FOURTH AMENDATORY AGREEMENT

This **FOURTH AMENDATORY AGREEMENT** is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the "City") and **DENVER HEALTH AND HOSPITAL AUTHORITY**, a body corporate and political subdivision of the State of Colorado, with its principal place of business located at 777 Bannock St., MC 1952, Denver, CO 80204 (the "Contractor"), jointly ("the Parties").

RECITALS:

A. The Parties entered into an Agreement dated February 19, 2021, a Revival and Amendatory Agreement dated November 15, 2021, a Second Amendatory Agreement dated December 13, 2022, and a Third Amendatory Agreement dated September 28, 2023 (the "Agreement") to perform, and complete all of the services and produce all the deliverables set forth on Exhibit A, the Scope of Work, to the City's satisfaction.

B. The Parties wish to amend the Agreement to extend the term, increase the maximum contract amount, amend the scope of work, and insert paragraph 36 – Compliance With Denver Wage Laws.

NOW THEREFORE, in consideration of the promises and the Parties' mutual covenants and obligations, the Parties agree as follows:

1. Section 3 of the Agreement entitled "**TERM**" is hereby deleted in its entirety and replaced with:

> "**3**. **TERM:** The Agreement will commence on **July 1, 2020** and will expire, unless sooner terminated, on **September 30, 2025**."

2. Section 4 of the Agreement entitled "**COMPENSATION AND PAYMENT**" Sub-section 4.1 entitled "**Fee**" is hereby deleted in its entirety and replaced with:

> "**4.1** **Fee:** The City shall pay and the Contractor shall accept as the sole compensation for services rendered and costs incurred under the Agreement the amount of **ONE MILLION FOUR HUNDRED SEVENTY-SEVEN THOUSAND EIGHT HUNDRED EIGHTY-TWO DOLLARS AND NINETY-ONE CENTS ($1,477,882.91)** for fees. Amounts billed may not exceed rates set forth in **Exhibit A-4**."

3. Section 4 of the Agreement entitled "**COMPENSATION AND PAYMENT**" Sub-section 4.4.1 entitled "**Maximum Contract Amount**" is hereby deleted in its entirety and replaced with:

> "**4.4.1** Notwithstanding any other provision of the Agreement, the City's maximum payment obligation will not exceed **ONE MILLION FOUR HUNDRED SEVENTY-SEVEN THOUSAND EIGHT HUNDRED EIGHTY-TWO DOLLARS AND NINETY-ONE CENTS ($1,477,882.91)** (the "Maximum Contract Amount"). The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by the Contractor beyond that specifically described in Exhibit A-4. Any services performed beyond those in Exhibit A-4 are performed at the Contractor's risk and without authorization under the Agreement."

4. Section 36 entitled "**COMPLIANCE WITH DENVER WAGE LAWS**" is hereby inserted into the Agreement and states:

> **"36. COMPLIANCE WITH DENVER WAGE LAWS:** To the extent applicable to the Contractor's provision of Services hereunder, the Contractor shall comply with, and agrees to be bound by, all rules, regulations, requirements, conditions, and City determinations regarding the City's Minimum Wage and Civil Wage Theft Ordinances, Sections 58-1 through 58-26 D.R.M.C., including, but not limited to, the requirement that every covered worker shall be paid all earned wages under applicable state, federal, and city law in accordance with the foregoing D.R.M.C. Sections. By executing this Agreement, the Contractor expressly acknowledges that the Contractor is aware of the requirements of the City's Minimum Wage and Civil Wage Theft Ordinances and that any failure by the Contractor, or any other individual or entity acting subject to this Agreement, to strictly comply with the foregoing D.R.M.C. Sections shall result in the penalties and other remedies authorized therein."

5. **Exhibit A-3** is hereby deleted in its entirety and replaced with **Exhibit A-4 Scope of Work**, attached and incorporated by reference herein. All references in the original Agreement to Exhibits A, A-1, A-2, and A-3 are changed to Exhibit A-4.

6. As herein amended, the Agreement is affirmed and ratified in each and every particular.

7. This Amendatory Agreement will not be effective or binding on the City until it has been fully executed by all required signatories of the City and County of Denver, and if required by Charter, approved by the City Council.

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Contract Control Number: SHERF-202473939-04/ Parent: SHERF-202056255-04
Contractor Name: DENVER HEALTH AND HOSPITAL AUTHORITY

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of:

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: ______________________________

____

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: ______________________________

REGISTERED AND COUNTERSIGNED:

By: ______________________________

By: ______________________________

Contract Control Number: SHERF-202473939-04/ Parent: SHERF-202056255-04:
Contractor Name: DENVER HEALTH AND HOSPITAL AUTHORITY

By: ____

Name: ______________________________________
(please print)

Title: ______________________________________
(please print)

ATTEST: [if required]

By: ____

Name: ______________________________________
(please print)

Title: ______________________________________
(please print)

Exhibit A-4: Statement of Work & Budget

1. **Definitions and Acronyms**

   The following list of terms shall be applied to this contract and Statement of Work, based on the services that are provided at each respective jails:

"Office of Civil and Forensic Mental Health" The OCFMH is a new cabinet member-led agency, housed within the Department of Human Services, designed to be the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health needs. The OCFMH was previously known as the Office of Behavioral Health (OBH).

"OCFMH" means the CDHS Office of Civil and Forensic Mental Health.

"Colorado Department of Human Services" CDHS means the state of Colorado, acting by and through the Department of Human Services; alternately referred to as "State."

"Client" means an individual ordered by the courts for evaluation of competency or found incompetent to proceed to trial, and who is referred to Contractor for receipt of services provided in this Contract.

"**CMHHIP"** means the Colorado Mental Health Hospital in Pueblo, a facility organized under and operated by CDHS.

"CMHHIFL" means the Colorado Mental Health Hospital in Fort Logan, a facility organized under and operated by CDHS.

"**Contract"** means this agreement, including all attached Exhibits, all documents incorporated by reference, all referenced statutes, rules and cited authorities, and any future modifications thereto.

"Contract Funds" means the funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under this Contract.

"Competency Enhancement Program" CEP refers to the interim mental health programming provided for individuals involved in competency

"Competency" or "Competent" means the present ability of a person arrested for or charged with a crime to understand the nature of the charges and proceedings brought against him/her and to effectively and rationally assist in his/her defense.

