 minutes away from the team location.

C. Types of Clients Who Will Receive Services

Each program should establish its eligibility criteria. The first critical decision around eligibility is determining a definition of early psychosis. This includes not only how long an individual can have had psychotic symptoms, but what constitutes psychotic symptoms. Each team also needs to determine whether they will include individuals with diagnoses associated with psychosis, such as psychosis due to a medical condition, substance-induced psychosis, or mood disorders with psychotic features. Finally, the team needs to decide if there are any diagnoses that would exclude an individual from admission, such as developmental delays, pervasive developmental disorders, oppositional defiant disorder, or substance abuse and/or dependence disorders.

Other domains to consider when determining eligibility for team services include:

- Age range
- Comorbid medication conditions
- Comorbid trauma
- Housing instability
- Legal problems or prisoner status
- Cultural diversity and need for culturally sensitive services
- Primary language other than English
- Insurance status

The eligibility criteria used for the Connection Program are listed in *Appendix 2*, along with the rationale for each. Service eligibility was determined prior to admission. If, after admission, the team obtained new information that indicated that the individual was not eligible for the CSC program, the team continued providing services.

D. Connection with State and Surrounding Partners

It is important for a first-episode specialty care program to link with other programs in the community that may be needed in the course of a young person's care. For example, emergency care services, inpatient substance abuse treatment programs, and other services are not provided by the CSC but may need to be accessed by clients. It is critical that CSC programs and their clinicians connect and develop relationships with these other services during the set-up phase, so that these services may be easily accessed in a crisis situation. To ensure smooth transitions, the partnerships need to be in place and ready for use.

E. Determine Funding/Operating Budget

Funding for FEP services will vary by locality and insurance source. In some states, FEP services may be state supported via Medicaid waivers or other categorical funding. For a detailed discussion of approaches to financing interventions for FEP, see: http://aspe.hhs.gov/daltcp/reports/2012/EarlyInt.pdf . Budget issues that need consideration for FEP programs are similar to those of any other clinic-based program: identification of payment sources, billing, budget management, expense tracking, supply ordering, and laboratory and pharmacy tracking and reimbursement.

F. Establish a Referral Network

A referral network is key for the success of the CSC program. Establishing a referral network has many components that are summarized in *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment*. Once established, the referral network needs ongoing management – referral sources contacted regularly, contact information updated, etc. The team or mental health center will also need to track referrals and outreach activities. Strategies for this are provided in detail in the *Outreach and Recruitment Manual*.

G. Application of Clinic Procedures to the Team

There are a range of procedural issues that are relevant to setting up a CSC team within an existing MHC.

1. ***Human Resources and Hiring.*** Administrators are responsible for hiring staff. Sample job descriptions are provided in *Appendix 3*. All agency rules regarding evaluation and credentialing should be followed. If possible, hire the Team Leader first so that the Team Leader can be involved in the hiring of the other team members.

2. ***Resources.*** Resources needed include space, computers, office equipment, and other transportation funds.

    - Setting. Issues pertaining to the setting and space for services (including the capacity to provide services outside of the clinic) need to be addressed between the team and the clinic administrators at the start. Early psychosis intervention teams serve a young population. The setting in which the team is located needs to appeal to young clients. The setting should be pleasant, inviting, and recovery-oriented. Integrating the service into community or general health services would be preferred. The team needs sufficient space to hold groups and team meetings as well as some space for private individual meetings. The space should, if possible, be in an area that is easily accessible, either via public transportation and/or with parking. There also needs to be the option of providing services outside of the clinic.

- Computer Access. It is important for all team members to have computer access in a large enough space to also accommodate clients and their families. During sessions or meetings, team members may use computers to access resources, direct clients and families to services, assist with job searches, and watch videos or view other treatment-consistent content. Ideally, team members would have access to a laptop computer that could be used in different locations and shared among team members.

- Medical Equipment. Basic medical equipment needed to dispense and monitor medication should be available so that clients can work with the Team Psychiatrist on site at regular appointments. This equipment includes a scale and blood pressure cuff, as well as a way of obtaining labs, either on site or off site. Working out the logistics of labs and injections is critical and must be addressed at the start of program implementation.

- Additional Resources. Programs should also have access to money for petty cash. These funds would be used to make small purchases such as refreshments, snacks, reading material, or cab fare. The team also needs access to transportation for community visits and to provide access to community services. This could include a car depending on the community. Telephones, cell phones, and computers should be provided according to agency policy.

3. ***Programmatic Oversight and Management.*** These tasks include supervision, consultation, back-up coverage, and other administrative management duties. All of these issues must be addressed collaboratively and constructively between the team and the MHC.

- Supervision. Access to supervision for each of the team members is a critical consideration. Supervision for the Team Leader within the reporting structure is also necessary to facilitate integrating the program into the overall agency structure. Ideally, the Team Leader should have administrative supervision with the clinic coordinator at least every 2 weeks, and monthly supervision with the clinic's program director. Optimal there would be an Individual Placement and Support Supervisor in the agency or available to the program.

- Consultation. Access to expert consultation and/or peer supervision, especially for the Team Psychiatrist, is also important. At the beginning of the program, it would be optimal for the physician to have access to consultative expertise to assist with unique problems that arise for FEP patients.

- Back-up Coverage. The clinic administration needs to have back-up plans for coverage for the Team Leader and the Team Psychiatrist in the event that either is out for a scheduled absence. Emergency back-up coverage is also necessary if the physician is not available.

- Management Duties. Other personnel and management tasks can include annual evaluations for the Team Leader and time tracking for all team members. The Team Leader presumably evaluates all team members. Psychiatrist evaluation should be done

according to program policy.

4. ***Adherence to/Compliance with clinic regulations.*** The Clinic Administration must ensure that FEP program elements are compatible with existing agency requirements. Suggested FEP forms should be compared and matched to required agency forms so that redundancy can be eliminated.

5. ***Clinical oversight and management tasks.*** These include medical records management, patient registration and tracking, evaluation of clients' insurance to confirm coverage, and census and visit tracking reports.

H. Staffing Requirements

First episode specialty teams are comprised of a group of professionals who have different but overlapping roles. At minimum, teams should have a main leader or coordinator who is responsible for the client's overall treatment plan and programming. In addition, each client should have a team member who provides in-depth individual and family support, suicide prevention planning and crisis management, and assistance with access to community resources and supports. This can be the Team Leader or primary clinician. Case management can also be provided, if needed, by the designated primary clinician or by another team member. Each team should have a psychiatrist or prescriber who works with clients on issues of medication, management, wellness, and side effects. Teams should also have a Supported Employment Specialist to work with clients on re-entry to school or work, as well as team members who can work with clients on goals that require social or coping skills training and attention to substance use. Each team must have someone dedicated to establishing and maintaining a referral network and evaluating potential clients as described in the *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment.*

Team members should have dedicated time for their team-related work. This is especially important for team members who are not 100% full-time equivalent (FTE). If someone's time is divided between the CSC team and other responsibilities, steps should be taken to ensure that their team time is preserved and differentiated from their other clinic-related responsibilities.

RAISE Connection Program Teams were comprised of a Team Leader, a Team Psychiatrist, an Individualized Placement and Support (IPS) Specialist, and a Recovery Coach. The Team Leader and IPS specialist were full-time clinicians, whereas the Recovery Coach and the Psychiatrist were part-time at 50% and 20% effort, respectively. Teams in other locations and under different circumstances may have alternate staffing configurations, so these particular titles may not apply. For example, OnTrackNY Teams have two full time equivalent staff covering the Team Leader, Primary Clinician, Recovery Coach and Outreach Coordinator roles. A full-time IPS specialist, 0.3 FTE prescriber, and 0.2 FTE nurse round out the team.

I. Team Features

There are specific aspects of CSC team functioning that are recommended in order to ensure program success:

1. ***Small Caseloads.*** The team should have small caseloads, consisting of 25–30 clients or less, to ensure that team members have sufficient time to fully address all areas of intervention. The small caseload will also enable team members to develop and nurture a trusting relationship with the client and allow the team member time to perform activities outside of the clinic setting, such as home visits and community outreach, as needed. This flexibility is particularly important during the earlier phases of intervention and engagement.

2. ***Frequent Team Meetings.*** The whole team should plan to meet once per week. At these meetings, the team will review the status of each client, discuss each team member's role in the client's care, and review progress towards treatment goals. Team meetings should model respect, recovery, and shared decision-making. These meetings give team members the opportunity to inform and be informed by one another. They also provide time for the Team Leader to "check in" with each team member regarding the activities and goals of each respective specialty. During team meetings, the principles and practices of CSC care are reinforced through review of current cases and ongoing training to improve clinical knowledge and skills. For instance, after a case is presented, the team may provide feedback on such issues as making the transition to the next phase of care, negotiating with community providers, and taking a harm-reduction approach to resolving problems.

   The team should save the hour following the weekly team meeting for treatment planning or updating with clients. When an initial treatment plan or an update is discussed with clients, the goal is to have all team members present. Scheduling time for treatment planning meetings following the weekly team meeting is an easy way of ensuring that all team members will be present.

   Section IV: Supervision provides a detailed discussion of team meetings for the purpose of supervision.

3. ***Central Point of Referral.*** As discussed in *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment*, referrals to the team should come to a staff member dedicated to outreach and referral activities. This may be a staff member on the team (Outreach and Referral Specialist), or a group of staff members on an outreach and referral team. All advertising about the FEP program should list appropriate contact information. A central referral process that involves a dedicated referral line staff makes calling and contacting the team an easy process for clients, families, community providers, and other potential referral sources.

4. ***Coordinating Entry to the Program.*** The person receiving referrals should work with the team to coordinate the initial team activities, including intake assessment and preliminary treatment planning. Based on the assessment, the team will engage in shared decision making with the client to plot an overall treatment plan to meet the individual's expressed

recovery goals; treatment planning is conducted in full consultation with the client. Clients' capacity and interest in formal goal setting and making decisions can fluctuate throughout the course of treatment; preference and comfort with the decision-making role should be regularly explored. For the RAISE Connection Program Teams in Maryland and New York, the Team Leader coordinated a young person's entry to the program after the Outreach and Referral Specialist identified them as eligible.

5. ***Working as a Team in a Shared Decision Making Framework.*** Although the CSC team works collaboratively in the treatment of a client, a client may only be working with one or two clinicians at any point in time. At a minimum, all clients should work with the Team Leader (or assigned primary clinician for programs with others serving in the primary role) and the Team Psychiatrist. Even clients who are not interested in taking medication should meet with the psychiatrist to learn about medication options, set goals regarding when a medication trial may be warranted, and establish a relationship with the psychiatrist in case his/her feelings about medication change. Working with other members of the team is not mandatory but strongly encouraged, and it is expected that these working relationships may change over time.

Case Narrative 1: Introduction to Team Members and Gradual Engagement with Different Team Components

The Connection Program Team uses treatment planning to help new clients learn about the different aspects of the program and decide, within a framework of Shared Decision Making, which components they wanted to use and when. For example, at program entry, one new client may be most interested in a trial of medication, and not be ready to work on skills training or employment. Another new client may be very interested in getting back to work or school, but less interested in medication or family work. A third might be willing to work on decreasing his/her substance use in order to benefit most from medication and prepare for an eventual job search. Getting started with the team is flexible such that what is most important to the client and his/her family can be addressed first, and components can be added later as clients feel better, revise their goals, and look to the future.

Although team members may cover for each other occasionally (e.g., the Team Leader may see a client and work on employment related goals if the employment specialist is not available one day), each team member specializes in his/her component of the intervention. If a team wants to be structured to be able to accommodate overlapping roles, it is important to hire people with common skill sets so that tasks can be shared across team members. As discussed in *Section III: Training,* role flexibility is also the reason why cross-team training is important; the team members should be trained in all components they will be expected to cover clinically. For example, *Maryland and New York Connection Teams were comprised of a Team Leader, a Team Psychiatrist, an Individualized Placement and Support (IPS) Specialist, and a Recovery Coach; these staff members largely focused on their individual areas of expertise and there was little overlapping of roles.*

While the RAISE Connection Program had little overlap in roles, new teams in other locations with different circumstances, may have alternate staffing configurations and be

structured to have more flexibility in sharing roles. OnTrackNY, is now being implemented in four locations in New York. *OnTrackNY teams will be made up of a Team Leader, a Primary Clinician, a Team Psychiatrist, an IPS Specialist, a Recovery Coach, a Team Nurse, and an Outreach and Referral Specialist. In this structure, the individuals serving as the Recovery Coach or Outreach and Referral Specialist can also serve in the Primary Clinician role.*

6. ***Connecting with Community Partners.*** The team helps the client create or re-establish a social network within and beyond the family. School and work provide other opportunities to establish and grow natural supports. Some clients need help connecting with resources to avoid housing loss or other adverse social outcomes. The team works with the client and family to develop advocacy skills.

   Use of community resources is directly linked to goals in the treatment plan. The role of the team members is to not only identify resources and make referrals, but actively assist the client and family in linking to and using these resources. This can include the Team Leader following up with a referral source to check on a client's progress, the Recovery Coach accompanying the client to meetings or appointments in the community, or other active assistance as needed. Identifying community resources will be actively encouraged and assisted by the team.

   There are several areas in which resources in the community may be sought:

   - Mental Health or Clinical Services Not Provided by the Team: examples include cognitive behavioral treatment for depression, anxiety disorders, or PTSD; inpatient substance abuse treatment; dialectical behavior therapy

   - Non-Psychiatric Medical Services: examples include primary care services, lab services, or other medical appointments; substance use detoxification

   - Peer or Community Support Resources: examples include National Alliance on Mental Illness (NAMI), Alcoholics Anonymous/ Narcotics Anonymous (AA/NA, Double Trouble, and the Depression and Bipolar Support Alliance. Consumer organizations, such as On Our Own Wellness and Recovery Centers, are also important resources for clients and families.

   It is also important to assist clients in re-connecting with their communities around activities that are social and pleasurable. These may be activities that consumers do with their families, friends, or alone.

Case Narrative 2: Ways to Re-Engage with the Community.

It is important to remember that clients with early psychosis are young people and an important component of their recovery is doing things they enjoy with other young people. The Team helped clients access social supports and engage or re-engage with their communities in line with their treatment goals. Clients looking to make new friends might participate in the team's social skills group, meet with the RC in the community to practice these skills, and then plan a community activity to do on his/her own in order to put these skills into practice. Clients were encouraged by team members to engage in community activities they found enjoyable or that would allow them to try out new skills gradually and prior to having to use them in an important situation. For example, one client had, before his hospitalization, enjoyed playing basketball at college with his friends. The team worked with him to identify places he could play basketball now that he was living at home, people he could ask to play ball with him, and times during the week when he could get a game together. Another client was distressed by the weight gain she experienced due to her medication and told the team that she wanted to start exercising. The team helped her talk to her brother about taking her to a gym; assisted her in signing up for a gym membership; and provided support, encouragement, and praise as she began to swim at the gym several times per week. The team helped another client who wrote poetry to find locations in the community where he could listen to poetry; he eventually presented some of his own work. In all of these examples, the team helped consumers engage with people, activities, and community settings in ways that were positive and in line with their recovery goals.

III. Training

Section Tools:

- ✓ ***Appendix 4: Background Readings and Resources – Team***
- ✓ ***Appendix 5:Background Readings and Resources – Recovery Coach Training***
- ✓ ***Appendix 6: Background Readings and Resources – Supported Employment and Education***
- ✓ ***Appendix 7. Vignettes to Use in Team Training***
- ✓ ***Appendix 8. Scripts for Training Role Plays***
- ✓ ***Appendix 9: Slides and Forms to Use for Team Training Topics***

A. Training Overview

As has been emphasized throughout this manual, developing a CSC program to serve individuals with emerging psychosis will be influenced by the clinic in which the team is going to function and by the needs and resources of that clinic. This means that not all teams will be exactly the same, though all will be implementing the same underlying principles of CSC care. Training should be tailored to the specific needs of the clinic and team staff. This section provides an overview of training approaches for the team members in clinical roles. Training considerations for those responsible for outreach and recruitment can be found in the *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment.*

Team member training encompasses two domains: Team Training and Specialty Training. Team Training focuses on information and skills needed by all team members, including the overall program philosophy and principles of the CSC program and the procedures that structure the team and guide the ways that team members work together and assign tasks within the team. Specialty Trainings are targeted to the responsibilities of each team member; these trainings focus on the skills and interventions required by particular team members to effectively deliver their assigned component(s). A program should decide up front how much flexibility there will be in role assignments. If there is greater flexibility, team members should be 'cross-trained' to competency in the various specialized areas in which they will be expected to serve.

Background readings and discussions are useful for all team members. More intensive in-person or in some cases on-line training is also needed. The amount of time devoted to training is influenced by the background and previous training/experience of team members. *In training the RAISE Connection Program Teams in Maryland and New York, initial in-person training lasted for 2 days and included presentations on the model supporting the work of the team, didactic presentations on the different components of the team, and exercises designed to illustrate clinical activities and ways for the team to work together to understand clients, their needs, and how these impact treatment planning.*

An important consideration is who should provide training as outlined in this section. New FEP teams need to identify the experts and resources in their communities and within the larger community of FEP treatment development. This manual includes a range of written and online resources. New teams should plan to reach out to national experts, local community

organizations and providers, and existing teams for assistance in accomplishing the training. Information can be found on the NIMH RAISE website (http://www.nimh.nih.gov/raise) or from the RAISE intervention program developers.

B. Team Training (Training the Team as a Whole)

1. Background Readings and Discussions

a) Readings. All team clinicians should be provided with background readings on FEP and the lived experience of psychosis, and topics that are important across program elements. The cross-cutting topics include: shared decision making, trauma-informed care, the recovery model, and suicide/safety planning. A list of background readings and resources is provided in *Appendices 4–6*. An experienced trainer or facilitator should lead discussions of the readings so that team members learn about and understand the unique challenges experienced by individuals experiencing an FEP and their families. In addition, readings should emphasize the importance of incorporating client and family input into treatment and goals and the strategies for how to interact with and include families in decision making while respecting the preferences of the young adult.

b) Online resources. In addition to readings, many online resources provide valuable information in different formats and allow team members to practice or learn new content and skills (See *Appendices 4–6*). The Voices of Recovery video series, developed for the RAISE project, can be found at the following link: http://practiceinnovations.org/ConsumersandFamilies/ViewAllContent/tabid/232/Default.aspx. A manual that provides guidance as to how the videos may be used for staff training, as well a discussion for how to use with clients and families is available at http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx.

c) Additional Perspectives in Training.

- Peers. Including peers or a consumer-professional who understand both receiving and providing services can provide an invaluable perspective to training. Peer/consumer knowledge of the subjective experience of psychosis and treatment is a critical perspective to represent in training. Existing resources on peer experience, such as those provided online or newly created materials to address this topic, can be key adjuncts to care.

- Family. The importance of understanding the perspective of family members who are often central in the lives of individuals experiencing psychosis cannot be overstated. Trainings should include family members or a family–professional who can communicate to staff how the family might be experiencing the situation and who understands the impact of accepting the changes and challenges taking place with their loved one. NAMI presentations and trainings might also be helpful for staff training.

2. Intensive, In-Person Activities

The purpose of the in-person, whole-team training activities is to present a thorough review of information that is key to understanding the team approach and to introduce and practice the concept of "team-ness" to the team members. In-person training sessions allow for presentation of material that is relevant to the team as a whole, and then for breakout sessions to present material by component.

The informational and didactic components of training should include:

- Topics relevant to the CSC conceptual model:
  - ✓ first episode psychosis
  - ✓ critical time intervention
  - ✓ mental health recovery
  - ✓ working with youth
  - ✓ shared decision making
  - ✓ trauma informed care
  - ✓ safety planning
  - ✓ person-centered treatment planning

- Topics relevant to the components of the team:
  - ✓ psychopharmacology
  - ✓ supported employment and education
  - ✓ working with families
  - ✓ social skills training and substance abuse treatment
  - ✓ relapse prevention planning

- A review of functional procedures of the team:
  - ✓ team member roles
  - ✓ small caseloads
  - ✓ frequent team meetings
  - ✓ progress notes and documentation of team activities
  - ✓ after hours roles and responsibilities

- A thorough review of the timing of team activities:
  - ✓ initial referral and treatment planning
  - ✓ a history and needs assessment done collaboratively by the Team Leader and the Team Psychiatrist
  - ✓ development and implementation of the initial treatment plan
  - ✓ Team Leader activities at the start of treatment (e.g., set up a family meeting; complete safety planning, develop a relapse prevention and crisis plan)
  - ✓ activities for other team members at the start of treatment (e.g., IPS Specialist and the Skills Trainer must introduce themselves to the client, meet with the client to describe what services they provide, and assess the client's needs and goals in their respective areas)
  - ✓ ongoing treatment

- ✓ issues around missed appointments/potential dropout/assertive outreach
- ✓ transition
- ✓ linking with community and peer resources

Forms to use for many of these topics are available in *Appendix 9*.

The experiential/practice components of the training should include:

- **Clinical Vignettes** (see samples in *Appendix 7*) can be used to stimulate discussion among the team members, asking them to identify the important administrative and personal aspects of the needs assessment process and determine how to address the relevant needs and issues.

- **Role Playing Situations** (see samples in *Appendix 8)* can illustrate key clinical concepts and activities relevant for new team members.

- **Mock Team Meetings** are also useful to practice/discuss how to coordinate, sequence, and prioritize the various treatments and services and engage a client and family in developing a full and integrated treatment plan. Materials including clinical vignettes and scripts for role plays are provided in *Appendix 9*.

C. Ongoing Training for the Team

Ongoing training is essential. Training key intervention components such as shared decision making, motivational enhancement, critical time intervention, and safety planning should be repeated regularly to make sure knowledge and skills stay fresh. Ongoing training can take the form of in-person expert training, reviewing and role-playing situations to get continued practice, or finding relevant (training experiences in the team's geographic area. Hospitals, colleges, universities, and other research institutions are excellent resources – the team should explore these settings, meet people doing related work, and get on listservs and mailing lists so that they will be aware of any training opportunities. The team will be faced with new experiences and situations each day; making ongoing training a priority will help prepare team members for new treatment issues when they arise. Team members should keep a list of areas they feel additional training is needed and work with MHC staff to link with training opportunities in these areas.

D. Specialty Training (Training Components of the Team)

Specialty training focuses on specific team roles. The in-person or intensive component is enhanced and more efficient when more than one team is being trained.

1. Background Readings and Discussion.

All team members should be provided with background readings on topics related to their specialty area. A list of background readings and resources relevant to different team members

is provided in *Appendices 4–6*. Team members should share what they learn with each other—this both reinforces new learning and also helps team members inform each other about their areas of expertise.

