

326

Contract Cover Sheet

Res 240

Note: Shaded areas are for County Executive review.

Department: HUMAN SERVICES	Contract/Addendum #: <u>83689C</u>																				
1. This contract, grant or addendum: <input checked="" type="checkbox"/> AWARDS <input checked="" type="checkbox"/> ACCEPTS	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:50%;">Contract</th> <th style="width:50%;">Addendum</th> </tr> <tr> <td colspan="2" style="text-align:center; font-size:small;">If Addendum, please include original contract number</td> </tr> <tr> <td><input type="checkbox"/> POS</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Grant</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Co Lease</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Co Lessor</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Intergovernmental</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Purchase of Property</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Property Sale</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/></td> </tr> </table>	Contract	Addendum	If Addendum, please include original contract number		<input type="checkbox"/> POS	<input checked="" type="checkbox"/>	<input type="checkbox"/> Grant	<input type="checkbox"/>	<input type="checkbox"/> Co Lease	<input type="checkbox"/>	<input type="checkbox"/> Co Lessor	<input type="checkbox"/>	<input type="checkbox"/> Intergovernmental	<input type="checkbox"/>	<input type="checkbox"/> Purchase of Property	<input type="checkbox"/>	<input type="checkbox"/> Property Sale	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
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<input type="checkbox"/> Other	<input type="checkbox"/>																				
2. This contract is discretionary <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																					
3. Term of Contract or Addendum: <u>11/1/17 - 12/31/17</u>																					
4. Amount of Contract or Addendum: <u>\$ 15,000</u>																					
5. Purpose: NA – Not required when Human Services signs.																					

6. Vendor or Funding Source: Journey mental Health Center

7. MUNIS Vendor Code: 5152

8. Bid/RFP Number:

9. Requisition Number:

10. If grant: Funds Positions? Yes No Will require on-going or matching funds? Yes No

11. Are funds included in the budget? Yes No

12. Account No. & Amount, Org & Obj. _____ Amount \$ _____
 Account No. & Amount, Org & Obj. _____ Amount \$ _____
 Account No. & Amount, Org & Obj. _____ Amount \$ _____

13. If this contract awards funds, a purchase requisition is necessary. Enter requisition # & year _____

14. Is a resolution needed? Yes No If yes, please attach a copy of the Resolution.
 If Resolution has already been approved by the County Board, Resolution No. & date of adoption 240

15. Does Domestic Partner equal benefits requirement apply? Yes No

16. Director's Approval: Symon Green

Human Services Only	a. Dane County Res. #	Approvals	Initials	Date
	b. HSD Res. ID#	g. Accountant	<u>SL</u>	<u>9/12/17</u>
	c. Program Manager Name <u>Campbell</u>	h. Supervisor	<u>SL</u>	<u>9-14-17</u>
	d. Current Contract Amount <u>11,319,317</u>	i. To Provider	<u>SL</u>	<u>9-14-17</u>
	e. Adjustment Amount <u>15,000</u>	j. From Provider	<u>SL</u>	<u>9-15-17</u>
	f. Revised Contract Amount <u>11,334,317</u>	k. Corporation Counsel	<u>SL</u>	<u>9-15-17</u>

Contract Review/Approvals				Vendor
Initials	Ftnt	Date In	Date Out	Vendor Name/Address
<u>ML</u> Received	_____	<u>9/26/17</u>	_____	Contact Person Phone No. E-mail Address
<u>SL</u> Controller	_____	_____	<u>9/25/17</u>	
N/A Corporation Counsel	See "k" above	_____	_____	
<u>SL</u> Risk Management	_____	<u>9/28/17</u>	<u>9/29/17</u>	
<u>SL</u> Purchasing	_____	<u>9/29/17</u>	<u>9/29/17</u>	
_____ County Executive	_____	_____	_____	