"CJI" means criminal justice information collected by

criminal justice agencies needed for the performance of their authorized functions, including, without limitation, all information defined as criminal justice information by the U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Security Policy, as amended and all Criminal Justice Record as defined under **§24-72-302, C.R.S.**

"Forensic Support Team" is a work unit within the Forensic Services Department of OCFMH that is responsible for collaborating on services for incarcerated individuals involved in competency.

"FST" means the Forensic Support Team

"Facility" means the relevant county facility where the Service is taking place

"PHI" means any protected health information, including, without limitation any information whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes, but is not limited to, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act.

"Program" means the Contractor's Services.

"Risk Assessment Instrument" is a tool that is used to inform future violence and is contrived by a number of different components, including youth risk and protective factors, treatment needs, and likelihood of responsibility to treatment.

"Bridges Program/Court Liaison" means an individual employed or contracted with the State Court Administrator's Office (SCAO) to implement and administer a program that identifies and dedicates local behavioral health professionals as court liaisons in each judicial district. These individuals are responsible for facilitating communication and collaboration between judicial and behavioral health systems.
https://www.courts.state.co.us/Administration/Unit.cfm?Unit=bridgesThese

"Case Manager" assists in the planning, coordination, monitoring, and evaluation of services for a client with emphasis on quality of care, continuity of services, and cost effectiveness

"Certified Addiction Specialist" - CAS (Formerly CAC II & III) requires a Bachelor's degree in a Behavioral Health specialty (Psychology, Social Work, Human Services). This does not include Criminal Justice, Sociology or Nursing. These individuals are approved to provide Clinical Supervision and consultation to individuals working towards CAT or CAS. 2,000 clinically supervised hours (1,000 direct clinical hours beyond the Technician). Must pass the NCAC II exam and Jurisprudence exam.

"Certified Addition Technician" - CAT (Formerly CAC I) requires 1000 hours of clinically supervised work hours (does not require DORA registration prior to the 1000 hours). Once these hours are met, the individual is not able to perform duties until the CAT is officially approved), in addition to passing the NCAC I Exam and passing the Jurisprudence Exam.

"Services" means the State of Colorado, acting by and through the Department of Human Services; alternative referred to as "CDHS"

"State Confidential Information" means any and all State Records not subject to disclosure under CORA. State Confidential Information shall include, but is not limited to, CJI, PHI, and State Personnel records not subject to disclosure under CORA.

"Subcontractor" means third Parties, if any, engaged by Contractor to aid in performance of the Work.

"Critical Incidents" means a critical incident is any significant event or condition that must be reported to the Department that is of public concern and/or has jeopardized the health, safety and/or welfare of individuals or staff.

"Forensic Navigators" are not case managers, clinicians, or involved in community supervision. The Navigators act as case coordinators, working to ensure that all internal and external stakeholders have access to up-to-date client information. In collaboration with stakeholders, the Navigators help to ensure that services are being delivered to clients in an appropriate and effective manner.

"LAC", or "**Licensed Addiction Counselor"** is a behavioral health clinician who can provide co-occurring services. Master's degree or higher in Substance Use Disorders/Addiction and/or related counseling subjects (social work, mental health counseling, marriage & family, psychology, medical doctor) from a regionally accredited institution of higher learning 3,000 clinically supervised hours (2,000 direct clinical hours). Must pass the MAC and jurisprudence exam. Designated providers of Clinical Supervision for all levels of certification and licensure, in the addiction's profession.

"LCSW", or Licensed Clinical Social Worker, is a social worker trained in psychotherapy who helps individuals deal with a variety of mental health and daily living problems to improve overall functioning.

"LMFT", or Licensed Marriage and Family Therapist help couples and family members manage problems within their relationships.

"LPC", or Licensed Professional Counselor, is a person engaged in the practice of counseling who holds a license as a licensed professional counselor issued under the provisions of the state of Colorado.

"Long Acting Injectable (LAI)" is an injectable medication that allows for the slow release of medicine into the blood. An LAI can last anywhere from 2-12 weeks, which helps to control symptoms of mental illness and / or substance use.

"Memorandum of Understanding", or MOU, means a type of agreement between two or more parties. It expresses a convergence of will between the parties, indicating an intended common line of action.

"Screening Tools" are brief questionnaires or procedures that examine risk factors, mental health/trauma symptoms, or both to determine whether further, more in- depth assessment is needed on a specific area of concern, such as mental health, trauma, or substance use.

"Contact" may involve face-to-face meetings, or other forms of direct client interaction where CEP staff directly engage with clients to assess their needs, provide support, offer counseling, and collaborate on developing and implementing intervention strategies.

"Monitoring"collecting relevant collateral information to gain a comprehensive understanding of the client's current presentation, circumstances and acuity to include reviewing Electronic Health Records (EHRs), jail reports, and input from other mental health or support staff within the jail.

2. General Terms and Conditions

2.1 Purpose. In May 2019, the Colorado General Assembly passed Senate Bill 19-223; legislation that mandates the provision of interim mental health services for individuals who have been court-ordered for inpatient competency restoration and who are waiting for admission to an inpatient bed. To compensate for these specialty services, SB 19-223 allocates funding to the Jail Based Behavioral Health Services (JBBS) program to address gaps in services in the jail for those with mental health disorders that are

awaiting restoration services.

In July of 2022, the JBBS program (including Competency Enhancement Programs) moved to the Office of Civil and Forensic Mental Health (OCFMH). Because the Office of Civil and Forensic Mental Health (OCFMH) serves as a central organizing structure and responsible entity for the provision of competency restoration education services and coordination of competency restoration services ordered by the court, it was agreed that the JBBS-CEP program should return to the OCFMH.

a. The jail competency enhancement funding is used to provide interim mental health services to individuals who are in jail and have been court-ordered to the Colorado Department of Human Services (CDHS) to receive competency restoration services.

b. Funding is also to be used to provide mental health services to individuals who are returning to the jail after receiving restoration services at a CDHS designated inpatient restoration site.

c. Coordination of services with the Forensic Support Team (FST) and, if assigned, Court Liaisons (Bridges) shall occur when a court order has been received for an evaluation and/or when an competency involved individual is identified to be in crisis by the jail at the time of booking or while incarcerated.

2.3 Goal. Competency Enhancement Programs shall seek to support the CDHS Mission to collaborate as a partner to design and deliver high quality human and health services that improves the safety, independence, and health outcomes of individuals involved competency in the state of Colorado.