2. Intensive, In-Person Activities.

As noted above, in-person trainings allow for in-depth presentation of material. As part of a team-wide, in-person training, time should be allocated to breakout sessions to present material that is relevant and specific to each team member. These breakout sessions allow all Team Leaders, Psychiatrists, IPS Specialists, Recovery Coaches, and other team members to learn and practice topics and interventions that are specifically relevant to their areas of focus. Below is a brief listing of the topic areas to cover for each clinical role. These breakdowns reflect the division of roles and responsibilities used in the RAISE Connection Program.

- *Team Leaders*
  - ✓ How to be a Team Leader
  - ✓ Critical time intervention
  - ✓ Working with families
  - ✓ Safety planning
  - ✓ Relapse prevention planning

- *Team Prescriber*
  - ✓ Antipsychotic treatment schedules
  - ✓ Side effect monitoring
  - ✓ Linkage to primary care
  - ✓ Smoking cessation

- *Supported Employment/Education Specialists*
  - ✓ Background and implementation of supported employment and education

- *Recovery Coaches (see Appendix 5 for resources and readings)*
  - ✓ Treatment interventions and strategies – e.g., social skills training, substance abuse treatment
  - ✓ Coping skills
  - ✓ Helping clients become more active and master the skills needed to engage in different activities
  - ✓ Strategies for support and engagement activities

E. Training for Team Members

Ongoing training for team members in their areas of specialty is important. Team members should connect with community and state sources of support such as learning collaboratives, listservs, and interest groups, and should link with other FEP teams both locally and nationally. It is relatively easy to reach out to others doing FEP treatment, supported employment and education, family psycho-education, and behavioral family interventions, etc. Each team member

should keep a list of areas in which they feel they need additional training and work with MHC staff to locate training opportunities in these areas.

IV. Supervision

Section Tools:

- ✓ ***Appendix 10. Sample Forms for Supervision Notes***
- ✓ ***Appendix 11. Resources for Supervision***

A. Types of Supervision

CSC programs require several types of supervision. How supervision is handled may be contingent on where the program is located and the rules of the clinic in which the CSC program may be embedded. The following supervision is recommended:

1. ***Administrative Supervision*** involves oversight to ensure that the FEP team is following the rules and procedures of the clinic in which it is embedded. The format, frequency, and emphasis of this supervision will need to be worked out on a team-by-team basis as clinic needs vary. Generally, the individual who is leading the team will receive administrative supervision from someone within the clinic administration and then pass along information and monitor the rest of the team regarding issues such as changes in clinic policy or larger programmatic issues that impact the CSC team. *In the NIMH RAISE Connection Program, the Team Leader met weekly with the Clinic Coordinator and monthly with the clinic Program Director.*

2. ***Clinical Supervision*** involves reviewing clients' status to ensure sound and competent clinical care. The amount of clinical supervision will also vary by team depending on clinic rules and regulations. Supervision is distinct from team meetings, in which all members of the team meet, report on their work with an individual, and plan continued work towards goals; team meetings may often include the client and/or family member/s. In contrast, clinical supervision includes discussion of the specific activities and techniques the clinician is providing, periodic review of session tapes or notes, and identification of ways to improve or enhance clinical interactions. *In the RAISE Connection Program, the Team Leader conducted clinical supervision every other week with both the Recovery Coach and the Supported Employment Specialist.*

3. ***Clinical Consultation*** involves discussion of individual clients with someone outside of the team to maintain good clinical decision-making. The Team Leader and the psychiatrist each should identify an individual with similar credentials within the clinic but outside of the team to provide this consultation in monthly meetings.

4. ***"Component" Supervision*** can bring together team members across multiple teams. If there are multiple teams in a region or state, a creative addition to supervision would be to have a regular meeting of all the team members (e.g., a meeting of all of the Recovery Coaches, or supported employment/education providers). These meetings can provide a forum in which those with similar roles on teams would be able to share materials, resources, and successes, as well as help in problem solving and creative thinking. This mode of supervision is especially well-suited to issues related to family involvement as team members can discuss ways to engage families in care and give each other new ideas in this area. *For example, in the RAISE Connection Programs in New York and Maryland, Team Leaders from the two states met via conference call for component supervision, as did the Psychiatrists, Recovery Coaches, and IPS Specialists. These conferences occurred about once a month and were facilitated initially by national experts and then by local training teams.*

   The experience of the RAISE Connection Program generated suggested topics for component supervision meetings:

- Team Leader Component Supervision:
  - ✓ Case discussion
  - ✓ Integrating clinic requirements into care (e.g., clinic specific forms and assessments)
  - ✓ Integrating the model throughout all of the Team Leader roles and responsibilities, including the family component.

- Psychiatrist Component Supervision:
  - ✓ Case discussion
  - ✓ Problems encountered with the implementation of preferred medications
  - ✓ Strategies /approaches that have been found useful to help participants manage their illness and psychotropic medications.

- IPS Specialist Component Supervision:
  - ✓ Review of work and employment status of each client
  - ✓ Successes and challenges in job development
  - ✓ Applying the model to supported education
  - ✓ Creative ways to engage clients in job searches
  - ✓ How to coordinate and organize meetings with job sites, schools, etc.

- Recovery Coach Component Supervision:
  - ✓ Review areas being addressed (social skills training or substance abuse)
  - ✓ Challenges in teaching skills and supporting implementation outside the clinic
  - ✓ Ways to build rapport and engagement,
  - ✓ Educating clients about the role of the Recovery Coach
  - ✓ How to use motivational enhancement strategies and shared decision making when approaching clinical problems with clients
  - ✓ Discussions regarding strategies for talking with young clients about planning for goals and using new skills in their lives.

- Family Work Component Supervision:
  - ✓ implementation of monthly family education groups and other family program components
  - ✓ Engaging families
  - ✓ Educating family members about psychosis
  - ✓ Family work/issues not addressed during the regular supervision meetings.

5. ***Supervision in the Team-based Model:*** In the same way that training has team- and role-based components, supervision also requires both perspectives. Supervision in the team-based model involves all team members and focuses on whether the team is working together in accordance with the model. Model supervision involves client reviews or reviews of specific topics to ensure that the team is adhering to the underlying principles of mental health recovery, shared decision making, and critical time intervention. All members of the team participate in this monthly meeting. It can take the form of a team meeting in which a theme that runs across the care of different clients is discussed. This is also a good place to discuss issues that are common to many clients, such as how to address trauma or how to work with families within the team.

If all types of supervision are needed, decisions must be made about who will provide them and how to manage the amount of supervision so that there is not an excess of meetings. It will be up to the team and the clinic to decide how best to use supervision time to cover the needs of the team.

B. Ways to Deliver Supervision

Supervision can be done in person or on the phone. It is recommended that administrative and clinical supervision be done in person, and that the medical records for the clients being discussed be available during the meeting. This allows for review of records to make sure that forms are properly completed in a timely manner. Clinical consultation and model supervision can be done in person or on the phone. A plan for each should be developed and provided to attendees prior to the meeting. For clinical consultation, the Team Leader or the Team Psychiatrist should list one to two clients to discuss with the consultant, provide a brief write-up on the background of the case and the issues for which consultation is sought. For model supervision, each team member should be assigned a date to prepare a clinical case or several cases that illustrate an issue. A write-up of the case(s) should be provided to all attendees prior to the meeting.

While supervision can be done by telephone or in person, experience suggests that some in-person time is necessary and beneficial. The team and the clinic can decide the exact ratio of phone to in-person meetings. Some types of supervision—especially if it is component supervision shared among multiple teams—may be suited to the telephone. For example, "model" supervision could be shared among multiple teams, done over the phone or via video conference. The discussion could involve teams sharing common patterns or themes they see among clients and share how to address these while adhering to the model.

C. Supervision How-To's

Supervision is an important part of clinical care. Supervision should be on a regular day and time that is good for all attendees and should be identified as an important part of the service of the team.

Good supervision takes planning. As noted above, each supervision meeting should have a leader who is responsible for planning the content of the meeting, creating an agenda, distributing the agenda to attendees, writing the supervision note, and recording attendance and what was discussed. A sample form for supervision notes is provided in *Appendix 10.* For some types of supervision (e.g., clinical), the leader of the meeting is generally the more senior person (e.g., Team Leader). In other cases, the leader of the supervision meeting can be alternated so that all members of the meeting are the leader at some point.

The following are some sample structures for supervision meetings:

Clinical Supervision, Team Leader/Recovery Coach

1. Review list of clients who are working with the Recovery Coach. Note clients who are nearing the end of their work with the Recovery Coach and provide a status summary to the Team Leader. Assign new cases to Recovery Coach; Team Leader can provide a summary of the case and a reason for the referral to the Recovery Coach.

2. Identify one or two clients to discuss in-depth. These could be cases that are progressing well and the Recovery Coach has ideas about additional work to be done, or cases that are challenging (e.g., poor engagement with Recovery Coach, lack of progress, feeling stuck). The Recovery Coach should be prepared to provide a summary of these cases and identify the issue or challenge to discuss with the Team Leader.

3. Check in regarding groups (e.g., social skills, substance abuse treatment, family) that are led by the Recovery Coach and update on attendance, topics covered, and how these topics can be integrated into individual work.

4. Other issues/action plan to work on between supervision meetings.

Administrative Supervision, Team Leader and Clinic Administrator

1. Review all clients receiving services from the Team. Make sure all forms are complete for all clients or identify what's needed for whom and when it's due.

2. Discuss any administrative challenges that have taken place since the last meeting.

3. Check in regarding new cases or cases that will soon be discharged/transitioned to community care.

4. Other issues/action plan to work on between supervision meetings.

Model Supervision, All Team Members Present

1. One team member is the leader of the meeting. This can rotate among team members.

2. The leader identifies an issue or client whose care is challenging for discussion and provides a care summary. These challenges are discussed and possible responses are identified according to the treatment model.

3. Discuss how each team member can contribute to this case in ways that are in line with the model.

4. Other issues/action plan to work on between supervision meetings.

A list of resources for supervision is provided in *Appendix 11.*

V. Fidelity

Section Tools:

- ✓ ***Appendix 12: Resources for Fidelity***

Fidelity measures are important because they provide valuable information to three stakeholder groups:

- Payers want to know if they are getting what they are paying for
- Trainers/supervisors want to know whether clinical staff are implementing the interventions as intended over time
- Clients/families want to know if the services they are investing their time/effort/finances in are up to par and can reasonably be expected to promote the outcomes they care about (school/work/friends/health)

A practical approach to fidelity is recommended, with measures drawn from information that is typically readily available in routine practice settings implementing the CSC program as described. Fidelity measures should support and draw from routine clinical operations.

Optimal fidelity measures are those that are good proxies for the components of the intervention that they are measuring. For example, a core expectation for the intervention is that antipsychotic medications are a central part of treatment for almost everyone. Hence, associated fidelity measures would examine the proportion of clients prescribed an antipsychotic and the proportion who had had an adequate trial on an antipsychotic, where "adequate" was specified clearly enough to be measured objectively. Routine service logs will support many fidelity measures so long as they note for each contact the client, staff involved, whether family was present, and the location of the service (office versus community). The presence of routine clinical forms such as those included in this manual to support the intervention can be used to document that those components of the intervention occurred. For example, if a program expectation is that safety is assessed at intake, then the presence of such a completed safety-assessment form at intake signifies that such an assessment was completed. Routine medication records and associated laboratory orders provide information necessary to assess fidelity to the psychopharmacology components of the intervention. *Appendix 12* provides, for each intervention component, core expectations and how they may be operationalized.

Most clinics or hospitals housing an FEP team will have staff record service contacts via an electronic record. All will have electronic claims records. Many also will have electronic health records for each client that will contain information such as weight, medications prescribed, and various symptom check lists. Whenever possible, fidelity data should be obtained from claims data and other electronic sources to minimize the data collection/compilation burden on clinical and administrative staff. As a fallback, payers can specify the data an FEP program is required to submit, and those submissions can be verified via site visits. *The RAISE Connection Program Teams in Maryland and New York were part of a research project operating in two very different sites and relied on abstracting information from specified locations in the project's required clinical forms maintained in clients' charts and entry of that data into a centralized database built for this study. Designing, building, debugging, and implementing such a chart abstraction*

system is cumbersome for short-term use, but is a feasible approach when abstraction from electronic claims is not an option.

Appendix List

Appendix 1: Getting Started Checklist

Getting Started Checklist:

	Activity
☑	Identify program structure and services
☑	Determine geographic boundaries
☑	Define clinic population and eligibility criteria
☑	Connect with state and surrounding partners
☑	Establish funding / operating budget
☑	Establish a referral network
☑	Apply clinic procedures to the team
☑	Establish programmatic oversight rules
☑	Assess staffing requirements
☑	Develop standards for team functioning
☑	Develop training plan

Appendix 2: Inclusion and Exclusion Criteria Used in the RAISE Connection Program

Inclusion Criteria: All Should Be Met

1. Age range: 15–35 years (Maryland 15–35; New York 16–35)
2. Diagnosis: schizophrenia, schizoaffective and schizophreniform disorders, delusional disorder, psychosis not otherwise specified (NOS)
3. Duration of psychotic symptoms > 1 week and < 2 years
4. Ability to speak and understand English
5. Anticipated availability to attend the clinic for 1 year

Exclusion Criteria: None Should Be Met

1. Other diagnoses associated with psychosis:
    - Substance-induced psychotic disorder
    - Psychotic affective disorder (e.g., major depressive or manic episode with psychotic features)
    - Psychotic disorder due to a general medical condition
2. Medical conditions that impair function independent of psychosis
3. Intellectual disability

Inclusion Criteria 1: Age range 15–35 years (Maryland 15–35; New York 16–35)**.** Treatment at each specialty clinic will be informed by the developmental stage of its clients. Each clinic will need to select the age range for services, and then ensure that the team is appropriately trained to meet the psychosocial treatment needs of that population. This is particularly true for IPS services, because educational and vocation needs can vary widely for different age groups. Recovery groups could also be targeted for developmental stages or goals, such as transitional aged youth or college groups.

Inclusion Criteria 2: Diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, psychosis not otherwise specified (NOS), or brief psychotic disorder. In the case of the Connection Program, the clinic served individuals who were in the early stages of a primary psychotic disorder. The interventions were selected and staff trained specifically for individuals experiencing these symptoms. Other clinics may consider expanding to include individuals experiencing mood-or substance-induced psychosis.

Inclusion Criteria 3: Duration of psychotic symptoms > 1 week and < 2 years. A wide variety of methods exist for defining the start of psychotic symptoms. For the Connection Program, the ORS evaluated the date of each of the earliest symptoms. Many individuals experience transient, attenuated symptoms of psychosis without ever developing psychosis. For an individual to be eligible for the Connection Program, the potential clients' symptoms were evaluated for

- the level of their symptom intensity (frequency),
- the impact on their behavior, and
- whether the individual experiences a reduced awareness that their unusual

perceptual experiences and/or unusual beliefs are symptoms.

Date of onset should be determined for each symptom. In the Connection Program, the earliest date of onset was used to calculate the duration of psychotic symptoms. Psychotic symptoms include:

- Delusions of reference—belief that others are taking special notice of them, talking about them, references on TV, reading material, etc.
- Persecutory delusions—belief that he or she is being attacked, harassed, persecuted, or conspired against
- Grandiose delusions—belief that he or she possesses special powers, exaggerated importance (rich or famous), or relationship to a deity
- Somatic delusions—belief that his or her body is grossly distorted; change or disturbance in appearance or functioning
- Other (religious, guilt, jealousy)—unusual religious experiences, belief that he or she must be punished for something (guilt), belief that partner was being unfaithful, or belief that he or she is in a relationship with someone famous
- Mind control (insertion/withdrawal)—belief that thoughts and/or actions are under the control of an external force. Individual may experience thoughts being placed into head and/or thoughts being taken out of his or her head.
- Thought broadcasting—belief that others can hear their thoughts or read his or her mind
- Hallucinations: auditory, visual, tactile, olfactory, and/or gustatory

A reduced awareness that a person's unusual perceptual experiences and/or unusual beliefs are symptoms must be present (e.g., a belief held with conviction despite evidence to the contrary). Additionally, either impact on behavior and/or intensity (symptoms occur at least intermittently or a preoccupation with belief) must be evident.

Other specialty clinics may use different criteria to determine the duration of psychotic symptoms. Examples include date of first antipsychotic medications prescribed for psychosis, or date of first psychiatric hospitalization due to psychosis. A date of onset can also be determined by subjective terms through a discussion between the ORS and the Senior Clinician.

Inclusion Criteria 4: Ability to speak and understand English. Language inclusion criteria should be determined based on the available services at each specialty clinic site. The Connection Program staff did not have bilingual staff members or available interpreters. For specialty clinics serving clients speaking other languages, this criteria item should be revised accordingly. If the service-seeker was a minor, the Connection Program required that at least one

parent/guardian could discuss and approve participation in English. Specialty clinics will need to communicate with parents/guardians about treatment and provide psycho-education to families. Consider carefully the languages and fluency levels that your clinic will require for parents/guardian attending the program to ensure that collaborative decision making can occur with parents/guardians as well as with the minor service-seekers.

Exclusion Criteria: None Should Be Met

Like the inclusion criteria, the Connection Program exclusion criteria were created based on the types of individuals that the clinic intended to serve and the available services at the program. Some individuals were experiencing symptoms and illnesses beyond the scope of the teams' specialized training. Other individuals were experiencing psychotic symptoms caused by illnesses other than a primary psychotic illness.

Substance-Induced Psychosis.

- Type of substance and usual pattern of use
- Focus on alcohol, sedatives, hypnotics, and/or anxiolytics
- Focus on periods of significant increase or decrease in relation to onset of psychotic symptoms
- Qualifying psychotic symptoms must be present in the absence of substance intoxication and/or withdrawal

Affective Psychosis. Individuals experiencing affective psychosis were not included. This included individuals experiencing either a major depressive episode or a manic episode with psychotic features. Individuals with mood symptoms and substance abuse were accepted; however, these individuals experienced prominent psychosis, in the absence of any mood symptoms. Services for primary mood, substance use, or medical illnesses are substantively different from those with primary psychotic disorders. Other specialty clinics include individuals with mood- or substance-induced psychosis, and each clinic will need to choose parameters for psychosis substance and mood.

a) Presence of Mood Symptoms (Based on DSM-IV) (Focus on temporal relationship between mood symptoms and onset of psychotic symptoms)
    - Major Depressive Episode: Five or more of the following symptoms with impact on functioning for a period of 2 weeks or greater (1 or 2 must be present)
        1) Depressed mood most of the day or nearly every day
        2) Markedly diminished loss of interest in activities previously enjoyed
        3) Significant weight change (loss or gain)
        4) Insomnia nearly every day
        5) Psychomotor agitation or retardation nearly every day
        6) Fatigue or loss of energy
        7) Feelings of worthlessness or excessive guilt
        8) Diminished ability to concentrate or indecisiveness
        9) Suicidal ideation and/or suicidal attempt
    - Mania: Persistently expansive or irritable mood, plus three or more of the

following symptoms within a distinct period (at least 1 week)

1) Inflated self-esteem or grandiosity
2) Decreased need for sleep
3) Pressured speech
4) Flight of ideas/racing thoughts
5) Distractibility
6) Increase in goal-directed activity or psychomotor agitation
7) Excessive engagement in pleasurable risk-taking behaviors

- Qualifying psychotic symptoms must be present and primary with an absence of mood symptoms for at least 2 weeks.

Psychosis Due to a General Medical Condition

- Prominent psychotic symptoms due to the direct physiological effects of a general medical condition
- General Medical Conditions include: neurological conditions (including traumatic brain injuries), endocrine conditions, metabolic conditions, autoimmune disorders with central nervous system involvement

Medical Conditions that Impair Function Independent of Psychosis

As defined by disability necessitating the person to be on or to apply for Supplemental Security Income [SSI], Social Security Disability Insurance [SSDI], workers compensation, veterans disability, or similar benefits.

Intellectual Disability

Operationalized as an IQ below 70 for the intervention, but we recommend raising this to exclude borderline intellectual functioning (IQ below 85).

Appendix 3: Sample Job Descriptions for Team Hires

At full capacity, the team's caseload would be 30 clients. Clients will receive services for 2 years. Training will be provided to all staff members working with individuals experiencing their first episode of psychosis and in the specific treatments that will be provided.

1. Team Leader, 1.0 FTE
   An experienced Master's level clinician who is trained in working with individuals experiencing FEP. He or she will be the primary contact person for clients and families and will spearhead efforts to engage clients in treatment. The Team Leader's primary goals are to build a positive relationship with participants and assist them in developing their abilities for illness self-management. The Team Leader will work with participants using a shared decision-making process to develop and modify treatment plans. The Team Leader will provide support, education, consultation, and basic services to participants and their families. With younger individuals, work with families will be more prominent since they play a pivotal role in the individuals' lives during adolescence and the first years of adulthood. The Team Leader will monitor, oversee, and supervise the team-based process.

2. Supported Education and Employment Specialist, 1.0 FTE
   A Bachelor's level position; someone in this position should ideally have prior experience as a supported education or employment specialist. He or she will focus on assisting participants to continue, resume, or adapt their academic or vocational activities successfully, using the IPS (individual placement and support) model.

3. Recovery Coach, 0.5 FTE
   An experienced Master's level clinician who will help clients clarify goals, cope with stressful situations, interact more effectively with other people, and in general, overcome barriers to their recovery. This is done within a framework that is empowering and cultivates peer support through the use of structured behavioral interventions aimed at learning new skills and supporting behavior change, including social skills training, substance abuse treatment, behavioral activation, coping skills training, and psycho-education.

4. Outreach and Referral Specialist, 0.5 FTE
   The designated individual(s) should be a Master's level clinician (or possess a higher clinical degree) and the ability to identify primary psychosis and perform differential diagnoses for symptom profiles related to psychosis. A program may choose to identify persons within the clinical team to lead outreach and recruitment activities, or establish a separate team of individuals who will only be responsible for such activities.

5. Psychiatrist, 0.2 FTE
   He or she will be responsible for diagnosis, medical care needs, medication management, and acute management of suicidality and safety concerns. Medication management will be guided by a medication algorithm that provides information about evolving best practices. A shared decision-making framework will be used.

Appendix 4: Background Readings and Resources - Team

National Alliance on Mental Illness (NAMI)
Information on First Episode of Psychosis
http://www.nami.org/template.cfm?section=First_Episode

Substance Abuse and Mental Health Services Administration (SAMHSA)
Recovery to Practice
http://www.samhsa.gov/recoverytopractice/

Choices in Recovery
http://www.choicesinrecovery.com/

Shared Decision Making
http://patients.dartmouth-hitchcock.org/shared_decision_making.html

Lived Experience:

Addington J, Coldham E, Jones B, et al. (2003). The first episode of psychosis: the experience of relatives. *Acta PsychiatrScand*, 108, 285–289.

Compton MT and Broussard B. (2009). *The First Episode of Psychosis: A Guide for Patients and their Families.* NY: Oxford University Press.

Deegan, PE (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatr Rehabil J*, 31(1), 62–69.

Deegan, P. (1988). Recovery: the lived experience of rehabilitation. *Psychosoc Rehabil J,* 9(4), 11–19.