2.4 Target Population. Adults 18 years of age and older that are awaiting an in-custody competency evaluation, awaiting inpatient competency restoration services, or are returning from a CDHS designated inpatient restoration site after receiving restoration services and meet any of the following criteria:

a. Have a serious and persistent mental health disorder.
b. Are experiencing acute psychosis or major mood dysregulation.
c. Have substance use issues, especially if suspicion of intoxication is present.
d. Have an intellectual deficit, neurodevelopmental issues, or significant cognitive issues.
E. Have a neurocognitive disorder, including dementia.
e. Have a known previous competency history.
f. Have a Traumatic Brain Injury (TBI).
g. Individuals who are suspected of becoming incompetent to proceed while in jail are not a primary target population; however, may be eligible for CEP support if services offered may help divert the individual from an impending competency process.

2.5 Services. It is best practice that all jails should be utilizing evidence-based screening tool(s) and practices to screen for any potential mental health

and/or substance use disorders and withdrawal, as well as suicide risk.

The Contractor shall:

a. Provide adequate staff to complete behavioral health screenings, prescribe psychiatric medications as necessary; and provide mental health counseling, substance use disorder treatment and transitional care coordination.

b. Assess all individuals involved in competency at the jail facility for psychiatric medication needs by requesting and reviewing medical and prescription history.

c. Have access to psychiatric medications, as defined by the medication formulary established pursuant to section 27-70-103 or by their contracted medical provider.

d. Coordinate services with local community behavioral health providers prior to the release of a defendant to ensure continuity of care following their release from the jail.

2.6 Training and Meetings. The Contractor shall provide training to improve correctional staff responses to people with mental illness. The Contractor shall determine the amount of training necessary to ensure, at a minimum, a group of trained staff is able to cover all time shifts. The training should provide sufficient opportunities for hands-on experiential learning, such as role play and group problem solving exercises. Cross-training opportunities shall be provided to behavioral health personnel and other stakeholders to help improve cross-system understanding. Collaborative meetings may be required to best support this mission and fluid communication.

2.6.1 Contractor will engage in OCFMH meetings no less than quarterly, which will include identification of training needs.

2.7 Evidence-Based Practices. The Contractor shall use evidence-based and promising practices within the screening and service delivery structure to support effective outcomes. The use of a risk/need/responsivity (RNR) model is encouraged to assess various factors such as substance use disorders, mental illness, cognitive or physical impairments, financial issues, family dynamics, housing instability, developmental disabilities, low literacy levels, and lack of reliable transportation, all of which may need to be addressed to support success.

2.8 Individualized Service Provision. The Contractor shall link individuals referred to the program to community based behavioral health supports and services, as appropriate, based on the specific needs of the individual to ensure wraparound services are in place to reduce the risk of the individual returning into the justice system.

2.9 Subcontracting.

2.9.1 Contractor shall subcontract to provide necessary Program services to support the Program.

2.9.2 Contractor shall absorb the cost of services provided by any subcontractor from the State payment.

2.9.3 Contractor shall provide copies of any executed agreements.

2.5.4 A Sheriff who is the custodian of a county jail or city and county jail may enter into agreements with community agencies, behavioral health organizations, and substance use disorder treatment organizations to assist in the development and administration of medication-assisted treatment in the jail.

2.9.4 OCFMH reserves the right to review, inspect, contribute, or otherwise approve any agreement and services delivered by any subcontractor related to this Contract.

2.9.4.1 The Contractor shall provide the OCFMH a copy of any proposed subcontract associated with fulfilling requirements of this contract, by email in order to be evaluated for compliance with the maximum rates established in the Annual Budget provided by the OCFMH.

2.9.5 Contractor shall ensure any subcontractor complies with this Contract and any State requirements. Contractor shall provide the OCFMH with documentation confirming such for each subcontractor.

2.9.6 CDHS may conduct both unannounced and announced monitoring visits and/or documentation audits, to assure that individuals placed in the custody of CDHS are receiving appropriate services, and are cared for in accordance with all CDHS and OCFMH regulations, policies, and procedures.

2.9.7 If CDHS notifies Contractor of deficiencies found, Contractor shall respond with an action plan to correct any identified deficiencies within the time frames specified in the written findings of the monitoring visit, and shall perform in accordance with the remedial action plan until all deficiencies are corrected. Non-performance with the terms of any action plan may lead to performance and compliance remedies within this Contract.

2.10 Auditing. OCFMH reserves the authority to monitor and audit Contractor's Services.

2.10.1 OCFMH may conduct unannounced and announced monitoring visits, to assure that individuals are receiving appropriate services, and are cared for in accordance with this contract and regulations.

2.10.2 OCFMH may conduct audits at a frequency determined through entity-specific needs and performance. Audits may include review of all documentation, assessments, treatment team meetings, treatment rounds, personnel files, data reporting, staffing, financial documents, and general milieu dynamics.

2.10.3 If OCFMH notified Contractor of deficiencies found, Contractor shall respond with an action plan to correct any identified deficiencies within the time frame specified in the written findings of the monitoring visit, and shall perform in accordance with the remedial action plan until all deficiencies are corrected. Non-performance with the terms of any action plan may lead to performance and compliance remedies within this Contract.

2.10.3.1 Contractors who do not meet the deliverables above, or any additional deliverables listed below, for which they have been provided funding, shall be asked to submit a plan of action to improve

program performance for the current or next fiscal year.

2.10.4 Failures in performance by subcontractors will subject the Contractor to Liquidated Damages.

2.11 Amending. This Contract shall allow for bilateral amending in the event OCFMH ceases to have the need for this service. In the event where referrals of eligible participants are reduced or if funds for the continued fulfillment of this Contract by OCFMH are at any time not forthcoming or reduced by the Colorado General Assembly or otherwise, then OCFMH will have the right to reduce and amend this Contract at no additional cost. OCFMH will provide at least thirty (30) days advance written notice of changes or termination.

2.12 Policies and Plans. Contractor shall adhere to the most current Forensic Services Critical Incident policy **Exhibit C-1**.

2.12.1. Contractor shall adhere to the policy or plan for its jail submitted to satisfy the deliverable described in **Exhibit** C-1

2.12.2 Contractor shall ensure policies remain updated in order to reflect contractual obligations and regulations.

2.13 The Contractor may serve individuals who are awaiting Medicaid approval or other funds to pay for initial treatment services.

2.14 The Contractor shall provide services in a manner that respects and protects individual rights. This requirement includes providing the subcontractor with the required space to offer individual and group treatment services described in this Contract.