Leete, E. (1989). How I perceive and manage my illness. *Schizophr Bull*, 15(2), 197–200.

Saks, ER (2007). *The Center Cannot Hold: My Journal Through Madness.* New York: Hyperion.

Schiller L, and Bennett A. (1994). *The Quiet Room: A Journey Out of the Torment of Madness.* NY: Warner Books.

Peers/Community:

The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities
http://tucollaborative.org/index.html

The Institute for Recovery and Community Integration
http://www.mhrecovery.org/

Recovery Model and Implications for Treatment:

Bellack AS. (2006). Scientific and client models of recovery in schizophrenia: Concordance, contrasts, and implications. *Schizophr Bull*, 32: 432–442.

Davidson L, Drake RE, Schmutte T, et al.(2009). Oil and water or oil and vinegar? Evidence-based medicine meets recovery. *Community Ment Health J*, 45:323-332.

Davidson L, Harding C, Spaniol L, eds. (2005). *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice.* Volume 1. Center for Psychiatric Rehabilitation Sargent College of Health and Rehabilitation Sciences Boston University.

Harding CM, and Zahniser JH. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatr Scand Suppl*, 384, 140–146.

Kreyenbuhl J, Nossel IR, and Dixon LB. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *SchizophrBull*35(4), 696–703.

Melle I, Johannesen JO, Friis S, et al. (2006). Early detection of the first episode of schizophrenia and suicidal behavior. *Am J Psychiatry*, 163(5), 800–804.

Trauma-Informed Care:

Morrison AP, Frame L, and Larkin W. (2003). Relationships between trauma and psychosis: A review and integration. *Br J Clin Psychol*, 42 (Pt 4), 331–353.

Neria Y, Bromet EJ, Sievers S, et al. (2002). Trauma exposure and posttraumatic stress disorder in psychosis: Findings from a first-admission cohort. *J ConsultClinPsychol*, 70(1), 246–251.

ShevlinM, DorahyMJ, and Adamson G. (2007). Trauma and psychosis: An analysis of the National Comorbidity Survey. *Am J Psychiatry*, 164(1), 166–169.

Voices of Recovery videos
http://practiceinnovations.org/ConsumersandFamilies/ViewAllContent/tabid/232/Default.aspx

http://www.theannainstitute.org/TSA-ADULTS.htm

http://www.ptsd.va.gov/index.asp

Shared Decision Making:

Adams J R, and Drake R E. (2006). Shared decision-making and evidence-based practice. *Comm Ment Health J*, 42(1), 87–105.

Deegan PE, and Drake RE. (2006). Shared decision making and medication management in the recovery process. *Psychiatr Serv*, 57, 16361639.

Examples of decision aids in the public domain can be found at the following sites:

- http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=10 – decision aid on antidepressants
- http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=za1120 - decision aid on whether to use medicine to help sleep
- http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=zw1124&SECHWID=zw1124-Intro - decision aid on whether to use medicine to quit smoking
- http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=aa45364&SECHWID=aa45364-Intro - decision aid for using medicine to treat PMS
- http://mentalhealth.samhsa.gov/clientsurvivor/shared.asp - includes SAMHSA "Cool Tools"

Suicide / Safety Planning:

CaldwellCB, and Gottesman JI. (1990). Schizophrenics kill themselves too: A review of risk factors for suicide. *SchizophrBull*16(4): 571–589.

Drake R E, Gates C, Cotton PG, et al. *(*1984). Suicide among schizophrenics: who is at risk? *J Nerv MentDis,* 172, 613–617.

Harkavy-FriedmanJM and NelsonEA (1997). Assessment and intervention for the suicidal patient with schizophrenia. *Psychiatr Q*, 68(4): 361–375.

Harkavy-Friedman JM, Restifo K, Malaspina D, et al. (1999). Suicidal behavior in schizophrenia: characteristics of individuals who had and had not attempted suicide. *Am J Psychiatry*, 156(8): 1276–1278.

Harkavy-Friedman, JM,Kimhy D, Nelson, EA, et al. . (2003). Suicide attempts in schizophrenia: the role of command auditory hallucinations. *J Clin Psychiatry*, 64(8): 871–874.

Harkavy-Friedman JM, Nelson EA, Vernarde DF, et al. (2004). Suicidal behavior in schizophrenia and schizoaffective disorder: examining the role of depression. *Suicide Life-ThreatBehav*, 34(1): 66–76.

Mamo DC. (2007). Managing suicidality in schizophrenia. *Can J Psychiatry*, 52: 59–70.

Melle I, Johannesen JO, Friis S, et al. (2006). Early detection of the first episode of schizophrenia and suicidal behavior. *Am J Psychiatry*, 163: 800–804.

Stanley B andBrown GK. (2008). *Safety planning: An intervention to mitigate suicide risk.* Washington, D.C: Veterans Health Administration Publication.

Stanley B, Brown F, Brent D, et al. (2009). Cognitive behavior therapy for suicide prevention (CBT-SP): treatment model, feasibility and acceptability. *JAmn AcadChild AdolescPsychiatry*, 48(10): 1005–1013.

Appendix 5: Background Readings and Resources - Recovery Coach Training

VA VISN5 MIRECC Social Skills Training Program
http://www.mirecc.va.gov/visn5/training/social_skills.asp

The Institute for Recovery and Community Integration
http://www.mhrecovery.org/

Motivational Interviewing
http://www.motivationalinterview.org/

SAMHSA – Co-occurring Disorders
http://www.samhsa.gov/co-occurring/

Person Centered Planning / Strengths Based Care
http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/pcp-instructionmanual2-3-10.pdf

Stages of Change
http://www.aafp.org/afp/2000/0301/p1409.html

Substance Abuse Treatment Resources
http://casaa.unm.edu/

Addington J, Penn D, Woods SW, et al.(2008). Social functioning in individuals at clinical high risk for psychosis. *Schizophr Res*, 99(1-3), 119–124.

Ballon JS, Kaur T, Marks .I, et al.(2007). Social functioning in young people at risk for schizophrenia. *Psychiatry Res*, 151(1-2), 29–35.

Bellack AS. (2004). Skills training for people with severe mental illness. Psychiatr RehabJ, 27, 375–391.

Bellack AS, Bennett ME, and Gearon JS. (2007). *Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals.* NY: Taylor and Francis.

Bellack AS, and DiClemente CC. (1999). Treating substance abuse among clients with schizophrenia. *PsychiatrServ*, 50(1), 75–80.

Bellack AS, and Gearon JS. (1998). Substance abuse treatment for people with schizophrenia. *Addictive Behaviors*, 23(6), 749–766.

Bertrand MC, Sutton H, Achim AM, et al. (2007). Social cognitive impairments in first episode psychosis. *SchizophrRes*, 95(1-3), 124–133.

Bradizza CM, Maisto SA, Vincent PC, et al.(2009). Predicting post-treatment-initiation alcohol

use among clients with severe mental illness and alcohol use disorders. *J Consult Clin Psychol*, 77(96), 1147–1158.

Carey KB, Leontieva L, Dimmock J, et al. (2007). Adapting motivational interviewing for comorbid schizophrenia and alcohol use disorders. *Clinical Psychology: Science and Practice*, 14, 39–57.

Compton MT, Kelley ME, Ramsay CE, et al. (2007). Association of pre-onset cannabis, alcohol, and tobacco use with age of onset of prodrome and age ot onset of psychosis in first-episode clients. Am J Psychiatry, 166(11), 1251–1257.

Dixon LB, Dickerson FB, Bellack AS, et al. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr Bull*, 36(1), 48–70.

Drake RE, O'Neal EL, and Wallach MA. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental illness and substance use disorders. *Journal of Substance Abuse Treatment*, 34(1), 123–138.

Gearon JS, Kaltman SI, Brown C, et al.2003). Traumatic life events and PTSD among women with substance use disorders and schizphrenia. *PsychiatrServ*, 54(4), 523528.

Kurtz MM and Mueser KT. (2008). Meta-analysis of controlled research on social skills training for schizophrenia. *J Consult Clin Psychol*, 76, 491–504.

Miller WR, and Rollnick S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behaviors.* New York: Guilford Press.

Miller WR, and Rollnick S. (2002). *Motivational Interviewing: Preparing People for Change* (2nd ed.). New York: Guilford Press.

Mueser KT, and Bellack AS (1998). *Social skills and social functioning. In K.T. Mueser and N. Tarrier (Eds.), Handbook of Social Functioning in Schizophrenia.* Needham Heights, MA: Allyn & Bacon (pp. 79-96).

Mueser KT, Yarnold PR, Levinson DF, et al.(1990). Prevalence of substance abuse in schizophrenia: Demographic and clinical correlates. *SchizophrBull*, 16, 31–56.

Mueser K T, Bennett M, and Kushner MG. (1995). Epidemiology of substance use disorders among persons with chronic mental illnesses. In A. F. Lehman and L. B. Dixon (Eds.), *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders, Vol. 3*, (pp. 9–25). Longhorne, Pa: Harwood Academic Publishers.

Mueser KT, Noordsy D L, Drake R E, and Fox L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: The Guilford Press.

Pilling S, Bebbington P, Kuipers E, et al (2002). Psychological treatments in schizophrenia: II.

Meta-analyses of randomized controlled trials and social skills training and cognitive remediation. *Psychol Med*, 32(5), 783–791.

Reiger DA, Farmer ME, Rae DS, et al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse results for the epidemiologic catchment area (ECA) study. *JAMA*, 264, 2511–2518.

Sullivan WP, and Rapp CA. (1994). Breaking away: The potential and promise of a strengths-based approach to social work practice. In R.G. Meinert, J.T. Pardeck, & W.P. Sullivan (Eds.), *Issues in social work: A critical analysis* (pp. 83–104). Westport, CT: Auburn House.

Tenhula WN and Bellack AS. (2008) Social Skills Training. In K. Mueser & D. Jeste (Eds.) *Clinical Handbook of Schizophrenia*. Guilford Press, New York.

Weick A, Rapp C, Sullivan WP, et al. (1989). A strengths perspective for social work practice. *Social Work*, 34, 350–354.

Whelan G. (2007). Impact of severity of substance use disorder on symptomatic and functional outcome in young individuals with first-episode psychosis. *J Clinl Psychiatry*, 68(5), 767–774.

Appendix 6: Background Readings and Resources - Supported Employment and Education

Supported Employment

Dartmouth IPS Supported Employment Center
http://www.dartmouth.edu/~ips/

SAMHSA
http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365

Becker D, and Drake R. (2003). *A Working Life for People with Severe Mental Illness*. NewYork: Oxford Press.

Drake R E, McHugo GJ, Becker D R, et al. (1996). The New Hampshire study of supported employment for people with severe mental illness. *J Consult Clin Psychol, 64*, 391–399.

Killackey E J, Jackson H J, and McGorry P D. (2008). Vocational intervention in first-episode psychosis: Individual Placement and Support.versus treatment as usual. *BrJ Psychiatry, 193*, 114–120.

Nuechterlein H, Subotnik K L, TurnerL R, et al. (2008). Individual placement and support for individuals with recent-onset schizophrenia: integrating supported education and supported employment. *Psychiatr Rehabil J, 31*(4), 340–349.

Appendix 7: Vignettes to Use in Team Training

Note: The goal in using vignettes is to demonstrate correct and incorrect ways of completing a needs assessment with a young adult client and his or her family member. Discussion of the vignette included all team members as a way to identify the important administrative and personal aspects of the needs assessment process.

Vignette 1: Addressing Various Treatment Foci

Context/Details:

1) Review the summary of the needs assessment. The team as a whole can address relevant considerations and issues relevant to their work as a team, as well as how they would engage the client in moving forward with treatment planning and delivery of related supports and services.

2) Next each break-out team can meet separately to discuss how they would address the relevant needs and issues summarized in the assessment summary.

First group:	Psychiatry and Medication Specialists
Second group:	IPS team
Third group:	RCs
Fourth group:	Team Leaders (with consideration of range of treatment foci including family, trauma, safety planning, housing/income, wellness self-management, etc.)

3) Next the full group will re-assemble for a "mock" team meeting. Participants will be charged with discussing how to coordinate/sequence/prioritize the various treatments and services and engage the client in the development of a full and integrated treatment plan. We also use this as a learning opportunity to discuss the challenges of working as a team.

Summary of Needs Assessment:

A 23-year-old woman was referred to the RAISE Connection Team at discharge from a 2-week hospitalization for treatment of her first psychotic episode. She completed her first round of meetings with various team members and the following information was collected as part of her initial needs assessment. Consideration of this "report" should be discussed from the perspective of each team so that each team can focus on and explore what services it has to offer and how they might be presented to the client and his/her family.

Medication: The client had a favorable therapeutic response to oral risperidone and received an injection of risperidone micorspheres (Risperdal CONSTA) 25 mg IM just before discharge. At her first team meeting, the client reported that she has been sleeping well, that the voices are greatly diminished and no longer intrusive, and that she feels safe again. However, she reported concern about weight gain and stated that she was distressed by this. She also expressed concern that she is pregnant because her menstrual period has not occurred this month; she denies recent sexual activity.

Wellness Management: The client is concerned about recent weight can and also expressed interest in getting fit and learning how to eat better. She also noted that she would like to learn more about stress management.

Education and Employment: The client has a GED. She reported an interest in considering going

to a local community college. She also noted that she is tired of not having much money and expressed interest in getting a job. She has only had a few part-time jobs and expressed anxiety about the prospect of entering the job market.

Family Support: Client lives with her mom and step-dad. She has no siblings and reports having no friends. She sees her biological father only about once or twice a year.

Housing and Income: Client lives with her mom and step-dad but reports that she is not happy there and that her step-dad "creeps her out." She has no health insurance and no source of income. Her biological father, who lives out of state, provides her with intermittent financial support.

Substance Abuse: Client smokes 2 packs of cigarettes a day. She reports feeling ambivalent about quitting. She knows she "should" but is not sure she's ready or able to.

Trauma: Client has hinted she may have been sexually abused as a child. She is unwilling to discuss this but has referenced "bad" experiences that leave her feeling freaked out about getting involved with anyone sexually. She also witnessed a stabbing in her neighborhood when she was 13 and says that she prefers to hang at home because it's safer than dealing with her neighborhood.

Safety: Client was actively suicidal at the time of her hospitalization. She currently notes that she no longer is pre-occupied with wanting to end her life and that she only intermittently has thoughts about hurting herself. She says that she has no current plans to hurt herself.

Vignette 2: How to Engage the Full Team and Client in Coordinated Treatment Planning

Context/Details:

1) Review the summary of the needs assessment. The team as a whole can address considerations and issues relevant to their work as a team, as well as how they would engage the client in moving forward with coordinated treatment planning and delivery of related supports and services.

2) Next each break-out team can meet separately to discuss how they would address the relevant needs and issues summarized in the assessment summary.

First group:	Psychiatry and Medication Specialists
Second group:	IPS team
Third group:	RCs
Fourth group:	Team Leaders (with consideration of range of treatment foci including family, trauma, safety planning, housing/income, wellness self-management, etc.)

3) Next the full group will re-assemble for a "mock" team meeting. Participants will be charged with discussing how to coordinate/sequence/prioritize the various treatments and services and engage the client in the development of a full and integrated treatment plan. We also use this as a learning opportunity to discuss the challenges of working as a team.

Summary of Needs Assessment

An 18-year-old male was referred to the Connection Team by the psychologist embedded in his inner-city public high school, where he was struggling to complete his junior year. He lives with his grandmother and two half-siblings. He and his grandmother have already met with the Team Leader and Team Psychiatrist but both have been reluctant to meet with the other team members.

Medication: After 4 4-week trials each of perphenazine (up to 16 mg. daily at which coarse EPSE were apparent) and risperidone (up to 6 mg daily at which he appeared slightly akinetic and complained of sexual dysfunction), this young man continues to be preoccupied with voices that were a central feature of his first psychotic break 2 months ago without any abatement in frequency and intensity. Of note, his biological mother (who is currently incarcerated) and his grandmother both have Type II diabetes mellitus.

Wellness Management: The client is overweight, has a very poor diet, and is generally inactive. He reports significant difficulties with sleep. Although he huffed glue regularly for several years and reported a history of poly-substance use, he reports that he has not used any substances for the past 6 months. He also has moderate to severe asthma.

Education and Employment: The client repeated the third grade and has a long history of learning disabilities. His current IEP provides access to a school counselor and additional

educational services. He has been having difficulty in school this current year and has missed several days. He reports that he hates school and would like to drop-out. He has never held a paying job.

Family Support: Client lives with his grandmother and two half siblings (ages 16 and 11). His grandmother works full time as nurses' aide with a rotating day-evening work schedule. The client's mother is currently in jail.

Substance Abuse: As noted, the client acknowledged that he huffed glue regularly for several years and reported a history of poly-substance use. He reports that he has not used any substances (other than cigarettes) for the past 6 months. The client smokes about a pack of cigarettes a day.

Trauma: Client was removed from his mother's care by Child Protective Services at age 4 secondary to investigated reports of neglect and physical abuse. He lived in one or two foster care placements until moving in with grandmother where he has remained for the past 10 years.

Safety: Client reports hearing command hallucinations to hurt himself. Although he says he is able to ignore these demands and that he is not suicidal, he reports feeling concerned that the voices will get stronger and more powerful as he gets older.

Vignettes Related to Psychopharmacology for Team Psychiatrist Training

Psychopharm Vignette 1: A 23-year-old woman is referred to the Connection Team at discharge from a two week hospitalization for treatment of her first psychotic episode. She had a favorable therapeutic response to oral risperidone and received an injection of risperidone microspheres (Risperdal CONSTA) 25 mg IM just before discharge. When you first meet her in clinic, she and her family report that she has been sleeping well, that voices are rare and not intrusive, and that she feels safe again. However, she reports that she has gained weight and that her clothes have become too tight. She also expresses concern that she is pregnant because her menstrual period has not occurred this month; she denies sexual activity.

> Issues to discuss: Prolactin, long-acting injected med, birth control, convincing patient/family to consider a switch in medications

Psychopharm Vignette 2: After 4 week trials each of perphenazine (up to 16 mg daily at which coarse EPSE were apparent) and risperidone (up to 6 mg daily at which he appeared slightly akinetic and complained of sexual dysfunction), this 18-year-old man continues to be preoccupied with voices that were a central feature of his first psychotic break 2 months ago. He has been unable to engage with vocational and social programming. You consider trials of olanzapine, and later clozapine, if the olanzapine fails. His mother has Type II diabetes mellitus.

> Issues to discuss: Metformin (preemptive or reactive), fish oil, exercise

Psychopharm Vignette 3: A 22-year-old man with first episode psychosis and ongoing abuse of marijuana and alcohol remains unable to engage in programming despite being assured antipsychotic treatment with a long-acting injected medication. He repeatedly fights with his step-father and has made two suicide attempts. He has not engaged in substance use treatment despite numerous attempts

> Issues to discuss: Hospitalization, clozapine

Psychopharm Vignette 4: A 19-year-old woman responded favorably to oral fluphenazine during a hospitalization for her first psychotic episode. At discharge, she was given an injection of fluphenazine decanoate 25 mg IM. At her first visit, she is akinetic and has clear cog-wheeling. Her family report she sleeps 18 hours per day. They want her taken off this "poison."

> Issues to discuss: sensible dosing, rapid interventions—aripiprazole, family: all meds can be toxic if dosed incorrectly

Appendix 8: Scripts for Training Role Plays

Note: Role plays contain scripts for encounters done "well" and done "poorly." It is recommended that the poor example be done first, with the discussion focused on what made it poor. This should be followed by the done "well" example and discussion of what was improved and how the interaction was more consistent with the principles of the recovery model, shared decision making, and compassionate interacting with young people with FEP.

Role Play 1: Young Adult, First Meeting with Team Leader for Initial Needs Assessment

Context/Details: John is a 22-year-old single man who was working full time as a front desk clerk for a hotel until 4 months ago, when he started showing increasing signs of psychosis. He had never been a very outgoing person, but he was able to interact appropriately with hotel guests until about a year ago. His job involved answering the phones, taking reservations, greeting and checking in guests, fielding customer service complaints, and assisting with luggage. He sometimes had difficulty dealing with guests complaints, especially when the guest was angry. His supervisor had to step in on occasion to help, but she was happy with his work until about a year ago.

About a year ago, John became more sensitive about customer complaints at the hotel and sometimes felt that the customers were blaming him personally for problems they were having with their rooms. He thought that perhaps he was not concentrating as well as he had in the past, and felt this might be contributing to mistakes he sometimes made in assigning rooms and working on billing for hotel charges. However, John increasingly felt that customers were being unreasonable in their complaints. He started trying to avoid those customers who he thought were troublemakers. This caused additional trouble when these customers complained to his supervisor. She tried to work with John to help him improve his interactions with customers.
About 4 months ago, John started believing that some hotel customers were deliberately trying to trick him into making mistakes on their hotel bills, which they would then blame on him and ask him to correct. John started hearing an accusatory voice talking to him while he worked at the hotel, which he attributed to hotel customers who were trying to influence his mind and get him fired. Then the voices started occurring when John was at home as well, so John got increasingly upset. John called the police to report that some guests at the hotel were working together to force him to make errors on the job and get him fired. John was then hospitalized for his paranoid delusions and auditory hallucinations.

John was referred to the Connection Team for eligibility screening. He still thinks that customers at the hotel were the main cause of his problems. He is aware, however, that his concentration has been poor and that he has been very upset with the things that have been happening to him. John has been given antipsychotic medication, but he is not sure that it is doing him any good and wonders whether he needs to continue taking it. He would just like to put the whole period behind him and get back to work as soon as possible.

Role play that models the encounter "done poorly":

> Team Leader: Thanks for coming in today to meet with me. I want to use our time today to complete a needs assessment so that I can put your treatment plan together. I apologize in advance for the number of questions I'm going to ask, but we've got to get through this full assessment today (hold up papers). Ok let's get started. I see from your intake form that you were hospitalized 4 months ago. Can you tell me why you were hospitalized.
>
> John: I was having concerns about my job. I was only in the hospital for a few days, though.

Team Leader: That's good. Do you remember what medications you were taking when you left the hospital?

John: Yes. They started me on something called Respira something

Team Leader: Riperidone?

John: Yeah, that's it.

Team Leader: Are you still taking that medicine.

John: Yes…well sort of. I mean, I'm not sure if I really need it.

Team Leader: Sounds like medication compliance is something that we should put on your treatment plan. I will let your psychiatrist know so you can talk to her about why taking medicine is so important. I can also work with you to helpwith your medication compliance.

John: Uh, ok. I really don't think I want to take the medicine though. I don't think I need it. Do you think I can stop taking it?

Team Leader: Well…. I can't really answer that question. Again, I know that you will be meeting your psychiatrist soon, so I suggest you discuss that issue with her. OK. Great. Now back to your last hospitalization. What symptoms were you experiencing at that time.

John: Well, I was really having trouble at work.

Team Leader: That's right you mentioned that. Were you having any specific symptoms that were making it difficult for you at work? For example, was your mood a problem, or were you having any unusual thoughts or concerns, or feeling very distracted, things like that.

John: I was having a hard time dealing with difficult guests at the hotel where I work. Still a lot of stuff going on there but I'm hoping that it will get better soon.

Team Leader: OK. Since you are going to be meeting with the psychiatrist too, so you can talk more about specific symptoms when you meet with her. Ok. Great, now the next set of questions is about substance abuse. Are you using drugs or alcohol?

John: I smoke marijuana sometimes.

Team Leader: How often?

John: A couple of times a week. Usually just at night before I go to bed.

Team Leader: Any other substances?

John: No.

Team Leader: Do you smoke cigarettes?

John: Yes.

Team Leader: How much do you smoke?

John: About a pack a day.

Team Leader: Ok. We don't have time today, but it sounds like we may want to focus on helping you with your smoking both cigarettes and marijuana. I know that these substances can interfere with one's life and of course as you know they both present significant health risks too.

I can also tell you about various resources and treatments to help with smoking cessation next time we meet. OK. Let's see (while turning pages) Let's move on. Next, I'd like to ask about your educational background. How far did you get in school?

John: I graduated from high school. I also took some classes at Washington County Community College.

Team Leader: That's great. What are your goals regarding your education?

John: Well, I don't know.

Team Leader: That's OK. Next time we meet we can talk more about this and get a feel for your ideas about this. OK...regarding employment, you mentioned that you work the front desk at the Marriott Courtyard in Washingtonville.

John: That's right.

Team Leader: Great. How long have you been working there?

John: About a year now.

Team Leader: That's great. I do know, however, that you said things have been difficult at work for you lately. I'm sure we will talk more about this as we get to know each other. Part of learning how to live with mental illness is learning how it will challenge you at work and in your relationships, etc. As you learn more about living with your illness we can work together to help you make sure that you're prepared to deal with these challenges.

(NOTE FROM FACILITATOR)...."Alright, we're now going to fast forward and re-join this

meeting right before it wraps up."

Team Leader: Terrific. I apologize again for moving across so many topics but I wanted to make sure that we completed the assessment. You were very helpful. I feel I learned about you and look forward to working with you!

Facilitated Discussion re: what was missing/done poorly:

This should include review/application of intervention principles/clinical concepts etc. (SDM, recovery-oriented, active/focused Stance, use of open-ended explorations, flexibility and consistency, autonomy/availability).

Role play that models the encounter done "well":

Team Leader: Hello (reach out to shake client's hand). Very nice to meet you in person. OK, as I mentioned what I hope to do today is learn more about how things are going for you and how we can be of help to you.

John: OK.

Team Leader: Great. OK. You talked a lot about your job when we spoke briefly on the phone. Sounds like work is a big and important part of your life right now.

John: I guess so. Although it's stressing me out and really hoping I don't get fired.

Team Leader: OK let's start there. Help me understand how the stress has interfered with things at work.

John: Well. I've been having trouble with hotel guests. I get angry all the time cause they're deliberately trying to make my job harder and get me fired.

Team Leader: Tell me more about feeling angry and how that affects your job.

John: I get so angry that I get confused and have trouble concentrating and my thoughts start racing and I get all pre-occupied.

Team Leader: Those sound like they would make any job difficult. I guess step one is to decide if those are problems you want to address right now.

John: Well I don't want to lose my job.

Team Leader: I hear that. That sounds like a clear goal. Let's talk about what things might be helpful in working on this goal.

John: OK. How do we do that.

Team Leader: Well, we can start by talking about options and then review what the pros and cons are for those options. For example, medication is one option. We can also figure out together who else you'd like to have involved in making decisions and what your preferences are so that you can identify how you'd like to proceed.

John: I'm not sure I want to take medication at all. I'm currently taking those pills they started me on when I was in the hospital and I'm gaining all this weight and not sure I even really need 'em, let alone what I'm taking them for.

Team Leader: You don't need to make any decisions today. Does sound like you want to explore this further, though. Also sounds like you may have some questions, concerns or want more information. I know that you are going to be meeting with the psychiatrist soon so we can talk more at our next meeting about how to prepare for that meeting and what to expect so that you can be fully involved in making decisions about medication.

John: OK.

Team Leader: Great. I also want to make sure we spend some time talking about what you've been doing or used to do to help deal with the stress you've been talking about.

John: You're not gonna wanna hear this, but smoking a joint before going to bed helps and smoking cigarettes also helps me chill out.

Team Leader: That's helpful to know, thanks. Any down sides or concerns you have about smoking a joint or smoking cigarettes.

John: Well, in addition to the money, the pot does sometimes make me kinda paranoid.

Team Leader: Ok. So just like with all things there are going to be pros and cons to discuss for this too. Are you OK keeping this on our agenda as something to check in on?

John: Well. I guess. Although I am not feeling ready to quit.

Team Leader: OK. I hear that. Thanks for permission to check back in with you though.

John: Whatever.

Team Leader: OK in addition to identifying things you want to work on, I want to make sure we also make time to talk about what your life goals are and how you can best work toward reaching those goals.

John: Well, if I don't shape up, I'm gonna lose my job. I'm also scared that things are going to get worse. I don't even understand why this is getting worse.

Team Leader: I hear that you're stressed about that. I also hear that you have a lot of questions. That's very normal. Part of our journey is making sense of how our lives

unfold. I look forward to exploring those questions with you and offer assistance to help you move forward with you goals and achieve the full and rich life that you deserve. I know we need to end for today, but thanks for getting started with me. As we move forward know that I and others on the team will be available to meet with you to help you stay connected to your goals and the services we have available here. We are also available to help you identify and choose what you'd like to work on, and get the supports you need to. Again, thanks for coming today.

Facilitated Discussion re: what was done well: This should include review/application of intervention principles/clinical concepts etc. (e.g., Shared Decision Making , recovery-oriented, active/focused stance, use of open-ended explorations, flexibility and consistency, autonomy/availability).

Role Play 2: Follow-up Meeting with a Teenager and Team Leader to Formulate/Develop Treatment Foci/Goals

Context/Details: Max is a 16-year-old 10th grade boy who was recently discharged from the hospital where he had been admitted for suicidal ideation and substance abuse after a 3 week hospitalization. Although he stated that he was abusing multiple substances, his urine tox screen was negative and also had been negative when he was hospitalized 2 months previously for similar complaints. His parents noted that he has become increasingly withdrawn over the past two years and now only interacts with a few friends. He has always been hard to motivate to do schoolwork, but his grades slipped from mostly B's to C's and D's over the past year. Last summer he worked as an assistant at a drama camp for elementary age kids and enjoyed it, but he did not apply this year. He did not run track this year, but thinks he might continue cross country in the fall.

During his evaluation, he admitted to almost constantly feeling like his mind was arguing with itself, hearing an old woman talking to him saying what a bad person he is, feeling someone standing behind him, and seeing odd light trails that others do not see. He notes that he is concerned that people in the government and in his neighborhood are monitoring him and want to put him in jail. He feels that if he stays in the house with the curtains closed and lights off it will be harder for them to catch him. He also changes his email frequently and avoids talking on the phone to make it harder to catch him. He sometimes gets messages from the TV. He reports recent suicidal thoughts but has no current plan. He denies homicidality but does not know what he would need to do if the neighbors or government entered his house. He reports that it has been hard to pay attention in school with his head arguing and that he is not sure that he will pass some of his classes.

At the time of his recent discharge, he was not able to identify any activities that he was sure he would enjoy. He was open to the idea of trying the drama class again. He continued to hear the woman especially late at night or when he was alone for an extended period of time, but knew others thought she was not real. He knew others thought the government was not interested in him but was not sure they would really know and continued to be concerned about this. He still preferred to be alone and continued to maintain that he had been abusing drugs.

Client and his mother return after 3 weeks for another team meeting. In the meantime, they have met with the Team Leader three times once in the family home, with the psychiatrist once and with the supported education worker once. The supported education worker has observed the client at school and obtained additional information from school staff. Skills specialist has not had any separate meetings with client or his family.

The Team Leader notes that the client seems to get upset when his mother, father, or brother express concern about him by clenching his fists or looking down at the floor. He does seem to be relaxed when the family dog sits by him or he is listening to music. He also seems more agitated when news shows or talk shows are on TV. She has gone over the shared decision making card with him and his parents. His parents have told the Team Leader that he can be very irritable if they ask about his homework or try to get him to sit with them after dinner. They also note that he is eating a lot and his clothes are getting tight. At times he seems very anxious and

preoccupied, and occasionally, he will talk quietly to himself but they are unsure what he is saying. Max's brother notes that Max is being teased at school, and Max reports that other students comment on his weight gain and untidy appearance. Other kids accuse him of using drugs, and most kids who are in classes with him seem to be afraid of him.

The supported education worker notes that the client currently is failing one class and has C's and D's in the others. His first period teacher (English) said he frequently puts his head down on the desk and appears to be asleep. He is not contributing to discussions in that class or in world history. If pushed in class, he begins muttering to himself or clenching his fists. He is also having trouble turning in homework and has particular trouble in geometry with understanding what to do or what formulas to use. He eats by himself in an isolated hallway. He will sometimes go watch people on the track after school. He reports difficulty paying attention in school, with his arguing head and that he is not sure that he will pass some of his classes.

He notes that he continues to hear the woman especially late at night or when he is alone for an extended period of time, but knows she is not real. He knows others think the government is not interested in him but is not sure how they would really know and continues to be concerned about this. He still prefers to be alone and continues to maintain that he had been abusing drugs.

He has been taking his risperidone, but has noted some sleepiness that makes school harder. He is worried about his weight.

Role play that models the encounter "done poorly":

> **Team Leader:** Welcome to the meeting. You are really lucky that everyone could come. We wanted to see how things were going and what else needs to be done. You know everyone here don't you?
>
> **Max:** Uh, I guess so?
>
> **Mother:** I don't remember everyone's names and I don't think I know the person on your left.
>
> **Team Leader:** Oh don't worry about remembering everyone's names. We know this is a stressful time for you. This is Sue, the skill trainer. Now let's see how things are going. Max, do you have any things that you especially want to work on?
>
> **Max:** Not really.
>
> **Team Leader:** Ok, Max are you having any thoughts about hurting yourself or someone else now?
>
> **Max:** Not really.
>
> **Mother:** But his brother did tell me that some of the kids were afraid of him.

Team Leader: Are you afraid of him and have you had any complaints from school staff?

Mom: No, but he does ball his fists up sometimes.

Team Leader: Max, would you tell someone if you were really feeling like hurting someone.

Max: Probably.

Team Leader: Good. Then it probably isn't a concern. Probably just their lack of awareness about schizophrenia. How are your symptoms Max?

Max: They seem a little bit better but I'm still having problems at school.

Psychiatrist: That is great. Are you having any stiffness, any restlessness?

Max: No.

Mother: He is eating a lot.

Psychiatrist: Don't worry. We can add a side effect medicine called metformin that I'll call in. And you should encourage him to eat more fruits. Any other concerns?

Max: Uhh, nah.

Team Leader: OK, are you doing things with friends or doing any things you enjoy.

Max: I talked to some guys on the track team the other day and that was ok. I like to play my games.

Team Leader: Great. Keep working on that. Ok. Now let's hear what the education specialist has to say about school.

IPS: Well, I've observed Max at school and talked to his teachers. They all seem very willing to help him but feel like he has to do his part. Max, they are concerned that you aren't turning in a lot of your work. Can you try to do better with that? I think it would really help you to use a planner to keep track of your assignments. Will you try that?

Max: I am trying. I already use a planner, but I keep losing it. It is really hard for me to pay attention sometimes because of the arguments and the noise.

IPS: We can have you sit in the front of the class so you won't get so distracted. We'll have to set up an IEP meeting. I know you are failing geometry, so I'll get you a tutor for that. The other thing the teachers brought up was your muttering under your breath and being more fidgety at times. I know that it is hard to do what adults ask you to do, but

you really have to or you'll be suspended. Can you try to be more respectful?

Max: I guess so, mumbles, "I am respectful, it's the other people who aren't."

Team Leader: Let's see what's left. No issues with family support, money, trauma or substance use so I guess we're done. Does anyone want to add anything or have any comments? OK, well see you in 2-3 weeks. We'll call to set something up. Thanks. Bye.

Facilitated Discussion re: What was Missing/Done Poorly:

This should include review/application of intervention principles/clinical concepts etc. (e.g., SDM, recovery-oriented, active/focused stance, use of open-ended explorations, flexibility and consistency, autonomy/availability).

Consideration of intervention components reviewed during previous session (including supported employment/education, social skills training/substance abuse, medication adherence, family support, etc.)

Role Play that Models the Encounter Done "Well":

Team Leader: Welcome to the meeting. Thank you all for coming. Helping Max get back to his usual self is going to take all of us working together as a team. We especially need your input Max and Mrs. Brown. The rest of us are here to help you understand what has happened with Max's thoughts and feelings and to help you figure out ways to make things work out better for him. We each have different experiences and skills that can be helpful to young people in situations like Max's, but everyone is unique and we need the two of you to tell us what is important to you and what you want to do. I know you have met most of the people here, but I wanted to have us all go around and introduce ourselves again and tell you a little bit about what we can help you figure out. Team goes around and introduce themselves and briefly describes the kinds of services they can provide and the kinds of problems they can help with.

Team Leader: This meeting is really to make sure we are going in the right directions and that you two don't have any other things that you want to work on right now or that other people on the team haven't noticed things that it might be helpful to consider. Max, how do you think things have been going the last few weeks?

Max: Uh, I don't know. It has been hard going back to school and everybody gets on my case all the time. But my brain isn't arguing with itself as much and I'm not hearing that mean lady as much.

Team Leader: It's great to hear that your symptoms are a bit better, but sounds like you wish things were better with school and people getting on your case. Would you rather talk about school or people getting on your case first.

Max: I don't know. I guess school. There isn't a lot of time left in the semester and I am

afraid I'm going to flunk out.

Team Leader: Can you help us understand more about what has been hard at school?

Max: I feel like people are looking at me and talking about me and I just want them to shut up.

Team Leader: That can be a really uncomfortable feeling. When does that happen?

Max: It happens a lot in class and there are these three guys who keep bothering me during lunch. They keep calling me a druggie and a zombie.

Team Leader: Do you have any ideas why those guys are saying that?

Max: No.

Mom: Your brother had mentioned that you often talk about using drugs at school. I know that you still talk about it at home sometimes. Do you think that has anything to do with it?

Max: I don't know.

IPS: I noticed that you often put your head down in class and don't very often talk unless you are upset and talking under your breath.

Max: It's when I am upset that people start looking at me and talking about me in class. They act like I am going to hurt them.

IPS: You can look a bit scary then because you also often make your hands into fists. Maybe we could help you figure out a different way to deal with being upset. Would you like that?

Max: Yeah. But it would be even better if people quit upsetting me by getting on my case. I try to stay awake but in the morning it is really hard. Sometimes it is just too much with my head arguing with itself and the teacher talking or asking why I don't say something or didn't turn in my work. When that happens I just try to tune everything out, if I try to keep up with the teacher I think my head will explode.

IPS: It sounds like there are lots of things going on at school. Let me see if I understand what you have said so far. You are worried about your grades. There is a problem with being sleepy in the morning. There are still problems with your head arguing that make it hard to pay attention. There are problems with people pushing you to hard. There are problems with people looking at you and talking with you that might have something to do with talking about using drugs or looking scary when you are upset. Is there anything I misunderstood or anything else going on at school that you want to tell us about.

PSYCHIATRIC HISTORY

Please provide a brief psychiatric history, including relevant information regarding (1) psychiatric hospitalizations, and (2) current and past medications

Please describe any known family psychiatric history:

RELEVANT MEDICAL HISTORY

Please describe any relevant medical history:

WORKING DIAGNOSIS (if obtained via medical records or from a provider):

Primary Diagnosis	
R/O:	
R/O:	

ADDITIONAL INFORMATION

Please provide any additional information that may be relevant to this potential client's treatment (especially potential client strengths, as well as important psychosocial history, family involvement, etc.):

Appendix 8. Evaluation Form

Dimension	Criterion	Check if criterion is met
Age	**Date of Birth** **Current Age**	____/____/____ ____ ____
IQ	**No history of IQ<70**	☐
Qualifying Symptoms of Psychosis ○ **Reduced Awareness that Unusual Experiences or Unusual Beliefs are Symptoms** **AND** ○ **Symptom Intensity and/or Impact on Behavior** **lasting at least a week**	**Check symptoms meeting criteria** ☐ **Beliefs of Reference** ☐ **Persecutory Beliefs** ☐ **Grandiose Beliefs** ☐ **Somatic Beliefs** ☐ **Other Unusual Beliefs** (Include unusual religious beliefs, beliefs of guilt, jealous beliefs, and erotomanic beliefs): ☐ **Beliefs of Being Controlled** (Include thought insertion or withdrawal): ☐ **Thought Broadcasting** ☐ **Unusual sensory experiences not shared by others. Check all that apply** ☐ **Auditory** ☐ **Visual** ☐ **Tactile** ☐ **Other** (includes Gustatory and/or Olfactory)	

Duration of Illness	**Qualifying symptoms of psychosis began less than 12 months ago. Provide date of onset (using date of earliest qualifying symptom)**	**Date of Onset** **____/____/____** **Age (at the time of onset)** **___ ___**
Qualifying Diagnostic Criteria	**Symptoms of psychosis not due to substance abuse** **- -** **Symptoms of psychosis not accounted for by a primary mood disorder** **- -** **Symptoms of psychosis not due to a general medical condition**	☐ ☐ ☐
DSM-V Diagnosis	**☐ Schizophrenia (295.90)** **☐ Schizoaffective Disorder (295.70)** **__ Bipolar Type** **__ Depressive Type** **☐ Schizophreniform Disorder (295.40)** **☐ Delusional Disorder (297.1)** **☐ Other specified schizophrenia spectrum and other psychotic disorder (298.8)** **☐ Unspecified schizophrenia spectrum and other psychotic disorder (298.9)**	
Proximity/Availability:		

Timeline (optional)

Date: Start/Stop	Symptoms of Psychosis	Mood Episode	Substance Use	General Medical Condition

Eligible for Program

- ☐ No (indicate Reason
- ☐ Yes: Proceed to Enrollment

Outreach and Recruitment Coordinator

Print Name:_____ Date: _____/_____/_____

Signature:_____

Senior Clinician

Print Name:_____ Date: _____/_____/_____

Signature:_____

Appendix 9. Evaluation Narrative

Name: _____

Date of birth: _____/_____/_____

Date of Evaluation: _____/_____/_____

Evaluating Clinician: _____

DEMOGRAPHICS AND HISTORY: age, current living situation, and current and recent educational or employment status

MEDICAL HISTORY: current non-psychiatric medications and medical conditions

OUTPATIENT PSYCHIATRIC TREATMENT HISTORY: emphasis on past 6 months

PREVIOUS HOSPITALIZATIONS and/or treatment for psychiatric conditions (including medication)

QUALIFYING SYMPTOMS OF PSYCHOSIS (symptom, brief description, and date of onset)

RELEVANT SUBSTANCE USE (including temporal relationship to onset of psychosis)

CURRENT AND PAST MOOD EPISODES (including temporal relationship to onset of psychosis)

If applicable, CORROBORATIVE INFORMATION (include source of information)

***Append copies of any medical records received during evaluation process**

Appendix 10. Resources List Template

Area Emergency Rooms (including psychiatric emergency programs
Local Emergency Department/Nearby Transportation (i.e., subway lines)
_____

Local Emergency Department/Nearby Transportation (i.e., subway lines)

Mobile Crisis teams and Psychiatric Emergency phone numbers

Psychiatric Emergency: 1-800-555-1212

Community District or Location/Main contact/phone #s:
_____

Community District or Location/Main contact/phone #s:
_____

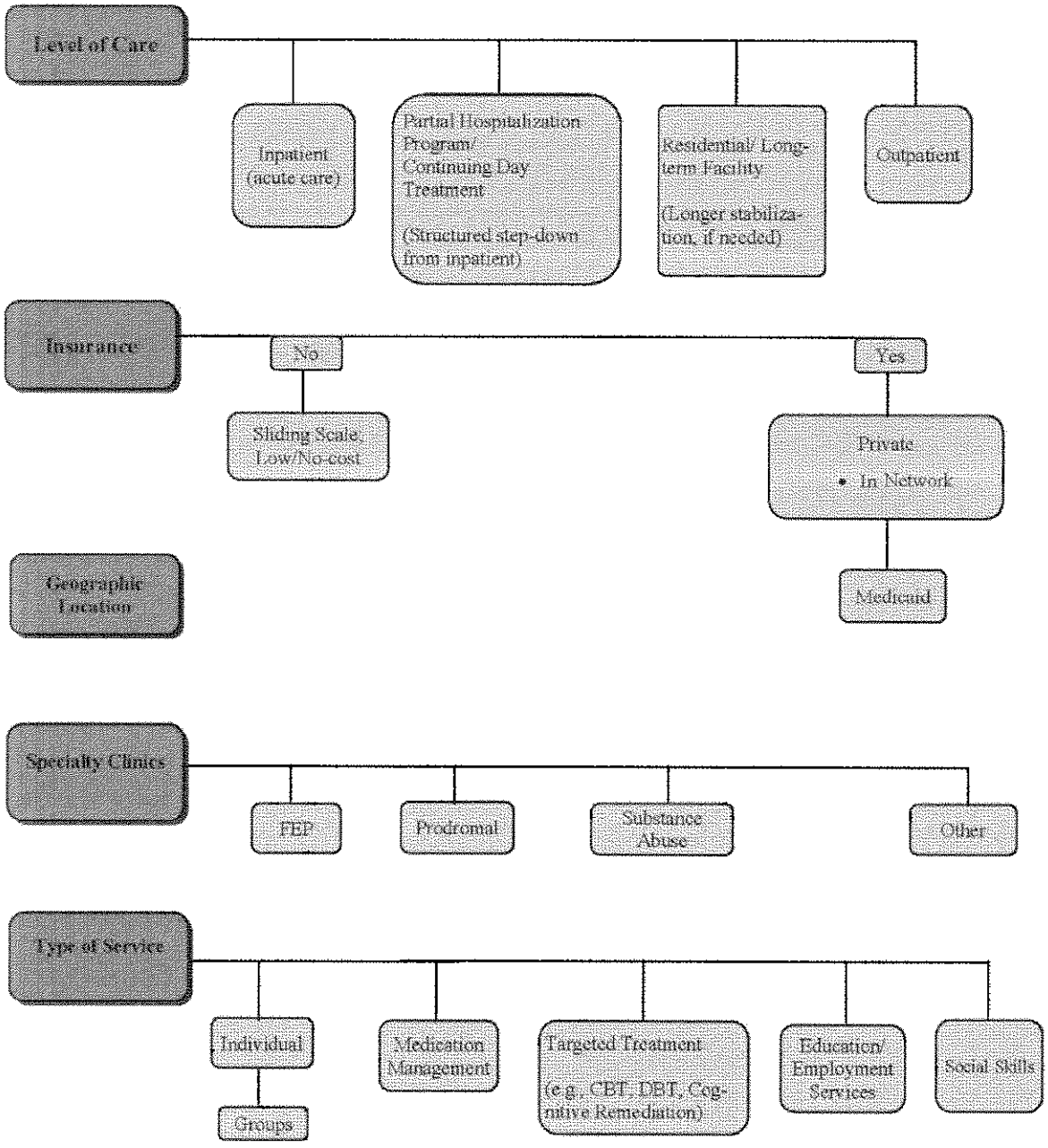
Clinics and Programs

- Organization name: _____
- Specific program/unit within the organization: _____
- Location and contact phone numbers (it can be helpful to include names of specific people you have talked to/established rapport with):
  Main contact: _____

  Phone #'s: _____

  Email: _____
- Population served (i.e., children, adolescents, adults): _____
- Insurance requirements and fees (if applicable): _____
- Catchment area requirements (if applicable): _____
- Services offered: Individual? Groups? Medication management? Supportive services?
  _____
- Conditions treated, including what they specialize in:
  _____

Appendix 11. Redirecting Referrals Diagram



Appendix 12. Establishing Outreach and Potential Client Tracking Systems

Two forms of tracking help to inform successful outreach: tracking outreach activities to your referral network and tracking potential client referrals received. These two sources of information will track where referrals are coming from, and which types of outreach activities are most successful. Table 1 provides an overview of the pros and cons of different tracking methods.