2.15 Recovery Support Services. SAMHSA (Substance Abuse and Mental Health Services Administration) encourages those involved in substance abuse and / or mental health treatment, to address their emotional, spiritual, intellectual, physical, environmental, financial, occupational, and social needs.

2.16 The Contractor may maintain supportive relationships with relevant partners in the criminal justice system, i.e., competency courts, Bridges Liaisons, FST Navigators, other JBBS programming available in the jail to support continuity of care for competency involved individuals. These interactions must adhere to HIPAA rules and regulations.

2.17 Cultural Competency. The Contractor shall provide culturally competent and appropriate services, per National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards), available at https://thinkculturalhealth.hhs.gov/clas/standards

2.18 The Contractor shall make accommodations to meet the needs of individuals who are physically challenged, deaf or hearing impaired, or blind.

3. Provision of Services

3.1 Program Referral Process:

3.1.1 The Contractor shall refer individuals for competency enhancement services through one of the following ways:

a. When a client has been ordered by the court to be evaluated for competency, found incompetent to proceed (ITP), and/or when inpatient restoration has been ordered.
B. Upon return from a CDHS designated inpatient restoration site.
3.1.2 Priority should be given to individuals who have been found incompetent to proceed and are awaiting admission to the state hospital. Priority should also include individuals who are awaiting a competency evaluation and are highly acute and/or in crisis.
3.1.3 The Contractor shall establish clear procedures for referrals based on court orders, CDHS transitions, and jail-identified crisis situations.

3.2 Jail Mental Health Evaluation, Triage, and Treatment Planning. The Contractor shall ensure that a mental health evaluation, screening, or risk assessment is performed promptly (preferably within 48 hours) on all individuals that have been identified as the "Target Population" referenced in section 2.4, either through the court-ordered referral process or through the jail-identified process. A jail mental health evaluation shall identify treatment needs, inform triage categories, and direct treatment plans while the individual is awaiting court proceedings or a CDHS designated inpatient restoration site bed. Mental Health Evaluations shall be shared with the assigned Forensic Navigator(s).

3.2.1 Each jail may develop their own Mental Health Evaluation/ Screening form but must submit a copy with their CEP work plan for approval.

Individuals involved in the CEP program are required to complete an evidence based behavioral health screen for each of the following five categories:

i. Substance Use Disorder
ii. Mental Health,
iii. Suicide
iv. Trauma and Traumatic Brain Injury

3.2.2 Each jail shall implement standardized protocols for behavioral health screenings within 48 hours of booking or identification

3.2.3 Each jail shall develop a system for triaging individuals into high, moderate, or low acuity categories with FST collaboration as described in Section 3.2 of this contract.

3.3.3 Each jail shall create treatment plans tailored to acuity levels, ensuring immediate care for high acuity individuals, monitoring, and contact requirements listed in Section 3.2 of this contract. Treatment plans shall be individualized based on clinical needs, including medication management and counseling.

3.2 OCFMH Competency Order: Client Contacts and Level of Care Categories. Taking into consideration those clients with an active court order for competency evaluation and/or treatment, current clinical presentation, any assessment or evaluation, and placement of an individual within the jail, treatment services and contact standards should be based on the following three categories:

a. High Clinical Acuity:

These individuals are in need of immediate crisis intervention.

Contact and Monitoring Requirements:
These individuals should have daily monitoring, weekly contact, and access to crisis intervention and/or stabilization services through the contractor. Weekly updates are to be provided to FST Navigator for High Acuity clients following Exhibit D-1. Information shall be provided using shared documentation or weekly collaborative meetings with FST.

These individuals may be identified via the following:

i. Non-compliant with medication, may require the use of court-ordered and involuntary medications.

1. When clinically appropriate and especially for Clients who have a history of medication noncompliance, psychiatric staff shall use a long-acting injectable medication.

Ii. Meets C.R.S. Title 27 Article 85 (27-65)

"Danger to the person's self or others" means:(a) A person poses a substantial risk of physical harm to the person's self as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm to the person's self; or(b) A person poses a substantial risk of physical harm to another person or persons, as manifested by evidence of recent homicidal or other violent behavior by the person in question, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt, or threat to do serious physical harm by the person in question.

"Gravely disabled" means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for the person's essential needs without significant supervision and assistance from other people. As a result of being incapable of making these informed decisions, a person who is gravely disabled is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of the person's essential needs that could result in substantial bodily harm. A person of any age may be "gravely disabled", but the term does not include a person whose decision-making capabilities are limited solely by the person's developmental disability.

ii. Placed in a special management unit due to significant medical or behavioral health concerns.

iv. Significant behavioral concerns including verbal and physical threats or need for physical restraint or other involuntary control methods.

1. Unable or unwilling to perform activities of daily living (i.e., catatonic, immobile, consistently not eating/drinking/bathing)
2. Significant risk behavior (unsafe behaviors, such as those listed above, of any type, more than 50% of the time)

3. Client has little or no insight into risks
4. Client with significant/severe cognitive or emotional problems that could be barriers to safer behavior
5. Client who has no understanding of or control of behavior

b. Moderate Clinical Acuity:

These individuals have identified psychiatric and/or behavioral health needs, as well as identified risk factors associated with their current overall wellbeing and safety.

Contact and Monitoring Requirements:

These individuals should have daily monitoring, regularly scheduled in person contact (the frequency of which shall be reported to OCFMH), and access to crisis intervention and/or stabilization services as needed. If an individual has increased risk factors or is on safety protocols, they should be seen more frequently. Alternative treatment locations should be considered when available. Biweekly updates are to be provided to FST Navigator for Moderate Acuity clients.

Efforts shall be made to assist in the stabilization of these individuals. If clinically appropriate, these individuals should be assessed for and offered treatment services. These treatment services should include, but are not limited to, groups, individuals, medication management, crisis intervention, and / or MAT referrals.

These individuals may be identified via the following:

i. Individuals have a change in behavior resulting in moving from a previous assigned low acuity or high acuity status

ii. Generally compliant with psychotropic medication and jail based behavioral health or other resources (under some circumstances may be non-compliant with medications, actively experiencing symptoms of a mental health disorder, but not posing a significant or immediate risk of danger to self or others)

1. When clinically appropriate and especially for Clients who have a history of medication noncompliance, psychiatric staff shall use a long-acting injectable medication.

iii. Housing in the general population or transitioning from a special management unit

iv. In general population with psychotropic medication compliance decreasing to less than 80% of the time

v. Temporary medical conditions

vi. Increased ability or willingness to perform activities of daily living from the previous baseline

vii. Moderate risk behavior (unsafe behaviors of any type more than 20-50% of the time)

1. Client has a poor understanding of risks
2. Client has mild/moderate cognitive or emotional problems that could be a barrier to safer behavior

c. Low Clinical Acuity:

These individuals have identified psychiatric and/or behavioral health needs that are relatively well maintained but require ongoing monitoring for potential changes.