Table 1: Tracking Methods

Tracking Modality	Easy to Implement	Easy to search	Shared Entry	Reporting Capacity
Pen and Paper				
Word Document				
Basic Spreadsheet				
Automated Spreadsheet				
Database				

Pen and paper systems are easiest to implement; however, they can be difficult to search. Maintaining current records becomes difficult if shared across multiple individuals, and any reporting must be generated by hand. Both word processing documents and basic spreadsheets ease implementation and facilitate searches for specific potential clients or referral organizations. However, only one person can be updating a word processing document or spreadsheet at any given point in time. Basic spreadsheets have improved reporting capacity over word documents, but staff will need to be familiar with the spreadsheet software in order to generate reports. Automated spreadsheets will take more time to implement in exchange for improved reporting. However, only one individual can update the tracking system at a time. A database will take more time to implement; however, it will provide the most functionality.

Choose a method to track potential referral sources and outreach activities. Methods for tracking outreach and referral activities may vary by available technology at each organization and the number of individuals responsible for tracking outreach activities and service. Be sure to check existing systems at the clinic to determine if they can be expanded to include this work.

Establishing an Outreach Tracking System (OTS)

Develop a tracking system to monitor all outreach contacts and establish processes for making initial contact with potential clients to facilitate understanding the flow of referrals. Use this information to optimize the referral network as it grows. This tracking system should contain a list of organizations in the referral network and a list of activities performed at each organization.

Reporting. The OTS can be created to generate reports listing all recent outreach activities. It can also list organizations, the assigned ORS, and information about the last contact. This can remind the ORS to follow up with referral organizations periodically. It can also be used to schedule annual presentations, and maintain standard mailing and email lists of the referral network. Information from the Potential Client Tracking System can be combined with the RNOTS to provide information on which referral sources and outreach activities yield potential client referrals.

Data to Collect. Information on the organizations should be collected, as well as information on each outreach activity. Consider collecting the following information for each organization:

- Organization or Provider Name
- Organization or Provider Address and Contact Information, including email.
- Staff Names and contact information including phone numbers and emails
- Outreach activities conducted for that organization
- A planned date of next contact with each organization
- An assigned staff member, if establishing the referral network is to be distributed across multiple outreach staff members

Tracking types of outreach activities helps indicate which types of activities work successfully for different organizations. It can also notify staff member of the last outreach activity and times for follow up. For each outreach activity, consider tracking outreach activities using the following categories:

- Date of Activity
- Type of Activity
    - Individual Call: a telephone call between an outreach staff member and an individual contact at a potential referral source.
    - Individual Email: an e-mail exchange between an outreach staff member and an individual contact at a potential referral source.
    - Check-in: An outreach team member makes an onsite visit with at least one individual contact at a potential referral source.
    - Brochures: Distribution of brochures or flyers via standard mail, e-mail or in person to a potential referral source
    - Team Meeting: An outreach team member attends a staff or team meeting of professionals at a potential referral source.
    - Grand Rounds
    - Presentation
    - Blast Emails
    - Other
- Notes regarding the outreach activity, such as levels of interest or the names of outreach and referrer staff members involved

Populate the tracking system using the professional networks of individuals on the outreach and specialty clinic team. Develop a list of potential referral sources and contact

names of individuals and organizations that may encounter potential clients.

Establishing a Potential Client Tracking System (PCTS)

The early engagement process often requires multiple contacts with potential clients, family members, and clinicians over a period of days or months. As a result, a method for tracking the progression of individuals through the outreach and admission process becomes essential for effective follow up with potential clients. The Potential Client Tracking System (PCTS) helps the ORS and the clinical team follows the status of referred potential clients through the clinic admission process.

Reporting

The PCTS can be created to generate reports listing the referrals in process, the assigned ORS, and information about the last contact. This allows the ORS to follow up with potential clients, families, and clinicians in appropriate timeframes. The ORS and the clinical team can communicate regularly (e.g., weekly) about pending referrals, their stage in the evaluation and admission process and their anticipated admission date. This allows the ORS and the treatment team to effectively guide the potential client through the evaluation and admission process as quickly and seamlessly as possible.

Data to Collect:

If the PCTS will contain identifying potential client information, the system must be stored in compliance with HIPAA regulations. For each potential client referred, the outreach team may consider tracking the following descriptors:

- Person making initial contact: the individual who initially contacted the program about services, such as potential clients, family members, or clinicians;
- Potential client name
- Contact information
- Referred by: the institutions or sources suggested or arranged contact with the program;
- "Heard about from": How did the Person Making Initial Contact hear about the program? This includes both outreach methods (presentations, e-mails) and intermediaries, such as outpatient clinicians, community organizations, or the outreach staff member;
- Outreach method: the outreach mechanism that informed individuals making initial contact about the program;
- Disposition: the final status of each potential client indicating whether referral resulted in an admission, the individual did not meet admission criteria, or the individual refused.
- Notes

These data describe which initial contacts, outreach methods, and referral sources were most effective for potential clients based on the ratio of potential clients to admissions for that category. They provide information about which referral sources are sending

potential clients to the program, which outreach activities may be most effective, and who is contacting the program with referrals. This information can inform future decisions for optimizing and maintaining the referral network.

Appendix 13. Outreach Tracking Template

Name of Organization:

_____

Specific Department or Unit:

_____

Location and Main Phone #:

_____

Specific person(s) of interest, title/role, and their direct contact information (i.e., Sheila Johnson, MSW; discharge coordinator; phone#, email address)

Name: _____

Phone #: _____

Email: _____

Tracking Outreach

Date of Contact	ORS Name	Type of Outreach	Follow-Up Plan

Appendix 14. Referral Tracking Template

Date of Referral	Caller Name and/or Name of Potential Client	Organization (providers only)	Outcome of Referral (Screening/Evaluation in Progress; Intake; Referred Out- Not eligible; Referred Out-Waitlist

Appendix 15. Commonly Used Substances

Adapted from the Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-RV)

Sedatives-hypnotics-anxiolytics: ("downers")

Methaqualone (Quaalude, "ludes"), barbiturates, secobarbital (Seconal, "reds," "seccies," "dolls"), butalbital (Fiorinal), ethchlorvynol (Placidyl, "jelly-bellies"), meprobamate (Miltown, Equanil, "happy pills"), diazepam (Valium), alprazolam (Xanax), clonazepam (Klonopin), flunitrazepam (Rohypnol, "roofies"), gamma-Hydroxybutyric acid (GHB), temazepam (Restoril), flurazepam (Dalmane), chlordiazepoxide (Librium), lorazepam (Ativan), triazolam (Halcion), Ambien, Sonata, Lunesta

Cannabis:

Marijuana ("pot", "grass", "weed", "reefer"), hashish ("hash"), THC

Stimulants: ("uppers")

Amphetamine (Benzedrine, Adderall, "bennies," "black beauties"), "speed", methamphetamine ("crystal meth," "crank," "ice"), dextroamphetamine (Dexedrine, "greenies"), methylphenidate (Ritalin, Concerta, Metadate, Focolin, "Vitamin R"), prescription diet pills

Opioids:

Heroin ("smack," "dope"), morphine, opium, methadone (Dolophine), dextropropoxyphene (Darvocet, Darvon), codeine, oxycodone (Percodan, Percocet, OxyContin, Roxicet), hydrocodone (Vicodin, Lorcet), fentanyl (Duragesic, "percopop"), meperidine (Demerol), hydromorphone (Dilaudid)

Cocaine: Snorting, IV, freebase, crack, "speedball"

Hallucinogens: ("psychedelics")

LSD ("acid"), mescaline, peyote, psilocybin (mushrooms), MDMA ("STP," "Ecstasy")

Dissociative Anesthetics (includes PCP)

PCP ("angel dust", "peace pill"), ketamine ("Special K," "Vitamin K")

Other:

Steroids, solvents (paint thinners, gasoline, glues, toluene), gases (butane, propane, aerosol propellants, nitrous oxide (laughing gas, 'whippets')), nitrites (amyl nitrite, butyl nitrite, "poppers," "snappers"), DXM (DM, "Robo"), over-the-counter sleep or diet pills, ephedra, atropine, scopolamine

Appendix 16. Psychosis Associated with General Medical Conditions

Patients with psychotic symptoms that can be attributed to one or other medical illness will be excluded. Determination of a cause effect relationship between a medical illness and psychosis is not always easy. However such a relationship can be inferred by the presence of a temporal relationship between onset of the medical illness and the onset of psychosis, and between the offset or treatment induced remission of the medical illness and the resolution of psychotic symptoms. The following medical/ neurological illnesses are well known to be associated with psychotic symptoms.

1. Epilepsy
2. Head trauma
3. Dementias
4. Cerebrovascular disease, such as stroke or arteriovenous malformations
5. Hydrocephalus
6. Demyelinating diseases, such as multiple sclerosis
7. Huntington's disease
8. Wilson disease
9. Parkinson's disease
10. Autoimmune diseases, such as systemic lupus erythematosus
11. Infections such as viral encephalitis (e.g., herpes simplex, HIV infection), neurosyphilis, CNS-invasive parasitic infections (e.g., cerebral malaria, toxoplasmosis, neurocysticercosis), and tuberculosis
12. Endocrinopathies such as hypoglycemia, Addison's disease, and Cushing's disease
13. Space-occupying lesions (e.g., tumors, cysts)
14. Nutritional deficiencies such as niacin deficiency (pellagra), vitamin B^{12} deficiency (pernicious anemia)
15. Metabolic diseases such as homocystinuria, phenylketonuria
16. Chromosomal abnormalities such as sex chromosomes (e.g., Klinefelter syndrome, XXX syndrome), Fragile X syndrome, and velocardiofacial syndrome.
17. Congenital diseases (e.g., corpus callosal agenesis, Chiari malformation)

Appendix 17. Blast Letter to Providers (sample)

Dear Colleagues,

I am pleased to inform you about the **RAISE Connection Program**, a clinical research study to help individuals who have experienced an initial psychotic episode.

The RAISE Connection Program is for individuals aged 16-35 who have experienced psychotic symptoms for at least one week in the prior two years. All study participants will receive comprehensive care for up to 2 years, using evidence based practices delivered by a clinical team specialized in early psychosis. Services offered include: psychiatric treatment, medication management, help with finding a job or returning to school, substance abuse treatment, family education and support, and other support services as needed. Participants who are uninsured will receive study services without charge. The study is being conducted at the Washington Heights Community Service, located at the New York State Psychiatric Institute in New York City.

Research suggests that the sooner treatment is initiated after a first episode of psychosis, the more likely the person will experience significant recovery. The goal of the Connection Program is to promote engagement and participation in treatment, foster recovery, and reduce or prevent disability.

To learn more or to refer a potential participant, please contact Sapna Mendon, the RAISE Project Manager, at 212-543-6736 or *mendons@nyspi.columbia.edu* or visit our website at *www.connectionprogram.org*. Patients and their families are also encouraged to call for information.

Sincerely,
Ilana Nossel, M.D.
Department of Psychiatry
College of Physicians and Surgeons, Columbia University

Appendix 18. Brief for the Maryland Coalition of Families for Children's Mental Health Newsletter

Teens and young adults who develop schizophrenia may experience problems with hearing voices, paranoid or unusual thoughts, disorganized speech and behavior, as well as a significant decline in performance at school or work. Comprehensive, early intervention for this type of mental illness is important because it may be when problems are most responsive to treatment. The National Institute of Mental Health (NIMH) is funding the RA1SE Connection Program* to evaluate the best early interventions and treatments for individuals experiencing early psychosis.

The RA1SE Connection program is a research study that is evaluating early treatment interventions for adolescents and young adults who have experienced the onset of psychosis within the last two years. This study is being conducted in New York and Maryland. In Maryland, the study is being conducted at the Carruthers Clinic of the University of Maryland Community Psychiatry Program in Baltimore. The treatment assists the teen and family in obtaining needed services and emphasizes joint decision making between consumers and providers. The study will closely monitor how each adolescent or young adult is functioning socially and academically. Services are provided for up to two years. From this study, we hope to learn how treatments delivered in the earliest phases of illness can prevent disability among individuals with psychosis.

Your teenage or young adult family member may be eligible for the study if they are at least 15 years old and have had the onset of psychosis within two years. Information about the RA1SE connection program is available at *www.connectionprogram.org*, 888-864-5458 or *connection@psych.umaryland.edu.*

*The Connection Program has been funded in whole or in part with Federal funds from the American Recovery and Reinvestment Act of 2009 and the NIMH/NIH/HHS under Contract No. HHSN-271-2009-00020C.

Attachment A-5 LOC AEO Table Overview

Authorization Period: 180 Days **Recovery Plan: 180 Days**		
Average Monthly Utilization Standard For This Level of Care Is Base on Determined Need Across the population served at this level of care (LOC), some individual's may require more/less intense provision of services or utilize services at a higher/lower rate than others. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate and indicated in the recovery plan.		
Level of Care AEO **Estimated Utilization Per Month (These Are Guidelines Only)**		
Core Services: Identified by the uniform assessment and indicated in the recovery plan.	**Standard Therapeutic- 5.87 hours per month**	**High Need Therapeutic- 20.35 hours per month**
Psychiatric Diagnostic Interview Examination	1 Event/year, coded 90791, 90792	1 Event/year
Routine Case Management	1hr/ 4 units, coded T1017 (Individual)	6 hours/24 units T1017 Routine
Psychosocial Rehab (Individual)	3.5 Hours/ 14 units coded H2017	7 hours/29 units
Psychosocial Rehab (Group)	2.25 Hours/ 9 units coded H2017HQ	8.6 hours/35 units
Peer Support	Non-billable H0038	Non-billable
Pharmacological Management	.25 hours/ 1 unit, coded 99201-99205, 99211-99215, 99241-99245, M0064	0.5 hour/2 units
Administration of an injection	1 unit, coded 96372	1 unit, coded 96372
Medication Training & Support Services (Individual)	1 hour/ 4 units, coded H0034	1.5 hours/6 units
Medication Training & Support Services (Group)	.75 hour/3 units, coded H0034HQ	5 hours/21 units
Family Counseling	3 hours/3 events, coded 90847	4 hours/16 events
Individual Psychotherapy	3 hours/3 events, coded 90832, 90833, 90834, 90836, 90837, 90838	4 hours/16 events
Group Counseling (other than multiple family)	3 hours/3 Events, coded 90853	4 hours/16 events
Supported Housing	3 hours/12 units	4.25 hours/17 units
Supported Employment	3 hours/12 units	4.5 hours/18 units
Engagement Activity	105 hours/6 units	2.75 hours/11 units
Flexible Funds	Unit type: $1, coded H2016	Unit type: $1
Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Flexible Community Supports	Unit type: 15 min=1 unit, coded H2016	Unit type: 15 min=1 unit
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis.	**Utilization of crisis services within this Level of Care is the same as LOC-0.** Please refer to LOC-0 for utilization guidelines.	

Attachment A-6 LOC CEO Table Overview

Authorization Period: 180 Days Recovery Plan: 180 Days		
Average Monthly Utilization Standard For This Level of Care Is Base on Determined Need Across the population served at this level of care (LOC), some individual's may require more/less intense provision of services or utilize services at a higher/lower rate than others. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate and indicated in the recovery plan.		
Level of Care CEO Estimated Utilization Per Month (These Are Guidelines Only)		
Core Services: Identified by the uniform assessment and indicated in the recovery plan.	**Standard Therapeutic- 5.87 hours per month**	**High Need Therapeutic- 20.35 hours per month**
Psychiatric Diagnostic Interview Examination	1 event/year, coded 90791, 90792	1 Event/year
Pharmacological Management	.25 hours/1 unit, coded 99201-99205, 99211-99215, 99241-99245, M0064	0.5 hour/2 units
Administration of an Injection	As needed, coded 96372	
Skills Training and Development (Individual)	3 hours/12 units, coded H2014	4.5 hours/18 units
Skills Training and Development (Group)	3 hours/12 units, coded H2014	4.25 hours/17 units
Supported Employment and Education	coded H2023HA	
Supported Housing	coded H0046HAU2	
Medication Training & Support Services (Individual)	1 hour/4 units, coded H0034	1.5 hours/6 units
Medication Training & Support Services (Group)	.75 hour/3 units, coded H0034	5 hours/21 units
Individual Psychotherapy	3 hours/3 events, coded 90832, 90833, 90834, 90836, 90837, 90838	4 hours/16 events
Family Counseling	3 hours/3 events, coded 90847	4 hours/16 events
Multiple Family Psychotherapy	3 hours/3 events, coded 90849 This is not reimbursed by Medicaid	4 hours/16 events
Group Counseling (other than multiple family)	3 hours/3 events, coded 90853	4 hours/16 events
Family Partner Services	3.5 hours/14 units, coded H0038	7 hours/29 units
Case Management (Individual)	1hr/4 units, coded T1017 (Individual)	6 hours/24 units T1017 Routine 8 hours/32 units T1017 Intensive Individual (Wraparound)
Case Management (Family)	.5 hour/2 units, coded T1016 (Family)	1 hour/4 units
Family Training (Individual)	3 hours/12 units, coded H2019	6 hours/24 units
Family Training (Group)	3 hours/12 units, coded H2019	6 hours/24 units
Parent Support Group	1 hour/1 unit, coded H0025HAHQ	4 hours/4 units
Engagement Activity	6 hours/24 units, coded H0025HATS	

Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Flexible Funds	Unit type: $1, coded H2016	Unit type: $1
Flexible Community Supports	Unit type: 15 min=1 unit, coded H2016	Unit type: 15 min=1 unit
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis.	**Utilization of crisis services within this Level of Care is the same as LOC-0.** Please refer to LOC-0 for utilization guidelines.	

Attachment A-7: Acute Care Medical History Form

Individual's Name _____

Coordinated Specialty Care (CSC) Program Admission Date: _____

Primary Care Referral/Linkage Date: _____

First Appointment with Primary Care Physician (PCP) Date: _____

Subsequent Primary Care and Specialty Care Appointment Dates: _____

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Date: _____ **PCP** __ **Specialist** __

Notes: (Please document information related to the medical appointments that are pertinent to the persons CSC program and effectiveness or effects medical conditions may have on the individuals Mental Health condition)

	Instructions:
	Enter aggregate numbers associated
	Goal
1	10% of individuals enrolled
2	80% of individuals enrolled
3	60% of individuals enrolled
4	75% of individuals enrolled
5	50% of individuals enrolled
6	90% of individuals identified for discharge
7	90% of discharged individuals
	Goal
8	At least 90% of IPS Specialist's time should be devoted specifically to employment or education services
	Goal

9	Average length of stay for discharged individuals will not exceed 30 months
	[redacted]
10	1 meeting per week
11	2 meetings per month
	[redacted]

Attachment A-8 Early Onset Re

with each performance measure by quarter in cells below. The total and percent

Performance Measure	Quarter 1
The number of individuals in LOC EO who have received at least one visit in the community with the team lead, psychiatrist, psychiatric advanced practice nurse, psychiatric physician assistant, and/or skills trainer	
The number of individuals in LOC EO who have received at least one visit from an IPS specialist between the time of job/academic start and end dates	
Number of individual's prescribed antipsychotic medication	
Number of individual's who have had at least one trial of an antipsychotic medication prescribed for at least 4 weeks within the recommended dosage range	
Number of individual's whose family member/s have met with a member of the CSC team	
Number of individuals who participate in their discharge planning	
Number of discharged individuals who attend their first appointment with a mental health provider within 30 days of discharge	
	Enter Total IPS Spe and education belo

Performance Measure	Quarter 1
Documentation of IPS Specialist's work time	
	Enter average leng quarter below.

Performance Measure	Quarter 1

Average length of stay of indivuduals in LOC EO (adult and adolescent)	
	Enter the Amount
	Quarter 1
The number and frequency of Team Lead supervision with IPS specialist to review client situation and identify new strategies to help individuals in their work/school lives	
The number and frequency of client outcomes reviews conducted with the Team Lead and IPS specialist	

porting Form

:age reached for each performance measure will auto-calculate.

			DSHS Use Onl	
Quarter 2	Quarter 3	Quarter 4	Total	Average per Quarter
			0	#DIV/0!
			0	#DIV/0!
			0	#DIV/0!
			0	#DIV/0!
			0	#DIV/0!
			0	#DIV/0!
			0	#DIV/0!

:cialist time by hour spent per quarter on employment
)w.

Quarter 2	Quarter 3	Quarter 4	Total	Hours Worked in a Year
			0	1872

th of stay in months for discharged individuals per

Quarter 2	Quarter 3	Quarter 4	Total	Number of Program Months

			#DIV/0!	30
of Meetings per Week/Month per Quarter below				
Quarter 2	**Quarter 3**	**Quarter 4**	**Total**	**Number of Required Meetings**
			0	52
			0	24

y	
Percentage of Goal Reached	
0	
0	
0	
0	
0	
0	
0	
Percentage of Goal Reached	
0	
Percentage of Goal Reached	

#DIV/0!	
Percentage of Goal Reached	
0	
0	

Attachment A-9
EARLY ONSET
DATA DEFINITIONS

1. **Antipsychotic Medication-** The medications prescribed to an individual targeted at reducing the symptoms of psychosis.
2. **Antipsychotic Medication Trial-** Early Onset (EO) participant has tried at least one antipsychotic medication for a minimum of four weeks.
3. **Average Length of Stay per Quarter-** Add the total number of months each discharged participant accumulated, then divide the sum by the number of participants; this will give you the average; example: 30 participants discharged after 30 months of participation. 30 * 30 is 900. 900 is the total amount of participation months. Divide 900/30. 30 is the amount of discharged participants. The average number of participation months is 30.
4. **Community Visit-** Time spent with EO participant in location other than clinic.
5. **Discharge Follow-up Communication-** EO team will contact discharged participant to ensure follow-up services have been received.
6. **Discharge Planning-** EO team and participant collaborate together to determine best continuity of care plan for post-discharge services.
7. **EO Eligible Participant-** Individual between the ages of 15 and 30 who meet the admission criteria for the EO program.
8. **EO Enrolled Participant** – an EO eligible participant in Level Of Care (LOC) EO who has received at least one allowable service during the quarter of measure.
9. **Family/Team Meeting-** EO team and a member of the participant's family will meet for service provision discussion at least one time during the course of the participant's involvement with the EO program.
10. **IPS Follow Along Supports-** The 8th principle in the IPS model is Follow Along Supports. This is ongoing support provided after an individual has gotten employment and is continuous for as long as the individual receiving services wants it.
11. **IPS Specialist-** The person assigned to provide supported employment/education
12. **IPS Supervision Meeting-** Meeting between the Team Lead and the person providing supported employment/education
13. **Team Lead Meeting with IPS Specialist-** Meeting between the Team Lead and the person providing supported employment/education

Attachment A-10

SECURITY ADMINISTRATOR ATTESTATION & AUTHORIZED USERS LIST

I hereby attest to the following: Dave Hennessy

No unauthorized personnel (current or former) employed by Contractor have access to any Department of State Health Services (DSHS) database, or Texas Health and Human Services Commissioner (HHSC) database, that may be used in conducting business with the DSHS.

Access for all users who are no longer authorized to access DSHS and/or HHSC databases has been removed within 24 hours of authorization expiration, including for all Contractor's former employees.

A system for management of user accounts and user roles for the purpose of ensuring that all the user accounts are current has been developed and is being implemented by Contractor.

A written security policy that ensures adequate system security and protection of confidential information has been developed and maintained by Contractor, and I acknowledge that Contractor may be required to submit the policy to DSHS for review.

If any changes are made to the designated Security Administrator or the back-up Security Administrator, Contractor shall notify the DSHS Contract Manager using this Form no later than 10 business days after the change has been made.

The name, address and phone number for Security Administrator Personnel for my agency are:

Primary:
Name: Christopher Garrett
Address: 13800 Montfort Place Dallas, TX
Phone #: 214-743-1232
Email: Christopher.Garrett@metrocareservices.org

Secondary:
Name: Dave Hennessy
Address: 13800 Montfort Place, Dallas, TX
Phone #: 214-743-6141
Email: Dave.Hennessy@metrocareservices.org

This form is due no later than two weeks from date of executed contract, and every six (6) months thereafter. Information should be submitted via e-mail to the following e-mail address: mhcontracts@dshs.state.tx.us and a copy to the assigned DSHS contract manager.

Executive Director: John Burruss, MD / Linda Thompson, COO Date: 11/29/2016

Names of Employee, subcontracted labor or subcontractor	User Role	Date Added	Date Terminated

2017-049813-001

Categorical Budget:

PERSONNEL	$379,636.00
FRINGE BENEFITS	$91,113.00
TRAVEL	$20,800.00
EQUIPMENT	$20,448.00
SUPPLIES	$6,000.00
CONTRACTUAL	$0.00
OTHER	$183,253.00
TOTAL DIRECT CHARGES	$701,250.00
INDIRECT CHARGES	$77,917.00
TOTAL	$779,167.00
DSHS SHARE	$779,167.00
CONTRACTOR SHARE	$0.00
OTHER MATCH	$0.00

Total reimbursements will not exceed $779,167.00

Equipment List Attached.

The budgeted indirect cost amount is based on an indirect cost rate proposal prepared in accordance with OMB Circular A-87. A copy of the indirect cost rate proposal and supporting documents is on file in the contractors office and is subject to review by DSHS staff, or any of its duly authorized representatives. A copy of the current rate certification is on file at DSHS.

HHSC Uniform Terms and Conditions Version 2.12
Published and Effective: November 30, 2015
Responsible Office: Chief Counsel

TEXAS
Health and Human
Services Commission

Health and Human Services Commission

HHSC Uniform Terms and Conditions - Grant

Version 2.12

TABLE OF CONTENTS

ARTICLE I. DEFINITIONS AND INTERPRETIVE PROVISIONS

1.01 Definitions

As used in this Contract, unless the context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

"Amendment" means a written agreement, signed by the parties hereto, which documents changes to the Contract other than those permitted by Work Orders or Technical Guidance Letters, as herein defined.

"Attachment" means documents, terms, conditions, or additional information physically added to this Contract following the Signature Document or included by reference, as if physically, within the body of this Contract.

"Contract" means the Signature Document, these Uniform Terms and Conditions, along with any Attachments, and any Amendments, or Technical Guidance Letters that may be issued by the System Agency, to be incorporated by reference herein for all purposes if issued.

"Deliverable" means a work product prepared, developed, or procured by Grantee as part of the Services under the Contract for the use or benefit of the System Agency or the State of Texas.

"Effective Date" means the date agreed to by the Parties as the date on which the Contract takes effect.

"System Agency" means HHSC or any of the agencies of the State of Texas that are overseen by HHSC under authority granted under State law and the officers, employees, and designees of those agencies. These agencies include: the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of Family and Protective Services, and the Department of State Health Services.

"Federal Fiscal Year" means the period beginning October 1 and ending September 30 each year, which is the annual accounting period for the United States government.

"GAAP" means Generally Accepted Accounting Principles.

"GASB" means the Governmental Accounting Standards Board.

"Grantee" means the Party receiving funds under this Contract, if any.

"Health and Human Services Commission" or "HHSC" means the administrative agency established under Chapter 531, Texas Government Code or its designee.

"HUB" means Historically Underutilized Business, as defined by Chapter 2161 of the Texas Government Code.

"Intellectual Property" means patents, rights to apply for patents, trademarks, trade names, service marks, domain names, copyrights and all applications and worldwide registration of

such, schematics, industrial models, inventions, know-how, trade secrets, computer software programs, and other intangible proprietary information.

"Mentor Protégé" means the Comptroller of Public Accounts' leadership program found at: http://www.window.state.tx.us/procurement/prog/hub/mentorprotege/.

"Parties" means the System Agency and Grantee, collectively.

"Party" means either the System Agency or Grantee, individually.

"Program" means the statutorily authorized activities of the System Agency under which this Contract has been awarded.

"Project" means specific activities of the Grantee that are supported by funds provided under this Contract.

"Public Information Act" or "PIA" means Chapter 552 of the Texas Government Code.

"Statement of Work" means the description of activities performed in completing the Project, as specified in the Contract and as may be amended.

"Signature Document" means the document executed by both Parties that specifically sets forth all of the documents that constitute the Contract.

"Solicitation" means the document issued by the System Agency under which applications for Program funds were requested, which is incorporated herein by reference for all purposes in its entirety, including all Amendments and Attachments.

"Solicitation Response" means Grantee's full and complete response to the Solicitation, which is incorporated herein by reference for all purposes in its entirety, including any Attachments and addenda.

"State Fiscal Year" means the period beginning September 1 and ending August 31 each year, which is the annual accounting period for the State of Texas.

"State of Texas *Textravel*" means Texas Administrative Code, Title 34, Part 1, Chapter 5, Subchapter C, Section 5.22, relative to travel reimbursements under this Contract, if any.

"Technical Guidance Letter" or "TGL" means an instruction, clarification, or interpretation of the requirements of the Contract, issued by the System Agency to the Grantee.

1.02 Interpretive Provisions

a. The meanings of defined terms are equally applicable to the singular and plural forms of the defined terms.
b. The words "hereof," "herein," "hereunder," and similar words refer to this Contract as a whole and not to any particular provision, section, Attachment, or schedule of this Contract unless otherwise specified.
c. The term "including" is not limiting and means "including without limitation" and, unless otherwise expressly provided in this Contract, (i) references to contracts (including this Contract) and other contractual instruments shall be deemed to include all subsequent

Amendments and other modifications thereto, but only to the extent that such Amendments and other modifications are not prohibited by the terms of this Contract, and (ii) references to any statute or regulation are to be construed as including all statutory and regulatory provisions consolidating, amending, replacing, supplementing, or interpreting the statute or regulation.

d. Any references to "sections," "appendices," or "attachments" are references to sections, appendices, or attachments of the Contract.
e. Any references to agreements, contracts, statutes, or administrative rules or regulations in the Contract are references to these documents as amended, modified, or supplemented from time to time during the term of the Contract.
f. The captions and headings of this Contract are for convenience of reference only and do not affect the interpretation of this Contract.
g. All Attachments within this Contract, including those incorporated by reference, and any Amendments are considered part of the terms of this Contract.
h. This Contract may use several different limitations, regulations, or policies to regulate the same or similar matters. All such limitations, regulations, and policies are cumulative and each will be performed in accordance with its terms.
i. Unless otherwise expressly provided, reference to any action of the System Agency or by the System Agency by way of consent, approval, or waiver will be deemed modified by the phrase "in its sole discretion."
j. Time is of the essence in this Contract.

ARTICLE II PAYMENT METHODS AND RESTRICTIONS

2.01 Payment Methods

Except as otherwise provided by the provisions of the Contract, the payment method will be one or more of the following:

a. cost reimbursement. This payment method is based on an approved budget and submission of a request for reimbursement of expenses Grantee has incurred at the time of the request;
b. unit rate/fee-for-service. This payment method is based on a fixed price or a specified rate(s) or fee(s) for delivery of a specified unit(s) of service and acceptable submission of all required documentation, forms and/or reports; or
c. advance payment. This payment method is based on disbursal of the minimum necessary funds to carry out the Program or Project where the Grantee has implemented appropriate safeguards. This payment method will only be utilized in accordance with governing law and at the sole discretion of the System Agency.

Grantees shall bill the System Agency in accordance with the Contract. Unless otherwise specified in the Contract, Grantee shall submit requests for reimbursement or payment monthly by the last business day of the month following the month in which expenses were incurred or services provided. Grantee shall maintain all documentation that substantiates invoices and make the documentation available to the System Agency upon request.

2.02 Final Billing Submission

Unless otherwise provided by the System Agency, Grantee shall submit a reimbursement or payment request as a final close-out invoice not later than forty-five (45) calendar days following

the end of the term of the Contract. Reimbursement or payment requests received in the System Agency's offices more than forty-five (45) calendar days following the termination of the Contract may not be paid.

2.03 Financial Status Reports (FSRs)

Except as otherwise provided in these General Provisions or in the terms of any Program Attachment(s) that is incorporated into the Contract, for contracts with categorical budgets, Grantee shall submit quarterly FSRs to Accounts Payable by the last business day of the month following the end of each quarter of the Program Attachment term for System Agency review and financial assessment. Grantee shall submit the final FSR no later than forty-five (45) calendar days following the end of the applicable term.

2.04 Debt to State and Corporate Status

Pursuant to Tex. Gov. Code § 403.055, the Department will not approve and the State Comptroller will not issue payment to Grantee if Grantee is indebted to the State for any reason, including a tax delinquency. Grantee, if a corporation, certifies by execution of this Contract that it is current and will remain current in its payment of franchise taxes to the State of Texas or that it is exempt from payment of franchise taxes under Texas law (Tex. Tax Code §§ 171.001 et seq.). If tax payments become delinquent during the Contract term, all or part of the payments under this Contract may be withheld until Grantee's delinquent tax is paid in full.

2.05 Application of Payment Due

Grantee agrees that any payments due under this Contract will be applied towards any debt of Grantee, including but not limited to delinquent taxes and child support that is owed to the State of Texas.

2.06 Use of Funds

Grantee shall expend funds provided under this Contract only for the provision of approved services and for reasonable and allowable expenses directly related to those services.

2.07 Use for Match Prohibited

Grantee shall not use funds provided under this Contract for matching purposes in securing other funding without the written approval of the System Agency.

2.08 Program Income

Income directly generated from funds provided under this Contract or earned only as a result of such funds is Program Income. Unless otherwise required under the Program, Grantee shall use the addition alternative, as provided in UGMS § __.25(g)(2), for the use of Project income to further the Program, and Grantee shall spend the Program Income on the Project. Grantee shall identify and report this income in accordance with the Contract, applicable law, and the Contractor's Financial Procedures Manual located at http://www.dshs.state.tx.us/contracts/cfpm.shtm. Grantee shall expend Program Income during the Program Attachment term and may not carry forward to any succeeding term. Grantee shall refund program income not expended in the term in which it is earned to the System Agency. The System Agency may base future funding levels, in part, upon Grantee's proficiency in identifying, billing, collecting, and reporting Program Income, and in using it for the purposes and under the conditions specified in this Contract.

2.09 Nonsupplanting

Grantee shall not use funds from this Contract to replace or substitute for existing funding from other but shall use funds from this Contract to supplement existing state or local funds currently available. Grantee shall make a good faith effort to maintain its current level of support. Grantee may be required to submit documentation substantiating that a reduction in state or local funding, if any, resulted for reasons other than receipt or expected receipt of funding under this Contract.

ARTICLE III. STATE AND FEDERAL FUNDING

3.01 Funding

This Contract is contingent upon the availability of sufficient and adequate funds. If funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or agencies, amendment of the Texas General Appropriations Act, agency consolidation, or any other disruptions of current funding for this Contract, the System Agency may restrict, reduce, or terminate funding under this Contract. This Contract is also subject to immediate cancellation or termination, without penalty to the System Agency, if sufficient and adequate funds are not available. Grantee will have no right of action against the System Agency if the System Agency cannot perform its obligations under this Contract as a result of lack of funding for any activities or functions contained within the scope of this Contract. In the event of cancellation or termination under this Section, the System Agency will not be required to give notice and will not be liable for any damages or losses caused or associated with such termination or cancellation.

3.02 No debt Against the State

The Contract will not be construed as creating any debt by or on behalf of the State of Texas.

3.03 Debt to State

If a payment law prohibits the Texas Comptroller of Public Accounts from making a payment, the Grantee acknowledges the System Agency's payments under the Contract will be applied toward eliminating the debt or delinquency. This requirement specifically applies to any debt or delinquency, regardless of when it arises.

3.04 Recapture of Funds

The System Agency may withhold all or part of any payments to Grantee to offset overpayments made to the Grantee. Overpayments as used in this Section include payments (i) made by the System Agency that exceed the maximum allowable rates; (ii) that are not allowed under applicable laws, rules, or regulations; or (iii) that are otherwise inconsistent with this Contract, including any unapproved expenditures. Grantee understands and agrees that it will be liable to the System Agency for any costs disallowed pursuant to financial and compliance audit(s) of funds received under this Contract. Grantee further understands and agrees that reimbursement of such disallowed costs will be paid by Grantee from funds which were not provided or otherwise made available to Grantee under this Contract.

ARTICLE IV ALLOWABLE COSTS AND AUDIT REQUIREMENTS

4.01 Allowable Costs.

System Agency will reimburse the allowable costs incurred in performing the Project that are sufficiently documented. Grantee must have incurred a cost prior to claiming reimbursement and within the applicable term to be eligible for reimbursement under this Contract. The System Agency will determine whether costs submitted by Grantee are allowable and eligible for reimbursement. If the System Agency has paid funds to Grantee for unallowable or ineligible costs, the System Agency will notify Grantee in writing, and Grantee shall return the funds to the System Agency within thirty (30) calendar days of the date of this written notice. The System Agency may withhold all or part of any payments to Grantee to offset reimbursement for any unallowable or ineligible expenditure that Grantee has not refunded to the System Agency, or if financial status report(s) required under the Financial Status Reports section are not submitted by the due date(s). The System Agency may take repayment (recoup) from funds available under this Contract in amounts necessary to fulfill Grantee's repayment obligations. Applicable cost principles, audit requirements, and administrative requirements include-

Applicable Entity	Applicable Cost Principles	Audit Requirements	Administrative Requirements
State, Local and Tribal Governments	2 CFR, Part 225	2 CFR Part 200, Subpart F and UGMS	2 CFR Part 200 and UGMS
Educational Institutions	2 CFR, Part 220	2 CFR Part 200, Subpart F and UGMS	2 CFR Part 200 and UGMS
Non-Profit Organizations	2 CFR, Part 230	2 CFR Part 200, Subpart F and UGMS	2 CFR Part 200 and UGMS
For-profit Organization other than a hospital and an organization named in OMB Circular A-122 (2 CFR Part, 230) as not subject to that circular.	48 CFR Part 31, Contract Cost Principles Procedures, or uniform cost accounting standards that comply with cost principles acceptable to the federal or state awarding agency	2 CFR Part 200, Subpart F and UGMS	2 CFR Part 200 and UGMS

A chart of applicable Federal awarding agency common rules is located through a web link on the System Agency website at http://www.dshs.state.tx.us/contracts/links.shtm. OMB Circulars will be applied with the modifications prescribed by UGMS with effect given to whichever provision imposes the more stringent requirement in the event of a conflict.

4.02 Independent Single or Program-Specific Audit

If Grantee, within Grantee's fiscal year, expends a total amount of at least **SEVEN HUNDRED FIFTY THOUSAND DOLLARS ($750,000)** in federal funds awarded, Grantee shall have a single audit or program-specific audit in accordance with the 2 CFR 200. The $750,000 federal threshold amount includes federal funds passed through by way of state agency awards. If Grantee, within Grantee's fiscal year, expends a total amount of at least $500,000 in state funds awarded, Grantee must have a single audit or program-specific audit in accordance with UGMS, State of Texas Single Audit Circular. For-profit Grantees whose expenditures meet or exceed the federal or state expenditure thresholds stated above shall follow the guidelines in 2 CFR 200 or UGMS, as applicable, for their program-specific audits. The HHSC Office of Inspector General (OIG) will notify Grantee to complete the Single Audit Status Registration Form. If Grantee fails to complete the Single Audit Status Form within thirty (30) calendar days after notification by OIG to do so, Grantee shall be subject to the System Agency sanctions and remedies for non-compliance with this Contract. The audit must be conducted by an independent certified public accountant and in accordance with applicable OMB Circulars, Government Auditing Standards, and UGMS, which is accessible through a web link on the System Agency website at http://www.dshs.state.tx.us/contracts/links.shtm. Grantee shall procure audit services in compliance with this section, state procurement procedures, as well as with the provisions of UGMS

4.03 Submission of Audit

Within thirty (30) calendar days of receipt of the audit reports required by the Independent Single or Program-Specific Audit section, Grantee shall submit one copy to the Department's Contract Oversight and Support Section, and one copy to the OIG, at the following addresses:

Department of State Health Services
Contract Oversight and Support, Mail Code 1326
P.O. Box 149347
Austin, Texas 78714-9347
Health and Human Services Commission
Office of Inspector General
Compliance/Audit, Mail Code 1326
P.O. Box 85200
Austin, Texas 78708-5200

Electronic submission to the System Agency should be addressed as follows:
COSContractAdministration@dshs.state.tx.us

Electronic submission to HHSC should be addressed as follows:
Dani.fielding@hhsc.state.tx.us

If Grantee fails to submit the audit report as required by the Independent Single or Program-Specific Audit section within thirty (30) calendar days of receipt by Grantee of an audit report, Grantee shall be subject to the System Agency sanctions and remedies for non-compliance with this Contract.

ARTICLE V AFFIRMATIONS, ASSURANCES AND CERTIFICATIONS

5.01 General Affirmations

Grantee certifies that, to the extent General Affirmations are incorporated into the Contract under the Signature Document, the General Affirmations have been reviewed and that Grantee is in compliance with each of the requirements reflected therein.

5.02 Federal Assurances

Grantee further certifies that, to the extent Federal Assurances are incorporated into the Contract under the Signature Document, the Federal Assurances have been reviewed and that Grantee is in compliance with each of the requirements reflected therein.

5.03 Federal Certifications

Grantee further certifies, to the extent Federal Certifications are incorporated into the Contract under the Signature Document, that the Federal Certifications have been reviewed, and that Grantee is in compliance with each of the requirements reflected therein. **In addition, Grantee certifies that it is in compliance with all applicable federal laws, rules, or regulations, as they may pertain to this Contract.**

ARTICLE VI OWNERSHIP AND INTELLECTUAL PROPERTY

6.01 Ownership

The System Agency will own, and Grantee hereby assigns to the System Agency, all right, title, and interest in all Deliverables.

6.02 Intellectual Property

a. The System Agency and Grantee will retain ownership, all rights, title, and interest in and to, their respective pre-existing Intellectual Property. A license to either Party's pre-existing Intellectual Property must be agreed to under this or another contract.

b. Grantee grants to the System Agency and the State of Texas a royalty-free, paid up, worldwide, perpetual, non-exclusive, non-transferable license to use any Intellectual Property invented or created by Grantee, Grantee's contractor, or a subcontractor in the performance of the Project. Grantee will require its contractors to grant such a license under its contracts.

c. As used herein, "Intellectual Property" shall mean: inventions and business processes, whether or not patentable; works of authorship; trade secrets; trademarks; service marks; industrial designs; and other intellectual property incorporated in any Deliverable and first created or developed by Grantee, Grantee's contractor or a subcontractor in performing the Project.

ARTICLE VII RECORDS, AUDIT, AND DISCLOSURE

7.01 Books and Records

Grantee will keep and maintain under GAAP or GASB, as applicable, full, true, and complete records necessary to fully disclose to the System Agency, the Texas State Auditor's Office, the United States Government, and their authorized representatives sufficient information to determine compliance with the terms and conditions of this Contract and all state and federal rules, regulations, and statutes. Unless otherwise specified in this Contract, Grantee will maintain legible copies of this Contract and all related documents for a minimum of seven (7) years after the termination of the contract period or seven (7) years after the completion of any litigation or dispute involving the Contract, whichever is later.

7.02 Access to records, books, and documents

In addition to any right of access arising by operation of law, Grantee and any of Grantee's affiliate or subsidiary organizations, or Subcontractors will permit the System Agency or any of its duly authorized representatives, as well as duly authorized federal, state or local authorities, unrestricted access to and the right to examine any site where business is conducted or Services are performed, and all records, which includes but is not limited to financial, client and patient records, books, papers or documents related to this Contract. If the Contract includes federal funds, federal agencies that will have a right of access to records as described in this section include: the federal agency providing the funds, the Comptroller General of the United States, the General Accounting Office, the Office of the Inspector General, and any of their authorized representatives. In addition, agencies of the State of Texas that will have a right of access to records as described in this section include: the System Agency, HHSC, HHSC's contracted examiners, the State Auditor's Office, the Texas Attorney General's Office, and any successor agencies. Each of these entities may be a duly authorized authority. If deemed necessary by the System Agency or any duly authorized authority, for the purpose of investigation or hearing, Grantee will produce original documents related to this Contract. The System Agency and any duly authorized authority will have the right to audit billings both before and after payment, and all documentation that substantiates the billings. Grantee will include this provision concerning the right of access to, and examination of, sites and information related to this Contract in any Subcontract it awards.