Contact and Monitoring Requirements:
At a minimum these individuals should have weekly monitoring, regularly scheduled in person contact (the frequency of which shall be reported to OCFMH), and access to crisis intervention and/or stabilization services as needed. If an individual has increased risk factors or is on safety protocols, they should be seen more frequently. Alternative treatment locations should be considered when available. Every other week or monthly updates are to be provided to FST Navigator for Low Acuity clients.

If Low Acuity individuals have access to other jail programs or support services, the CEP may have less frequent in person contact (if able to reliably receive updates from other support services). If no other support services are available, CEP should have regularly scheduled contact with individuals. Efforts shall be made to assist in the stabilization of these individuals. If clinically appropriate, these individuals should be assessed for and offered treatment services. These services include, but are not limited to, groups, individuals, medication management, crisis intervention, and / or MAT referrals. Based on clinical acuity, this population may be better suited for outpatient restoration. CEP should work with and/or refer these individuals to the Forensic Navigator for potential community transition planning. Contractor shall coordinate services with the assigned Forensic Navigator(s).

These individuals may be identified via the following:

i. Consistently taking psychotropic medication on their own accord (at least 80% of the time)

1. When clinically appropriate and especially for Clients who have a history of medication noncompliance, psychiatric staff shall use a long-acting injectable medication.

ii. Ability to and willingness to perform activities of daily living.

iii. Placed in the general population or general supervision cell (this may include individuals with cognitive disorders as opposed to severe mental illness)

iv. Actively engaging in jail based behavioral health or other resources.

v. Occasional risk behavior (client has a fair understanding of risks - unsafe behaviors of any type less than 20% of the time)

3.3 Unordered Jail Defendants: Client Contacts and Level of Care Categories.
FST, CEP, JBBS, and/or the jail may identify clients who have past competency concerns or are in danger of having current competency concerns. CEP shall collaborate with the FST, JBBS, and/or the jail in order to offer support services for these individuals as needed.

a. Service Provision: As outlined below but are not limited to those services.These provisional services are an attempt to intervene and stabilize the identified individual before or after court-ordered competency is raised.

   i. Group treatment

ii. Individual treatment
iii. Medication management
   1. When clinically appropriate and especially for Clients who have a history of medication noncompliance, psychiatric staff shall use a long-acting injectable medication.
iv. Crisis intervention
v. Medication Assisted Treatment (MAT), if available in designated facility

3.5 Transition Plan.
The Contractor and assigned Forensic Navigator(s) shall collaborate to ensure that a transition plan is developed and communicated for individuals with complicated presentations and treatment needs upon acceptance to an OCFMH designated inpatient restoration facility in order to ensure CDHS facilities have all current information on transferred individuals.

3.6 Discharge Plan.
Upon the individual's return from a CDHS designated inpatient restoration site, the Contractor shall save a copy of the individual's discharge plan within the same day that individual returns. Once a copy is received, the Contractor shall ensure follow-up care is provided, according to that plan, within 24 hours upon return, as well as provide continual treatment services until the person is released from jail. The Contractor should make every attempt to continue the individuals on the prescribed course of treatment to include prescribed medications. Medications should not be altered solely based on cost or philosophy. Treatment courses should only be changed if medically or clinically indicated.

3.7 Outpatient and Community Transition Plans.
When the Contractor becomes aware that a client's competency and/or clinical status has improved (due to jail based behavioral health services, sobriety, or medication management), the Contractor shall work in collaboration with the Forensic Navigator to identify community supports and/or existing protective factors that would aid in a community transition/re-entry. CEP may work in collaboration with any existing jail based reentry/ case management services. CEP may also be asked to support a reentry plan when cases become bond eligible or a dismissal is being considered.

3.8 Information Sharing.
The Contractor is expected to provide updates to FST on a weekly or bi weekly basis depending on Acuity level. These updates should include at a minimum:

- Clinical presentation, housing placement within the jail, medication compliance and adherence, assessment and evaluation information, information related to transition planning, medical condition information, disciplinary/conduct information, classification and/or special alerts, and attempted interventions to address unmanaged symptoms. Please refer to Exhibit D-1

The FST shall provide weekly or bi weekly updates depending on Acuity Level to the assigned CEP providers. These updates should included at a minimum:

- Known client history that supports jail treatment interventions

- Updates regarding discharge plans/court processes/case closures/admissions
- Status of clients progress within the competency process
- Collaboration with community referrals and support services

3.9 Critical Incidents.
The Contractor shall report any critical incidents to the assigned Forensic Navigator(s) via email and may also telephone in addition to the written reporting immediately and no more than 24 hours after the event. When reporting, the information shall include the reporting individuals full name and title, in addition to the full name and DOB of the individual(s) involved in the incident, date, time, and location of the incident, any safety protocols in place, action steps taken, and the outcome of the incident. Please refer to Exhibit C-1 for the Critical Incident Policy. Critical incidents include but are not limited to:

a. Arrest
b. Death
c. Elopement
d. Escape
e. Incident where Media may be notified
f. Injury of a Patient
g. Injury of a CDHS Staff Member as a result of client contact
h. Physical Assault: Any such occurrence, whether by another patient, staff member or visitor. There must be intent, knowingly or recklessly, to harm and bodily injuries present.
i. Sexual Assault : Any such occurrence where the perpetrator is another patient, staff member or visitor must be reported. There are several elements, any of which can be present to be considered sexual abuse. These include "knowingly" touching; sexual intrusion, touching intimate parts of the body, observation or photographs of intimate parts, consent not given, physical force or threat used
j. Suicide Attempt
k. Suicide Completion
l. Duty to Warn

3.10 Continuous Improvement.
Each jail shall regularly review processes, identify gaps and barriers, incorporate efficiencies, and collaborate with stakeholders to refine service delivery protocols and processes.

3.10.1 Contractor shall conduct periodic evaluations to assess program effectiveness in meeting goals and outcomes. This will include analyzing data trends for areas of enhanced service delivery opportunities.