7.03 Response/compliance with audit or inspection findings

a. Grantee must act to ensure its and its Subcontractor's compliance with all corrections necessary to address any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle, or any other deficiency identified in any audit, review, or inspection of the Contract and the goods or services provided hereunder. Any such correction will be at Grantee or its Subcontractor's sole expense. Whether Grantee's action corrects the noncompliance will be solely the decision of the System Agency.

b. As part of the Services, Grantee must provide to HHSC upon request a copy of those portions of Grantee's and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to the State under the Contract.

7.04 SAO Audit

Grantee understands that acceptance of funds directly under the Contract or indirectly through a Subcontract under the Contract acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an audit or investigation in connection with those funds. Under the direction of the legislative audit committee, an entity that is the subject of an audit or investigation by the SAO must provide the SAO with access to any information the SAO considers relevant to the investigation or audit. Grantee agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. Grantee will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through Grantee and the requirement to cooperate is included in any Subcontract it awards.

7.05 Confidentiality

Any specific confidentiality agreement between the Parties takes precedent over the terms of this section. To the extent permitted by law, Grantee agrees to keep all information confidential, in whatever form produced, prepared, observed, or received by Grantee. The provisions of this section remain in full force and effect following termination or cessation of the services performed under this Contract.

7.06 Public Information Act

Information related to the performance of this Contract may be subject to the PIA and will be withheld from public disclosure or released only in accordance therewith. Grantee must make all information not otherwise excepted from disclosure under the PIA available in portable document file (".pdf") format or any other format agreed between the Parties.

ARTICLE VIII CONTRACT MANAGEMENT AND EARLY TERMINATION

8.01 Contract Management

To ensure full performance of the Contract and compliance with applicable law, the System Agency may take actions including:

a. Suspending all or part of the Contract;
b. Requiring the Grantee to take specific corrective actions in order to remain in compliance with term of the Contract;
c. Recouping payments made to the Grantee found to be in error;
d. Suspending, limiting, or placing conditions on the continued performance of the Project;
e. Imposing any other remedies authorized under this Contract; and
f. Imposing any other remedies, sanctions or penalties permitted by federal or state statute, law, regulation, or rule.

8.02 Termination for Convenience

The System Agency may terminate the Contract at any time when, in its sole discretion, the System Agency determines that termination is in the best interests of the State of Texas. The termination will be effective on the date specified in HHSC's notice of termination.

8.03 Termination for Cause

Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, the System Agency may terminate the Contract, in whole or in part, upon either of the following conditions:

a. **Material Breach**

The System Agency will have the right to terminate the Contract in whole or in part if the System Agency determines, at its sole discretion, that Grantee has materially breached the Contract or has failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of Grantee's duties under the Contract. Grantee's misrepresentation in any aspect of Grantee's Solicitation Response, if any or Grantee's addition to the Excluded Parties List System (EPLS) will also constitute a material breach of the Contract.

b. **Failure to Maintain Financial Viability**

The System Agency may terminate the Contract if, in its sole discretion, the System Agency has a good faith belief that Grantee no longer maintains the financial viability required to complete the Services and Deliverables, or otherwise fully perform its responsibilities under the Contract.

8.04 Equitable Settlement

Any early termination under this Article will be subject to the equitable settlement of the respective interests of the Parties up to the date of termination.

ARTICLE IX MISCELLANEOUS PROVISIONS

9.01 Amendment

The Contract may only be amended by an Amendment executed by both Parties.

9.02 Insurance

Unless otherwise specified in this Contract, Grantee will acquire and maintain, for the duration of this Contract, insurance coverage necessary to ensure proper fulfillment of this Contract and potential liabilities thereunder with financially sound and reputable insurers licensed by the Texas Department of Insurance, in the type and amount customarily carried within the industry as determined by the System Agency. Grantee will provide evidence of insurance as required under this Contract, including a schedule of coverage or underwriter's schedules establishing to the satisfaction of the System Agency the nature and extent of coverage granted by each such policy, upon request by the System Agency. In the event that any policy is determined by the System Agency to be deficient to comply with the terms of this Contract, Grantee will secure such additional policies or coverage as the System Agency may reasonably request or that are required by law or regulation. If coverage expires during the term of this Contract, Grantee must produce renewal certificates for each type of coverage.

These and all other insurance requirements under the Contract apply to both Grantee and its Subcontractors, if any. Grantee is responsible for ensuring its Subcontractors' compliance with all requirements.

9.03 Legal Obligations

Grantee will comply with all applicable federal, state, and local laws, ordinances, and regulations, including all federal and state accessibility laws relating to direct and indirect use of information and communication technology. Grantee will be deemed to have knowledge of all applicable laws and regulations and be deemed to understand them. In addition to any other act or omission that may constitute a material breach of the Contract, failure to comply with this Section may also be a material breach of the Contract.

9.04 Permitting and Licensure

At Grantee's sole expense, Grantee will procure and maintain for the duration of this Contract any state, county, city, or federal license, authorization, insurance, waiver, permit, qualification or certification required by statute, ordinance, law, or regulation to be held by Grantee to provide the goods or Services required by this Contract. Grantee will be responsible for payment of all taxes, assessments, fees, premiums, permits, and licenses required by law. Grantee agrees to be responsible for payment of any such government obligations not paid by its contactors or subcontractors during performance of this Contract.

9.05 Indemnity

TO THE EXTENT ALLOWED BY LAW, GRANTEE WILL DEFEND, INDEMNIFY, AND HOLD HARMLESS THE STATE OF TEXAS AND ITS OFFICERS AND EMPLOYEES, AND THE SYSTEM AGENCY AND ITS OFFICERS AND EMPLOYEES, FROM AND AGAINST ALL CLAIMS, ACTIONS, SUITS, DEMANDS, PROCEEDINGS, COSTS, DAMAGES, AND LIABILITIES, INCLUDING ATTORNEYS' FEES AND COURT COSTS ARISING OUT OF, OR CONNECTED WITH, OR RESULTING FROM:

a. GRANTEE'S PERFORMANCE OF THE CONTRACT, INCLUDING ANY NEGLIGENT ACTS OR OMISSIONS OF GRANTEE, OR ANY AGENT, EMPLOYEE, SUBCONTRACTOR, OR SUPPLIER OF GRANTEE, OR ANY THIRD PARTY UNDER THE CONTROL OR SUPERVISION OF GRANTEE, IN THE EXECUTION OR PERFORMANCE OF THIS CONTRACT; OR

b. ANY BREACH OR VIOLATION OF A STATUTE, ORDINANCE, GOVERNMENTAL REGULATION, STANDARD, RULE, OR BREACH OF CONTRACT BY GRANTEE, ANY AGENT, EMPLOYEE, SUBCONTRACTOR, OR SUPPLIER OF GRANTEE, OR ANY THIRD PARTY UNDER THE CONTROL OR SUPERVISION OF GRANTEE, IN THE EXECUTION OR PERFORMANCE OF THIS CONTRACT; OR

c. EMPLOYMENT OR ALLEGED EMPLOYMENT, INCLUDING CLAIMS OF DISCRIMINATION AGAINST GRANTEE, ITS OFFICERS, OR ITS AGENTS; OR

d. WORK UNDER THIS CONTRACT THAT INFRINGES OR MISAPPROPRIATES ANY RIGHT OF ANY THIRD PERSON OR ENTITY BASED ON COPYRIGHT, PATENT, TRADE SECRET, OR OTHER INTELLECTUAL PROPERTY RIGHTS.

GRANTEE WILL COORDINATE ITS DEFENSE WITH THE SYSTEM AGENCY AND ITS COUNSEL. THIS PARAGRAPH IS NOT INTENDED TO AND WILL NOT BE CONSTRUED TO REQUIRE GRANTEE TO INDEMNIFY OR HOLD HARMLESS THE STATE OR THE SYSTEM AGENCY FOR ANY CLAIMS OR LIABILITIES RESULTING SOLELY FROM THE GROSS NEGLIGENCE OF THE SYSTEM AGENCY OR ITS EMPLOYEES. THE PROVISIONS OF THIS SECTION WILL SURVIVE TERMINATION OF THIS CONTRACT.

9.06 Assignments

Grantee may not assign all or any portion of its rights under, interests in, or duties required under this Contract without prior written consent of the System Agency, which may be withheld or granted at the sole discretion of the System Agency. Except where otherwise agreed in writing by the System Agency, assignment will not release Grantee from its obligations under the Contract.

Grantee understands and agrees the System Agency may in one or more transactions assign, pledge, or transfer the Contract. This assignment will only be made to another State agency or a non-state agency that is contracted to perform agency support.

9.07 Relationship of the Parties

Grantee is, and will be, an independent contractor and, subject only to the terms of this Contract, will have the sole right to supervise, manage, operate, control, and direct performance of the details incident to its duties under this Contract. Nothing contained in this Contract will be deemed or construed to create a partnership or joint venture, to create relationships of an employer-employee or principal-agent, or to otherwise create for the System Agency any liability whatsoever with respect to the indebtedness, liabilities, and obligations of Grantee or any other Party.

Grantee will be solely responsible for, and the System Agency will have no obligation with respect to:

a. Payment of Grantee's employees for all Services performed;
b. Wnsuring each of its employees, agents, or Subcontractors who provide Services or Deliverables under the Contract are properly licensed, certified, or have proper permits to perform any activity related to the Work;
c. Withholding of income taxes, FICA, or any other taxes or fees;
d. Industrial or workers' compensation insurance coverage;
e. Participation in any group insurance plans available to employees of the State of Texas;
f. Participation or contributions by the State to the State Employees Retirement System;
g. Accumulation of vacation leave or sick leave; or
h. Unemployment compensation coverage provided by the State.

9.08 Technical Guidance Letters

In the sole discretion of the System Agency, and in conformance with federal and state law, the System Agency may issue instructions, clarifications, or interpretations as may be required during Work performance in the form of a Technical Guidance Letter. A TGL must be in writing, and may be delivered by regular mail, electronic mail, or facsimile transmission. Any TGL issued by the System Agency will be incorporated into the Contract by reference herein for all purposes when it is issued.

9.09 Governing Law and Venue

This Contract and the rights and obligations of the Parties hereto will be governed by, and construed according to, the laws of the State of Texas, exclusive of conflicts of law provisions. Venue of any suit brought under this Contract will be in a court of competent jurisdiction in Travis County, Texas unless otherwise elected by the System Agency. Grantee irrevocably waives any objection, including any objection to personal jurisdiction or the laying of venue or

based on the grounds of forum non conveniens, which it may now or hereafter have to the bringing of any action or proceeding in such jurisdiction in respect of this Contract or any document related hereto. Severability

If any provision contained in this Contract is held to be unenforceable by a court of law or equity, this Contract will be construed as if such provision did not exist and the non-enforceability of such provision will not be held to render any other provision or provisions of this Contract unenforceable.

9.10 Survivability

Termination or expiration of this Contract or a Contract for any reason will not release either party from any liabilities or obligations in this Contract that the parties have expressly agreed will survive any such termination or expiration, remain to be performed, or by their nature would be intended to be applicable following any such termination or expiration, including maintaining confidentiality of information and records retention.

9.11 Force Majeure

Except with respect to the obligation of payments under this Contract, if either of the Parties, after a good faith effort, is prevented from complying with any express or implied covenant of this Contract by reason of war; terrorism; rebellion; riots; strikes; acts of God; any valid order, rule, or regulation of governmental authority; or similar events that are beyond the control of the affected Party (collectively referred to as a "Force Majeure"), then, while so prevented, the affected Party's obligation to comply with such covenant will be suspended, and the affected Party will not be liable for damages for failure to comply with such covenant. In any such event, the Party claiming Force Majeure will promptly notify the other Party of the Force Majeure event in writing and, if possible, such notice will set forth the extent and duration thereof.

9.12 No Waiver of Provisions

Neither failure to enforce any provision of this Contract nor payment for services provided under it constitute waiver of any provision of the Contract.

9.13 Publicity

Except as provided in the paragraph below, Grantee must not use the name of, or directly or indirectly refer to, the System Agency, the State of Texas, or any other State agency in any media release, public announcement, or public disclosure relating to the Contract or its subject matter, including in any promotional or marketing materials, customer lists, or business presentations.

Grantee may publish, at its sole expense, results of Grantee performance under the Contract with the System Agency's prior review and approval, which the System Agency may exercise at its sole discretion. Any publication (written, visual, or sound) will acknowledge the support received from the System Agency and any Federal agency, as appropriate.

9.14 Prohibition on Non-compete Restrictions

Grantee will not require any employees or Subcontractors to agree to any conditions, such as non-compete clauses or other contractual arrangements that would limit or restrict such persons or entities from employment or contracting with the State of Texas.

9.15 No Waiver of Sovereign Immunity

Nothing in the Contract will be construed as a waiver of sovereign immunity by the System Agency.

9.16 Entire Contract and Modification

The Contract constitutes the entire agreement of the Parties and is intended as a complete and exclusive statement of the promises, representations, negotiations, discussions, and other agreements that may have been made in connection with the subject matter hereof. Any additional or conflicting terms in any future document incorporated into the Contract will be harmonized with this Contract to the extent possible by the System Agency.

9.17 Counterparts

This Contract may be executed in any number of counterparts, each of which will be an original, and all such counterparts will together constitute but one and the same Contract.

9.18 Proper Authority

Each Party hereto represents and warrants that the person executing this Contract on its behalf has full power and authority to enter into this Contract. Any Services or Work performed by Grantee before this Contract is effective or after it ceases to be effective are performed at the sole risk of Grantee with respect to compensation.

9.19 Employment Verification

Grantee will confirm the eligibility of all persons employed during the contract term to perform duties within Texas and all persons, including subcontractors, assigned by the contractor to perform work pursuant to the Contract.

9.20 Civil Rights

a. Grantee agrees to comply with state and federal anti-discrimination laws, including:
   1. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);
   2. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
   3. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*);
   4. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
   5. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
   6. Food and Nutrition Act of 2008 (7 U.S.C. §2011 *et seq.*); and
   7. The System Agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

   Grantee agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

b. Grantee agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or

limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. State and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. Grantee agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

c. Grantee agrees to post applicable civil rights posters in areas open to the public informing clients of their civil rights and including contact information for the HHS Civil Rights Office. The posters are available on the HHS website at: http://www.hhsc.state.tx.us/about_hhsc/civil-rights/brochures-posters.shtml

d. Grantee agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services shall not discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

e. Upon request, Grantee will provide HHSC Civil Rights Office with copies of all of the Grantee's civil rights policies and procedures.

f. Grantee must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office
701 W. 51st Street, Mail Code W206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone: (512) 438-4313
TTY Toll Free: (877) 432-7232
Fax: (512) 438-5885.

ATTACHMENT D
GENERAL AFFIRMATIONS

By entering into this Contract, Contractor affirms, without exception, as follows:

1. Contractor represents and warrants that these General Affirmations apply to Contractor and all of Contractor's principals, officers, directors, shareholders, partners, owners, agents, employees, Subcontractors, independent contractors, and any other representatives who may provide services under, who have a financial interest in, or otherwise are interested in this Contract.

2. Contractor represents and warrants that all statements and information provided to the Enterprise Agency are current, complete, and accurate. This includes all statements and information relating in any manner to this Contract and any solicitation resulting in this Contract.

3. Contractor has not given, has not offered to give, and does not intend to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with this Contract.

4. Under Section 2155.004, Texas Government Code (relating to financial participation in preparing solicitations), Contractor certifies that it is not ineligible to receive this Contract and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

5. Under Section 2155.006, Texas Government Code (relating to convictions and penalties regarding Hurricane Rita, Hurricane Katrina, and other disasters), Contractor certifies that it is not ineligible to receive this Contract and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

6. Under Section 2261.053, Texas Government Code (relating to convictions and penalties regarding Hurricane Rita, Hurricane Katrina, and other disasters), Contractor certifies that it is not ineligible to receive this Contract and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

7. Under Section 231.006, Texas Family Code (relating to delinquent child support), Contractor certifies that it is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Contract may be terminated and payment may be withheld if this certification is inaccurate.

8. Contractor certifies that: (a) the entity executing this Contract; (b) its principals; (c) its Subcontractors; and (d) any personnel designated to perform services related to this Contract are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal Department or Agency. This certification is made pursuant to the regulations implementing Executive Order 12549 and Executive Order 12689, Debarment and Suspension, 2 C.F.R. Part 376, and any relevant regulations promulgated by the Department or Agency funding this project. This provision shall be included in its entirety in Contractor's Subcontracts if payment in whole or in part is from federal funds.

9. Contractor certifies that it, its principals, its Subcontractors, and any personnel designated to perform services related to this Contract are eligible to participate in this transaction and have not been subjected to suspension, debarment, or similar ineligibility determined by any federal, state, or local governmental entity.

10. Contractor certifies it is in compliance with all State of Texas statutes and rules relating to procurement; and that (a) the entity executing this Contract; (b) its principals; (c) its Subcontractors; and (d) any personnel designated to perform services related to this Contract are not listed on the federal government's terrorism watch list described in Executive Order 13224. Entities ineligible for federal procurement are listed at **https://www.sam.gov/portal/public/SAM/**, which Contractor may review in making this certification. Contractor acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate. This provision shall be included in its entirety in Contractor's Subcontracts if payment in whole or in part is from federal funds.

ATTACHMENT D
GENERAL AFFIRMATIONS

11. In accordance with Texas Government Code Section 669.003 (relating to contracting with the executive head of a state agency), Contractor certifies that it (1) is not the executive head of the Enterprise Agency; (2) was not at any time during the past four years the executive head of the Enterprise Agency; and (3) does not employ a current or former executive head of the Enterprise Agency.

12. Contractor represents and warrants that it is not currently delinquent in the payment of any franchise taxes owed the State of Texas under Chapter 171 of the Texas Tax Code.

13. Contractor represents and warrants that payments to Contractor and Contractor's receipt of appropriated or other funds under this Contract are not prohibited by Sections 556.005, 556.0055, or 556.008 of the Texas Government Code (relating to use of appropriated money or state funds to employ or pay lobbyists, lobbying expenses, or influence legislation).

14. Contractor represents and warrants that it will comply with Texas Government Code Section 2155.4441, relating to the purchase of products produced in the State of Texas under service contracts.

15. Pursuant to Section 2252.901, Texas Government Code (relating to prohibitions regarding contracts with and involving former and retired state agency employees), Contractor will not allow any former employee of the Enterprise Agency to perform services under this Contract during the twelve (12) month period immediately following the employee's last date of employment at the Enterprise Agency.

16. Contractor acknowledges that, pursuant to Section 572.069 of the Texas Government Code, a former state officer or employee of the Enterprise Agency who during the period of state service or employment participated on behalf of the Enterprise Agency in a procurement or contract negotiation involving Contractor may not accept employment from Contractor before the second anniversary of the date the officer's or employee's service or employment with the Enterprise Agency ceased.

17. Contractor understands that the Enterprise Agency does not tolerate any type of fraud. The Enterprise Agency's policy is to promote consistent, legal, and ethical organizational behavior by assigning responsibilities and providing guidelines to enforce controls. Violations of law, agency policies, or standards of ethical conduct will be investigated, and appropriate actions will be taken. All employees or contractors who suspect fraud, waste or abuse (including employee misconduct that would constitute fraud, waste, or abuse) are required to immediately report the questionable activity to both the Health and Human Services Commission's Office of the Inspector General at 1-800-436-6184 and the State Auditor's Office. Contractor agrees to comply with all applicable laws, rules, regulations, and Enterprise Agency policies regarding fraud including, but not limited to, HHS Circular C-027.

18. Contractor represents and warrants that it has not violated state or federal antitrust laws and has not communicated its bid for this Contract directly or indirectly to any competitor or any other person engaged in such line of business. Contractor hereby assigns to Enterprise Agency any claims for overcharges associated with this Contract under 15 U.S.C. § 1, *et seq.*, and Texas Business and Commerce Code § 15.01, *et seq.*

19. Contractor represents and warrants that it is not aware of and has received no notice of any court or governmental agency proceeding, investigation, or other action pending or threatened against Contractor or any of the individuals or entities included numbered paragraph 1 of these General Affirmations within the five (5) calendar years immediately preceding the execution of this Contract that would or could impair Contractor's performance under this Contract, relate to the contracted or similar goods or services, or otherwise be relevant to the Enterprise Agency's consideration of entering into this Contract. If Contractor is unable to make the preceding representation and warranty, then Contractor instead represents and warrants that it has provided to the Enterprise Agency a complete, detailed disclosure of any such court or governmental agency proceeding, investigation, or other action that would or could impair Contractor's performance under this Contract, relate to the contracted or

similar goods or services, or otherwise be relevant to the Enterprise Agency's consideration of entering into this Contract. In addition, Contractor represents and warrants that it shall notify the Enterprise Agency in writing within five (5) business days of any changes to the representations or warranties in this clause and understands that failure to so timely update the Enterprise Agency shall constitute breach of contract and may result in immediate termination of this Contract.

20. Contractor understands, acknowledges, and agrees that any false representation or any failure to comply with a representation, warranty, or certification made by Contractor is subject to all civil and criminal consequences provided at law or in equity including, but not limited to, immediate termination of this Contract.

21. Contractor represents and warrants that it will comply with all applicable laws and maintain all permits and licenses required by applicable city, county, state, and federal rules, regulations, statues, codes, and other laws that pertain to this Contract.

22. Contractor represents and warrants that the individual signing this Contract is authorized to sign on behalf of Contractor and to bind Contractor.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT E
SUPPLEMENTAL & SPECIAL CONDITIONS

SUPPLEMENTAL CONDITIONS

THE FOLLOWING SUPPLEMENTAL CONDITIONS APPLY TO THIS CONTRACT AND MODIFY THE HHS UNIFORM TERMS AND CONDITIONS

Article III. State and Federal Funding, is revised to add:

Section 3.05 System Agency at its sole discretion, may adjust the funding amount of Contract based on performance measures, outcome measures, waitlist, and/or other criteria determined by System Agency. Contingent on availability of funds allocated for the adjustments System Agency may implement an alternative reimbursement methodology using the rates set forth herein (or using the rates that exist at the time a contract is executed). This alternative methodology may include the use of a case rate based on expected lengths of stay. The Parties may be required to execute a written amendment under this section.

Section 3.06 Funding for subsequent state fiscal years will be added on or before September 1st of each year and is contingent on the availability of state funds from System Agency. State fiscal years are defined as September 1st through August 31st.