3.12 Medication Management.
The contractor is expected to help coordinate a medication prescriber assessment and/ or access to medication as needed or at the request of an FST Navigator. Individuals shall have access to psychiatric medications, as defined by the medication formulary established pursuant to section 27-70-103 or by their contracted medical provider. Should the client be unable to timely receive provider services and/or access necessary/recommended medications, this shall be

immediately reported to OCFMH. Involuntary Court Ordered Medication or Long Acting Injectables may be used if the facility has these options available.

3.12.1 Medication Consistency (C.R.S. 27-70-103)

a**.** Contractor is encouraged, though not required, to participate in the Minnesota Multistate Contracting Alliance for Pharmacy Cooperative Purchasing Agreement to purchase medication and to utilize the Medication Consistency formulary developed by CDHS and HCPF.

b**.** If Contractor does not utilize the Medication Consistency formulary developed by CDHS and HCPF, Contractor shall provide a copy of the medication formulary available at Contractor's jail and submit updates as any changes are made. A copy of the CDHS and HCPF formulary is available on the CDHS Website.

b. Contractors should work with their medical departments for medication ordering and management. Medication Administration Record (MAR) shall be made available when requested. Records of each referral and visit to Prescriber shall be kept on each individual. Records of type of interaction, in person or virtual, shall be kept and if virtual visitation does not result in a therapeutic alliance then individuals shall be offered in person consultation. Individuals should be offered verbal and/ or written education on prescribed medication when appropriate.

3.13 Documentation

3.13.1 As referenced in section 3.8 and 3.9 of this contract, Contractor shall provide documentation utilizing Exhibit D-1 and Exhibit D-4 respectively and in accordance with the timelines outlined in section 3.2 of this contract.

3.13.2 Contractor shall include written updates of any referrals submitted on behalf of the client and any known outcomes as it pertains to community resources, outpatient restoration services, and/or disposition planning.

3.13.3 Contractor shall maintain detailed records of all assessments, treatments, and critical incidents.

3.14 Clinical Documentation

The Contractor is expected to document key treatment information within the jail's respective health record to include but not be limited to:

a. Basic individual demographic and working diagnosis information.
b. Booking date (date that the individual was booked into jail).
c. Screening date and results (Mental Health, Substance Use, Traumatic Brain Injury, Trauma, and Suicidality) for all individuals involved in competency processes.
d. Admission date (date that individual began receiving CEP).
e. Individual-level services provided (date of service, type of service, duration of service, and any additional applicable information).
f. Date, duration, and participants who provided individualized or group treatment or case management sessions.
g. End date for services (admitted into a CDHS restoration facility, transitioned into the community, case dismissed, found competent).
h. Disposition details (i.e., referrals for services, housing, community resources, etc.).

4. Staffing:
Contractor shall maintain all approved staffing requirements as outlined below. Contractor shall maintain all appropriate credentials to provide services.

4.1 Program Administrator The Contractor shall select a CEP Program Administrator, identify the positions' roles, responsibilities and authority, and develop a management plan that supports the CEP Programming; see Exhibit B.. Any changes to the Program Administrator's contact information shall be communicated via email to the Forensic Support Team within one business day of change.

a. OCFMH prefers that a staff person from the Sheriff's Department assume the role of Program Administrator. The Program Administrator shall be well versed in the CEP Program, including contractual requirements. The Program Administrator shall also attend CEP Quarterly Meetings, and shall oversee the CEP Program and its operations. The Program Administrator must also notify CEP Program Manager(s) to any change in personnel. The Sheriff's Department is encouraged to account for this administrative position in their budget. The Program Administrator shall:

- Oversee program implementation.
- Ensure contract requirements are consistently met.
- Provide training and request OCFMH collaboration when needed.
- Ensure understanding of purpose, goal, and population served.
- Measure the program's progress toward achieving stated goals.
- Ensure program effectiveness and performance is measured by specific client-centered health outcomes and reflected in the data collected in Section 5.1
- Resolve ongoing challenges to program effectiveness.
- Inform agency leaders and other policymakers of program costs, budgetary use of funds, developments, and progress.
- Develop policies and protocols to ensure clinical staff have the resources and support required for service provision.
- Secures and oversees any subcontracted services and staff.
- Submits data reporting requirements timely and accurately.

4.2 CEP Providers: The Contractor, providing required services can utilize and maintain a partnership with community provider(s)/individuals/contracting agencies that are licensed (LAC, LPC, LCSW or LMFT), who are in good standing with the Department of Regulatory Agencies (DORA), have the ability to provide services within the jail or through televideo options. If licensed staff are unable to be hired, unlicensed staff may be considered as a last resort and the Contractor must report this to the OCFMH and provide access to a licensed mental health clinician who can provide clinical consultation and supervision.

4.2.1 Mental Health Treatment Provider. The subcontracted mental health treatment provider/individual must be licensed and in good standing with the Department of Regulatory Agencies (DORA). The subcontracted mental health treatment provider(s) must adhere to all rules and regulations set forth by their license and are prohibited from practicing outside their scope of training. The parameters regarding potential use of unlicensed staff listed in 4.2 are applicable here as well.

4.2.2 Staff Coverage.
The Contractor will ensure that appropriate staff coverage is available (covering clinicians, etc.) in order to cover unplanned absences or leave without a disruption to services or contact, monitoring, and reporting obligations. Should Contractor be unable to meet the required staffing levels, it will be immediately reported to the OCFMH and include a plan of action.

6. Privacy and Liability

6.1 Additional Measures. The Contractor shall agree to the following additional privacy measures:

a. Safeguards. The Contractor shall take appropriate administrative, technical and physical safeguards to protect the data from any unauthorized use or disclosure not provided for in this agreement.
b. Confidentiality. The Contractor shall protect data and information according to acceptable standards and no less rigorously than they protect their own confidential information. The Contractor shall ensure that individual level identifiable data or Protected Health Information (PHI) shall not be reported or made public. The Contractor shall ensure that all persons (e.g., interns, subcontractors, staff, and consultants) who have access to confidential information sign a confidentiality agreement.

6.2 Contractor shall be liable for any fines levied as a result of loss of Protected Health Information data or claims based upon alleged violations of privacy rights through improper use or disclosure of Protected Health Information for which Contractor or its employees directly committed.

6.2.1 HIPAA Business Associate Addendum / Qualified Service Organization Addendum.
The Contractor shall agree to comply with the terms of the HIPAA Business Associate Addendum / Qualified Service Organization Addendum

6.2 Third Parties and Business Associate Addendum / Qualified Service Organization Addendum.

a. The Contractor shall require that any third parties, including subcontractors or other partner agencies, that it involves for work to be done pursuant to this Contract agree to the most recent CDHS version of the HIPAA Business Associate Addendum / Qualified Service Organization Addendum.
b. A HIPAA Business Associate Addendum / Qualified Service Organization Addendum is required between subcontracted treatment provider agencies for any program that has more than one treatment subcontractor agency rendering services in the jail in order to share assessments and screenings between subcontracted treatment provider agencies.

7. Medical Record

7.1 Contractor shall maintain a complete record of all medication, treatment, and services provided to Clients.
7.2 The shall be made available to CDHS and OCFMH departments FST, admission

and records department as requested.

8. Billing and Payment

8.1 Financial Report and Audit Requirements

8.1.1 Cost Reimbursement / Allowable Expenses. This contract is paid by cost reimbursement. See **Exhibit F**, Budget and Rate Schedule, for a list of reimbursable expenses. The Rate Schedule is non-exhaustive; other items expensed to this Contract must be reasonable toward completion of the contract terms, are reviewable by OCFMH, and shall not exceed any detail in the budget in this regard. J

8.1.2 Spending Projection Plan. If a contractor is underspent by greater than 40% of their budget by mid fiscal year (Nov 30), Contractor shall submit a spending projection plan. Failure to submit the spending plan and failure to effectively utilize funding could result in reduction in the current year budget.

8.1.3 Staff Time Tracking and Invoicing. The Contractor shall ensure expenses and staff are tracked and invoiced separately. Any other funding sources or in-kind contributions supporting the CEP shall be disclosed in the invoice submission. Invoices will be submitted to cdhs_OCFMHpayment@state.co.us by the 20th of the following month. Supporting documentation will only be required in the event of an audit, but these records should be maintained by the Contractor.

8.1.4.4 Proportional Reduction of Funds. The Office of Civil and Forensic Mental Health has the unilateral authority to proportionately reduce the contract budget amount to match current spending rates. If the Sheriff's Department has not spent 40% of the contract budgeted amount by November 30th, the Office of Civil and Forensic Mental Health may proportionately reduce the contract budget amount to match current spending rates. If the Sheriff's Department has not spent 65% of the contract budgeted amount by February 28th, the Office of Civil and Forensic Mental Health may again proportionately reduce the contract budget amount to match current spending rates.

8.1.5 Fiscal Agent County Responsibilities. Where a county is acting as a fiscal agent for other counties, the fiscal agent county shall pay invoices received by the catchment counties within 45 days of receipt.

8.1.6 Other Financial Provisions, including invoicing instructions can be found in **Exhibit H**, Miscellaneous Provisions.

9. Data Collection and Reporting

9.1 Monthly Contract Monitoring Tool. The Contractor shall submit a completed contract monitoring tool to their assigned CEP program manager no later than the 20th of the month with the prior months information. CEP program managers will update this internally.

9.2 Monthly Data Reporting. The Program Administrator shall provide OCFMH with a monthly written report (in MS Word format) and an electronic file submission (in either MS Excel or MS Access formats) by the tenth (10th) day of each month for the prior month, for both any Clients served via this

contract.

- 9.2.1 The monthly data requirements shall include:
    - Clients served by name
    - Booking date (date individual booked into jail)
    - Admission date to CEP services (date CEP initiated)
    - Clients served by legal status
    - Clients served by acuity category (as identified at end of month)
    - Monthly status snapshot of acuity levels
    - Monitoring or contact requirement lapses
    - Total Critical Incidents by type
    - Clients that admitted to a CDHS facility
    - Clients that transitioned into the community on bond
    - Clients that transitioned into outpatient restoration
    - Clients opined restored to competency while receiving CEP services

10. Adjunct Services:

10.1 Contractor shall collaborate with the subcontractor to ensure all American with Disabilities Act (ADA) requirements for this setting are met and followed.

10.2 Contractor shall ensure that Clients have access to bilingual staff, qualified translators, or sign-language interpreters (where applicable). Contractor shall employ consultant translators
and sign language interpreters, on an as-needed basis.

10.3 Contractor shall ensure materials are made available in large print for those Clients who are visually impaired but can read enlarged print.

11. Privacy Liability-

Contractor shall be liable for any fines levied as a result of loss of Protected Health Information data or claims based upon alleged violations of privacy rights through improper use or disclosure of Protected Health Information for which Contractor or its employees directly committed.

12. Performance and Non-Compliance

The State shall notify Contractor of non-compliance and subsequently, after consultation with Contractor, shall establish a schedule for Contractor to cure non-compliance.

12.1. Contractor shall be responsible for the submission of a plan of corrective action in accordance with said schedule.

12.2. If full compliance is not achieved, or a plan of action for correction is not submitted and approved by the State within the scheduled time frame, the State may exercise remedies specified in the General Provisions “X. Remedies” section of this Contract.

13. Termination

In the event this Contract is terminated, Contractor shall implement a service transition plan for enrolled Clients. The transition plan shall ensure that Clients are provided services through the termination date. Prior to the date of termination, Contractor agrees to work with the State and any State designated provider to ensure that continuity of care is maintained for Clients during and

subsequent to contract termination.

14. Notices and Representatives

14.1. Each individual identified below is the principal representative of the designating Party. All notices required to be given hereunder shall be hand delivered with receipt required or sent by certified or registered mail to such Party's principal representative at the address set forth below. In addition to, but not in lieu of a hard-copy notice, notice also may be sent by e-mail to the email addresses, if any, set forth below. Either Party may from time to time designate by written notice substitute addresses or persons to whom such notices shall be sent. Unless otherwise provided herein, all notices shall be effective upon receipt.

Exhibit B: Deliverables

1. CEP Work Plan

Complete a work plan to submit to the OCFMH within one month after activation of this contract.

The work plan, once approved by OCFMH, shall be incorporated into this Contract by reference as work requirements of the Contractor supplemental to Contractor work requirements under the current Contract Exhibit A, Statement of Work, as amended. Please use the template provided below to complete your work plan.