Section 7.01, Books and Records, Article VII. Records, Audit, and Disclosure, is revised to add the following:

a. If the federal retention period for services that are funded through Medicaid is more than seven years, then the Contractor will retain the records for longer period of time.
b. Contractor shall retain all records pertaining to this Contract that are the subject of litigation or an audit until the litigation has ended or all questions pertaining to the audit are resolved.
c. Contractor shall retain medical records in accordance with 22 TAC §165.1(b) or other applicable statutes, rules and regulations governing medical information.
d. Contractor shall include this provision concerning records retention in any subcontract it awards.
e. Contractor ceases business operations, it shall ensure that records relating to this Contract are securely stored and are accessible by the Department upon Department's request for at least four years from the date Contractor ceases business or from the date this Contract terminates, whichever is sooner.
f. Contractor shall provide, and update as necessary, the name and address of the party responsible for storage of records to the contract manager assigned to this Contract.

Section 8.01 Contract Management, Article VIII, Contract Management and Early Termination, Subsection e., is revised as follows:

e. imposing any other remedies authorized under this Contract:

The remedies and sanctions in this section are available to the System Agency against Contractor and any entity that subcontracts with Contractor for provision of services or goods.

Additionally, HHSC OIG may investigate, audit and impose or recommend imposition of remedies or sanctions to the System Agency for any breach of this Contract.

The System Agency may impose one or more remedies or sanctions for each item of noncompliance and shall determine remedies or sanctions on a case-by-case basis if Contractor breaches this Contract by failing to comply with one or more of the terms of this Contract, including but not limited to compliance with applicable statutes, rules or regulations, the System Agency may take one or more of the following actions:

1. Place Contractor on accelerated monitoring, which means more frequent or more extensive monitoring than ordinarily conducted by System Agency. System Agency may allow Contractor the opportunity to correct identified deficiencies prior to imposing other actions stated in this section.
2. Terminate this Contract by one of means provided in Article VII. If applicable, notify Contractor of the opportunity to request a hearing on the termination pursuant to Texas Government Code Chapter

2105 regarding administration of Block Grants;

3. Suspend all or part of this Contract by notifying that the Contractor that System Agency is temporarily discontinue performance of all or a part of the Contract as provided for in Article VII; as of the effective date of the suspension pending System Agency 's determination to terminate, amend the Contract or permit the Contractor to resume performance. Contractor shall not bill System Agency for services performed during suspension, unless expressly authorized by the notice of suspension;
4. Use as a basis to deny additional or enter into future contracts with Contractor;
5. Temporarily withhold cash payments to Contractor for proper charges or pending resolution of issues of noncompliance with conditions of this Contract or indebtedness to the United States or to the State of Texas;
6. Permanently withhold cash payments by retaining funds billed by Contractor;
7. Request that Contractor be removed from the Centralized Master Bidders List (CMBL) or any other state bid list, and barred from participating in future contracting opportunities with the State of Texas;
8. Declare this Contract void upon the System Agency's determination that this Contract was obtained fraudulently or was illegal or invalid from this Contract's inception and demand repayment of any funds under this Contract;
9. Delay execution of a new contract or renewal with Contractor while other imposed or proposed sanctions are pending resolution;
10. Demand repayment from Contractor when it has been verified that Contractor has been overpaid for reasons such as payments are not supported by proper documentation or failure to comply with Contract terms;
11. Pursue a claim for damages as a result of breach of contract;
12. Impose liquidated damages. Contractor agrees that noncompliance with the requirements specified in the Contract causes damages to System Agency that are difficult to ascertain and quantify. Contractor further agrees that System Agency may impose liquidated damages of $250 for the first and second occurrence of noncompliance with the same requirement during a fiscal year; and $500 for the third and subsequent occurrence(s) of noncompliance with the same requirement during the same fiscal year.
13. Require Contractor to prohibit any employee or volunteer of Contractor from performing under this Contract or having direct contact with System Agency -funded clients or participant, if the employee or volunteer has been indicted or convicted of the misuse of state or federal funds, fraud or illegal acts that are in contraindication to continued obligations under this Contract, as reasonably determined by System Agency;
14. Withhold any payment to Contractor to satisfy any recoupment imposed by System Agency and take repayment from funds available under this Contract in amounts necessary to fulfill Contractor's payment or repayment obligations;
15. Reduce the Contract term;
16. Recoup improper payments when Contractor has been overpaid for reasons such as payments are not supported by proper documentation, improper billing or failure to comply with Contract terms; and

Section 8.01 Contract Management, Article VIII, Contract Management and Early Termination, is revised to add Subsection g. Notice of Remedies or Sanctions as follows:

g. Notice of Remedies or Sanctions:
   1. System Agency shall formally notify Contractor in writing when a remedy or sanction is imposed, stating the nature of the remedies and sanction, the reasons for imposing them, the corrective actions, if any, that must be taken before the actions shall be removed and the time allowed for completing the corrective actions, and the method, if any, of requesting reconsideration of the remedies or sanctions imposed.
   2. Other than in the case of repayment or recoupment, Contractor is required to file, within 10 calendar days of receipt of notice, a written response to System Agency acknowledging receipt of such notice.
   3. If requested by the System Agency , the written response must state how Contractor shall correct the noncompliance by agreeing to a corrective action plan or demonstrate in writing that the findings on which the remedies or sanctions are based are either invalid or do not warrant the remedies or sanctions. If System Agency determines that a remedy or sanction is warranted, unless the remedy or

sanction is subject to review under a federal or state statute, regulation, rule, or guideline, System Agency's decision is final. System Agency shall provide written notice to Contractor of System Agency's final decision.

4. If required by the System Agency, Contractor shall submit a corrective action plan for System Agency approval and take corrective action as stated in the plan approved by System Agency. If System Agency determines that repayment is warranted, System Agency shall issue a demand letter to Contractor for repayment. If full repayment is not received within the time limit stated in the demand letter, and if recoupment is available, System Agency shall recoup the amount due to System Agency from funds otherwise due to Contractor under this Contract.

Section 8.03, Termination for Cause, Subsection a. Material Breach, Article VIII. Contract Management and Early Termination, is revised to add the following:

Actions or inactions that constitute breach of contract include, but are not limited to, the following:

a. Failure to properly provide the services and/or goods purchased under this Contract;
b. Failure to comply with any provision of this Contract including failure to comply with all applicable statutes, rules or regulations;
c. Failure to pay refunds or penalties owed to the Department;
d. Failure to comply with a repayment agreement with Department or agreed order issued by the Department;

Section 9.20, Civil Rights, subsection b., Article IX, Miscellaneous Provisions, is revised to add the following:

g. Contractor shall identify and document on the client records the primary language/dialect of a client who has limited English proficiency and the need for translation or interpretation services and shall not require a client to provide or pay for the services of a translator or interpreter.
h. Contractor shall make every effort to avoid use of any persons under the age of 18 or any family member or friend of the client as an interpreter for essential communications with a client with limited English proficiency unless the client has requested that person and using the person would not compromise the effectiveness of services or violate the client's confidentiality and the client is advised that a free interpreter is available.

SPECIAL CONDITIONS

Section 1.01 Notice of Legal Matter or Litigation.
Grantee shall notify the contract manager assigned to this Contract of any litigation or legal matter related to or affecting this Contract within seven calendar days of becoming aware of the litigation or legal matter.

Section 1.02 Notice of a Contract Action.
Grantee shall notify their assigned contract manager assigned to the contract if Grantee has had any contract suspended or terminated for cause by any local, state or federal department or agency or nonprofit entity within five days of becoming aware of the action and include the following:

a. Reason for such action;
b. Name and contact information of the local, state or federal department or agency or entity;
c. Date of the contract;
d. Date of suspension or termination; and
e. Contract or case reference number.

Section 1.03 Notice of Bankruptcy. Grantee shall notify in writing their assigned contract manager assigned of its plan to seek bankruptcy protection within five days of such action by Grantee.

Section 1.04 Notice of Criminal Activity and Disciplinary Actions.

a. Grantee shall immediately report in writing their contract manager when the Grantee has knowledge or reason to believe any that they or any person with ownership or controlling interest in the organization/business, or their agent, employee, subContractor or volunteer that is providing services under this Contract has engaged in any activity that:

   1. Would constitute a criminal offense equal to or greater than a Class A misdemeanor; and
   2. Reasonably would constitute grounds for disciplinary action by a state or federal regulatory authority; or
   3. Has been placed on community supervision, received deferred adjudication, or been indicted for or convicted of a criminal offense relating to involvement in any financial matter, federal or state program or felony sex crime.

b. Grantee shall not permit any person who engaged, or was alleged to have engaged, in any activity subject to reporting under this section to perform direct client services or have direct contact with clients, unless otherwise directed in writing by DSHS.

Section 1.05 Grantee's Notification of Change of Contact Person or Key Personnel. Within ten days shall notify in writing the contract manager assigned to the Contract of any change enumerated in the Grantee's Contact Person or Key Personnel.

Section 1.06 Education to Persons in Residential Facilities. Grantee shall ensure that all persons, who are housed in Department-licensed and/or -funded residential facilities and are 22 years of age or younger, have access to educational services as required by Texas Education Code § 29.012.

Grantee shall notify the local education agency or local early intervention program as prescribed by this Section not later than the third calendar day after the date a person who is 22 years of age or younger is placed in Grantee's residential facility.

Section 1.07 Disaster Services. In the event of a local, state, or federal emergency, including natural, man-made, criminal, terrorist, and/or bioterrorism events, declared as a state disaster by the Governor, or a federal disaster by the appropriate federal official, Grantee may be called upon to assist DSHS in providing the following services:

a. Community evacuation;
b. Health and medical assistance;
c. Assessment of health and medical needs;
d. Health surveillance;
e. Medical care personnel;
f. Health and medical equipment and supplies;
g. Patient evacuation;
h. In-hospital care and hospital facility status;
i. Food, drug and medical device safety;
j. Worker health and safety;
k. Mental health and substance abuse;
l. Public health information;
m. Vector control and veterinary services; and
n. Victim identification and mortuary services.

Section 1.08 Consent by Non-Parent or Other State Law to Medical Care of a Minor. Unless federal law applies, when a Grantee provides medical, dental, psychological or surgical treatment to a minor without parental consent, either directly or through contracts with subContractors, before the Grantee provides treatment to minor unless informed consent to treatment is obtained pursuant to Texas Family Code

Chapter 32.

Section 1.09 Telemedicine/Telepsychiatry Medical Services. If Grantee or its subContractor uses telemedicine/telepsychiatry, these services shall be in accordance with the Grantee's written procedures and using a protocol approved by Grantee's medical director and uses equipment that complies with the DSHS equipment standards. Grantee must adhere to TAC Title 22, Part 9, Chapter 174, relating to Telemedicicine and any other applicable standards. Grantee's procedures for providing telemedicine service must include the following requirements

a. Clinical oversight by Grantee's medical director or designated physician responsible for medical leadership;
b. Contraindication considerations for telemedicine use;
c. Qualified staff members to ensure the safety of the individual being served by telemedicine at the remote site;
d. Safeguards to ensure confidentiality and privacy in accordance with state and federal laws;
e. Use by credentialed licensed providers providing clinical care within the scope of their licenses;
f. Demonstrated competency in the operations of the system by all staff members who are involved in the operation of the system and provision of the services prior to initiating the protocol;
g. Priority in scheduling the system for clinical care of individuals;
h. Quality oversight and monitoring of satisfaction of the individuals served; and
i. Management of information and documentation for telemedicine services that ensures timely access to accurate information between the two sites. Telemedicine Medical Services does not include chemical dependency treatment services provided by electronic means under 25 Texas Administrative Code Rule § 448.911.

Section 1.10 Services and Information for Persons with Limited English Proficiency.

a. Grantee shall take reasonable steps to provide services and information both orally and in writing, in appropriate languages other than English, to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits and activities.

b. Grantee shall identify and document on the client records the primary language/dialect of a client who has limited English proficiency and the need for translation or interpretation services and shall not require a client to provide or pay for the services of a translator or interpreter.

c. Grantee shall make every effort to avoid use of any persons under the age of 18 or any family member or friend of the client as an interpreter for essential communications with a client with limited English proficiency unless the client has requested that person and using the person would not compromise the effectiveness of services or violate the client's confidentiality and the client is advised that a free interpreter is available.

Section 1.11 Third Party Payors. Except as provided in this Contract, Grantee shall screen all clients and may not bill the Department for services eligible for reimbursement from third party payors, who are any person or entity who has the legal responsibility for paying for all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other federal, state, local and private funding sources.

As applicable, the Grantee shall:

a. Enroll as a provider in Children's Health Insurance Program and Medicaid if providing approved services authorized under this Contract that may be covered by those programs and bill those programs for the covered services;
b. Provide assistance to individuals to enroll in such programs when the screening process indicates possible

eligibility for such programs;

c. Allow clients that are otherwise eligible for Department services, but cannot pay a deductible required by a third party payor, to receive services up to the amount of the deductible and to bill the Department for the deductible;
d. Not bill the Department for any services eligible for third party reimbursement until all appeals to third party payors have been exhausted;
e. Maintain appropriate documentation from the third party payor reflecting attempts to obtain reimbursement;
f. Bill all third party payors for services provided under this Contract before submitting any request for reimbursement to Department; and
g. Provide third party billing functions at no cost to the client.

Section 1.12 HIV/AIDS Model Workplace Guidelines. Grantee shall implement Department's policies based on the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), AIDS Model Workplace Guidelines for Businesses at http://www.dshs.state.tx.us/hivstd/policy/policies.shtm, State Agencies and State Grantees Policy No. 090.021.

Grantee shall also educate employees and clients concerning HIV and its related conditions, including AIDS, in accordance with the Texas. Health & Safety Code §§ 85.112-114.

Section 1.13 Medical Records Retention.
Grantee shall retain medical records in accordance with 22 TAC §165.1(b) or other applicable statutes, rules and regulations governing medical information.

Section 1.14 Notice of a License Action.
Grantee shall notify their contract manager of any action impacting its license to provide services under this Contract within five days of becoming aware of the action and include the following:

a. Reason for such action;
b. Name and contact information of the local, state or federal department or agency or entity;
c. Date of the license action; and
d. License or case reference number.

Section 1.15 Interim Extension Amendment.

a. Prior to or on the expiration date of this Contract, the Parties agree that this Contract can be extended as provided under this Section.

b. DSHS/HHSC shall provide written notice of interim extension amendment to the Grantee under one of the following circumstances:

    1. Continue provision of services in response to a disaster declared by the governor; or
    2. To ensure that services are provided to clients without interruption.

c. DSHS will provide written notice of the interim extension amendment that specifies the reason for it and period of time for the extension.

d. Grantee will provide and invoice for services in the same manner that is stated in the Contract.

e. An interim extension under Section (b)(1) above shall extend the term of the contract not longer than 30 days after governor's disaster declaration is declared unless the Parties agree to a shorter period of time.

f. An interim extension under Section (b)(2) above shall be a one-time extension for a period of time

determined by HHS/DSHS.

Section 1.16 Electronic and Information Resources Accessibility and Security Standards.

a. **Applicability.**

The following Electronic and Information Resources (EIR) requirements apply to the Contract because the Grantee performs services that include EIR that DSHS employees are required or permitted to access or members of the public are required or permitted to access.

This Section does not apply to incidental uses of EIR in the performance of the Agreement, unless the Parties agree that the EIR will become property of the State of Texas or will be used by HHSC's clients or recipients after completion of the Agreement.

Nothing in this section is intended to prescribe the use of particular designs or technologies or to prevent the use of alternative technologies, provided they result in substantially equivalent or greater access to and use of a Product.

b. **Definitions.**

For purposes of this Section:

"Accessibility Standards" means accessibility standards and specifications for Texas agency and institution of higher education websites and EIR set forth in 1 TAC Chapter 206 and/or Chapter 213.

"**Electronic and Information Resources**" means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes telephones and other telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.

"Electronic and Information Resources Accessibility Standards" means the accessibility standards for electronic and information resources contained in 1 Texas Administrative Code Chapter 213.

"Product" means information resources technology that is, or is related to EIR.

"Web Site Accessibility Standards/ Specifications" means standards contained in Volume 1 Tex. Admin. Code Chapter 206(c) Accessibility Requirements.

Under Tex. Gov't Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, DSHS must procure Products and services that comply with the Accessibility Standards when those Products are available in the commercial marketplace or when those Products are developed in response to a procurement solicitation. Accordingly, Grantee must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

c. **Evaluation, Testing, and Monitoring.**

1. DSHS may review, test, evaluate and monitor Grantee's Products and services, as well as associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing.
   Neither the review, testing (including acceptance testing), evaluation or monitoring of any Product or service, nor the absence of review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the Grantee's assertion of compliance with the Accessibility Standards.

2. Grantee agrees to cooperate fully and provide DSHS and its representatives timely access to Products, records, and other items and information needed to conduct such review, evaluation, testing, and monitoring.

d. **Representations and Warranties.**

1. Grantee represents and warrants that:

   i. As of the Effective Date of the Contract, the Products and associated documentation and technical support comply with the Accessibility Standards as they exist at the time of entering the Agreement, unless and to the extent the Parties otherwise expressly agree in writing; and

   ii. If the Products will be in the custody of the state or a DSHS client or recipient after the Contract expiration or termination, the Products will continue to comply with Accessibility Standards after the expiration or termination of the Contract Term, unless DSHS or its clients or recipients, as applicable, use the Products in a manner that renders it noncompliant.

2. In the event Grantee becomes aware, or is notified that the Product or service and associated documentation and technical support do not comply with the Accessibility Standards, Grantee represents and warrants that it will, in a timely manner and at no cost to DSHS, perform all necessary steps to satisfy the Accessibility Standards, including remediation, replacement, and upgrading of the Product or service, or providing a suitable substitute.

3. Grantee acknowledges and agrees that these representations and warranties are essential inducements on which DSHS relies in awarding this Contract.

4. Grantee's representations and warranties under this subsection will survive the termination or expiration of the Contract and will remain in full force and effect throughout the useful life of the Product.

e. **Remedies.**

1. Under Tex. Gov't Code § 2054.465, neither the Grantee nor any other person has cause of action against DSHS for a claim of a failure to comply with Tex. Gov't Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

2. In the event of a breach of Grantee's representations and warranties, Grantee will be liable for direct, consequential, indirect, special, or liquidated damages and any other remedies to which DSHS may be entitled under this Contract and other applicable law. This remedy is cumulative of any other remedies to which DSHS may be entitled under this Contract and other applicable law.

Section 1.17, Deadline for Closeout. Grantee shall submit all performance, and other Closeout reports required under this Contract within 45 calendar days after the Contract expiration or termination date.

Section 1.18 Reporting Abuse, Neglect, or Exploitation.
All Contractors shall promptly report any suspected case of abuse, neglect, or exploitation to the appropriate authority as required by the Texas Family Code, Chapter 261. All reports must be made within twenty-four (24) hours of the discovery of abuse, neglect, or exploitation.

Contractor shall develop, implement and enforce a written policy that includes at a minimum the Department's Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers and train all staff on reporting requirements.

Contractor shall use the SYSTEM AGENCY Child Abuse Reporting Form located at www.dshs.state.tx.us/childabusereporting, incorporated by reference, as required by the Department. Contractor shall retain reporting documentation on site and make it available for inspection by SYSTEM AGENCY.

This section is in addition to and does not supersede any other legal obligation of the Contractor to report child abuse.

Local Mental Health Authorities shall comply with the Texas Administrative Code, Chapter 414, Subchapter L. This includes, but is not limited to:

a. Amending their contracts to ensure contractors' compliance with this subchapter.
b. Implementing policies and procedures addressing disciplinary and other action in confirmed cases of abuse, neglect, and exploitation involving employees and agents, in accordance with Section 414.557.
c. Ensuring that a Client Abuse and Neglect Reporting form (AN-1-A) is completed within 14 calendar days of the receipt of the investigative report from the Department of Family and Protective Services or a decision made after review or appeal using the CANRS Definitions and the CANRS Classifications, when the perpetrator or alleged perpetrator is an employee or agent of the local mental health authority, community center, or contractor, or if the perpetrator is unknown.
d. Ensuring, within one working day after completion of the AN-1-A form, that:
    1. The information contained in the completed AN-1-A form is entered into the Client Abuse and Neglect Reporting System (CANRS); or
    2. If access to CANRS is unavailable, a copy of the completed AN-1-A form is forwarded for data entry to the Office of Consumer Services and Rights Protection–Ombudsman, P.O. Box 12668, Austin, TX 78711-2668

OMB Number: 4040-0007
Expiration Date: 01/31/2019

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
John Burruss, MD / Kenda Thompson	CHIEF EXECUTIVE OFFICER
APPLICANT ORGANIZATION	DATE SUBMITTED
DALLAS MHMR d/b/a Dallas Metrocare	11/29/2016

Standard Form 424B (Rev. 7-97) Back

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION

DALLAS COUNTY HOSPITAL d/b/a Dallas Metrocare Services

* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

Prefix: | * First Name: John | Middle Name:

* Last Name: BURRUSS | Suffix: M D

* Title: CHIEF EXECUTIVE OFFICER

* SIGNATURE: John Burruss, MD | * DATE: 11/29/2016

ATTACHMENT 1. SUBCONTRACTOR AGREEMENT FORM

HHS CONTRACT NUMBER _____

The DUA between HHS and CONTRACTOR establishes the permitted and required uses and disclosures of Confidential Information by CONTRACTOR.

CONTRACTOR has subcontracted with _____ (SUBCONTRACTOR) for performance of duties on behalf of CONTACTOR which are subject to the DUA. SUBCONTRACTOR acknowledges, understands and agrees to be bound by the identical terms and conditions applicable to CONTRACTOR under the DUA, incorporated by reference in this Agreement, with respect to HHS Confidential Information. CONTRACTOR and SUBCONTRACTOR agree that HHS is a third-party beneficiary to applicable provisions of the subcontract.

HHS has the right but not the obligation to review or approve the terms and conditions of the subcontract by virtue of this Subcontractor Agreement Form.

CONTRACTOR and SUBCONTRACTOR assure HHS that any Breach or Event as defined by the DUA that SUBCONTRACTOR Discovers will be reported to HHS by CONTRACTOR in the time, manner and content required by the DUA.

If CONTRACTOR knows or should have known in the exercise of reasonable diligence of a pattern of activity or practice by SUBCONTRACTOR that constitutes a material breach or violation of the DUA or the SUBCONTRACTOR's obligations CONTRACTOR will:

1. Take reasonable steps to cure the violation or end the violation, as applicable;
2. If the steps are unsuccessful, terminate the contract or arrangement with SUBCONTRACTOR, if feasible;
3. Notify HHS immediately upon discovery of the pattern of activity or practice of SUBCONTRACTOR that constitutes a material breach or violation of the DUA and keep HHS reasonably and regularly informed about steps CONTRACTOR is taking to cure or end the violation or terminate SUBCONTACTOR's contract or arrangement.

This Subcontractor Agreement Form is executed by the parties in their capacities indicated below.

CONTRACTOR		**SUBCONTRACTOR**	
BY:	_____	**BY:**	_____
NAME:	_____	**NAME:**	_____
TITLE:	_____	**TITLE:**	_____
DATE	_____, 201 .	**DATE:**	_____