The work plan must include but is not limited to the below components:

1. Identify the Project Name, Purpose, and Timeline
    - Project Name: Competency Enhancement Program (CEP) Implementation
    - Purpose: To provide interim mental health services to individuals in jail undergoing competency evaluations or restoration services ordered by CDHS.
    - Timeline: July 1, 2024 - June 30, 2025
2. Put Your Work Plan Into Context
    - Introduction: Overview of the CEP program within the facility.
    - Background: Describe the incorporation of CEP services, reasons for implementation, and anticipated program outcomes.
    - Overall Goal: Facilitate mental health services to improve the well-being of incarcerated individuals undergoing competency evaluations or restoration.
3. Establish Your Goals and Objectives
    - Assessments and Screenings: Define procedures for assessments between treatment provider agencies.
    - Interface with Other Agencies: Outline collaborations with other competency or mental health support service agencies internal to facility or external to community to fulfill treatment needs.
    - Security Protocol and Reporting: Describe expected security measures and reporting requirements from the treatment provider.
    - Screening Efforts: Outline existing or planned screening protocols for mental

health, substance use, and suicidality among incarcerated individuals.
- Continuum of Services: Specify the range of services offered based on evidence-based curricula, including frequency, duration, and staff allocation.

4. Define and Coordinate Your Resources
   - Organizational Structure: Design an effective administrative structure encompassing jail staff and subcontracted personnel.
   - Linking Community Bound Clients with Services: Plan to connect individuals with reentry planning services or post-custody community services when applicable.
5. Understand Your Constraints
   - Barriers to Treatment: Address obstacles within jail that may hinder service provision.
   - Resolution Strategies: Outline plans to mitigate identified barriers.
6. Discuss Risks and Accountability
   - Program Risks: Highlight foreseeable risks and assign accountability for different aspects of the program.

2. Management Plan

Administrator, identify the positions' roles, responsibilities and authority, and develop a management plan that supports the CEP Programming as described in above in Exhibit B 1, CEP Work Plan

Outline of a Dedicated Staffing Model

- Staffing structure: outline of roles of clinical team- each contract must have a plan for at least one primary clinician who is responsible for direct reporting to FST
- Qualifications and Experience: specify expected qualifications and experience levels for each role such as licenses, certification, years of experience
- Responsibilities and Duties: Detail specific responsibilities each role, including client interaction, administrative tasks, specialized duties
- Supervision and Training: describe how supervision will be conducted, how clinical oversight will be provided and include plans for initial and ongoing training.
- Define expected client caseload and how it aligns with contract requirements and service goals.

3. Program Implementation

a. Referral and Assessment Procedures
   i. Establish clear procedures for referrals based on court orders, CDHS transitions, and jail-identified crisis situations.

ii. Implement standardized protocols for behavioral health screenings within 48 hours of booking or identification.

b. Clinical Acuity Triage

i. Develop a system for triaging individuals into high, moderate, or low clinical acuity categories.

4. Service Delivery and Monitoring

a. Mental Health Evaluations and Treatment

i. Conduct mental health evaluations within 48 hours of identification of competency involved individuals.

ii. Implement individualized treatment plans based on evaluations and clinical needs, including medication management and counseling

iii. Individuals involved in the CEP program are required to complete an evidence based behavioral health screen for each of the following five categories:

iv. Substance Use Disorder

v. Mental Health,

vi. Suicide

vii. Trauma and Traumatic Brain Injury

viii. This information should be used to formulate a comprehensive treatment plan to include appropriate referrals. These may be the same screening tools provided by medical or JBBS services.

Exhibit C: Policies and Plans

1. Critical Incident Policy

All events that meet below criteria must be reported to the FST staff within 24 hours.

Critical Incidents can include, but are not limited to the following:

a. Arrest
b. Death
c. Elopement
d. Escape
e. Incident where Media may be notified
f. Injury of a Patient
g. Injury of a CDHS Staff Member as a result of client contact

h. Physical Assault: Any such occurrence, whether by another patient, staff member or visitor. There must be intent, knowingly or recklessly, to harm and bodily injuries present.
i. Sexual Assault : Any such occurrence where the perpetrator is another patient, staff member or visitor must be reported. There are several elements, any of which can be present to be considered sexual abuse. These include "knowingly" touching; sexual intrusion, touching intimate parts of the body, observation or photographs of intimate parts, consent not given, physical force or threat used
j. Suicide Attempt
k. Suicide Completion
l. Duty to Warn

Report To FST should include:

a. Full name and Title of who is reporting the incident to FST staff
b. Date, time, location of incidents as well as any safety protocols that may have in place at time of the incident.
c. Outcome of action steps taken by facility after incident

Exhibit D: Information Sharing, Service Contact, and Documentation

1. **Communication with Forensic Support Requirements**

- Acuity checklist designation for each client
- Meet FST workflow protocols- weekly/ bimonthly/ monthly client review
- Clients Housing (ad seg/ disciplinary/ medical/ group)
- Medication Compliance
- Any internal alerts/ precautions (assualt/ suicide/ etc)
- Notification of suicide percautions (within 72 hrs) and critical incidents (within 24 hrs)
- Client Presentation
- Notification of client transport or discharge outside of the jail within 24 hours

2. Standard CEP Support Services Provided

- Weekly contact with FST to review clients presentation and offered interventions
- Crisis Services
- Individualized treatment planning
- Referrals to internal jail programing or JBBS supports
- Re entry planning for transitioning clients

- Referrals to medical/ medication prescribers
- Worksheets/ groups/ support for identified areas of concern
- Compliance and Legal Requirements: ensure the staffing model adheres to legal and regulatory standards, including Hipaa compliance and relevant healthcare laws
- Adaptability: address how the model allows for scalability, adjustment to changing needs and potential expansion if the contract grows or scales down.

3. **Behavioral Health Screenings**

Individuals involved in the CEP program are required to complete an evidence based behavioral health screen for each of the following five categories:

- Substance Use Disorder
- Mental Health,
- Suicide
- Trauma and Traumatic Brain Injury

This information should be used to formulate a comprehensive treatment plan to include appropriate referrals. These may be the same screening tools provided by medical or JBBS services.

4. Clinical Documentation Minimum Requirements

- Basic individual demographic and working diagnosis information.
- Booking date (date that the individual was booked into jail).
- Screening date and results (Mental Health, Substance Use, Traumatic Brain Injury, Trauma, and Suicidality) for all individuals involved in competency processes.
- Admission date (date that individual began receiving CEP).
- Individual-level services provided (date of service, type of service, duration of service, and any additional applicable information).
- Date, duration, and participants who provided individualized or group treatment or case management sessions.
- End date for services (admitted into a CDHS restoration facility, transitioned into the community, case dismissed, found competent).

Budget 24-24	
Direct Personnel Costs	$280,000
Indirect Costs	$50,000
Total (All Categories):	**$330,000**