Footnotes:
 1. Budget needed

Return to: Name/Title: Spring Larson, CCA Phone: 608-242-6391 E-mail Address: Larson.spring@countyofdane.com	Dept.: Human Services Mail Address: 1202 Northport Drive
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Certification

The attached contract: *[check as many as apply]*

- conforms to Dane County's standard Purchase of Services Agreement form in all respects
- conforms to Dane County's standard Purchase of Services Agreement form with modifications and is accompanied by a revision copy¹
- is a non-standard contract which has been reviewed or developed by corporation counsel and which has not been changed since that review/development
- is a non-standard contract previously review or developed by corporation counsel which has been changed since that review/development; it is accompanied by a revision copy¹
- is a non-standard contract not previously reviewed by corporation counsel; it is accompanied by a revision copy
- contains non-standard/indemnification language which has been reviewed or developed by risk management and which has not been changed since that review/development
- contains non-standard insurance/indemnification language which has been changed since review/development or which has not been previously seen by risk management; it is accompanied by a revision copy
- contains non-standard affirmative action/equal opportunity language which has been reviewed or developed by contract compliance and which has not been changed since that review/development
- contains non-standard affirmative action/equal opportunity language which has been changed since the earlier review/development by contract compliance or which has not been previously seen by contract compliance; it is accompanied by a revision copy¹

Date: 9-21-17

Signed: 

Telephone Number 242-6469


Print Name: Lynn Green

Major Contracts Review (DCO Sect. 25.20) This review applies only to contracts which both exceed \$100,000 in disbursements or receipts and which require county board review and approval.

Executive Summary (attach additional pages, if needed).

1. **Department Head** Contract is in the best interest of the County.
Describe any deviations from the standard contracting process and any changes to the standard Purchase of Services Form Agreement.

Date: 9-21-17

Signature: 

2. **Director of Administration** Contract is in the best interest of the County.
Comments:

Date: _____

Signature: _____

3. **Corporation Counsel** Contract is in the best interest of the County.
Comments:

Date: 9-15-17

Signature: 

¹ A revision copy is a copy of the contract which shows the changes from the standard contract or previously revised/developed contract by means of overstrikes (indicating deletions from the standard language) and underlining (showing additions to the standard language).

ADDENDUM

THIS ADDENDUM is made and entered into by and between the County of Dane (hereinafter referred to as "COUNTY") and Journey Mental Health Center, Inc. (hereinafter "PROVIDER") as of the date representatives of both parties have affixed their respective signatures.

WHEREAS the COUNTY and PROVIDER have previously entered into a Purchase of Service Agreement No. 83689 (hereinafter the "Master Agreement"), pursuant to which PROVIDER has agreed to provide the COUNTY certain services more fully described in the Master Agreement; and

WHEREAS COUNTY and PROVIDER now wish to amend said Master Agreement,

NOW, THEREFORE, in consideration of the above premise and the mutual covenants of the parties the receipt and sufficiency of which is hereby acknowledged by each party for itself, the COUNTY and PROVIDER do agree that the Master Agreement shall continue in full force and effect unchanged in any matter by this addendum, except as specifically set forth herein. This addendum consists of six (6) pages.

<u>Current Cost</u> <u>for 2017</u>	<u>Addendum Amount</u>	<u>Revised Maximum</u> <u>Cost for 2017</u>
\$11,319,317	\$15,000	\$11,334,317

IN WITNESS WHEREOF, COUNTY and PROVIDER, by their respective authorized agents, have caused this addendum and its attachments, if any, to be executed, effective as of the date by which all parties hereto have affixed their respective signatures, as indicated below.

Date Signed: 09/15/2017

FOR PROVIDER:
Lynn A. Brady
Signature
Lynn A. Brady, CEO
Print Name and Title of Signer

Date Signed: _____

Signature

Print Name and Title of Signer

Date Signed: _____

FOR COUNTY:

JOE PARISI, County Executive
(when applicable)

Date Signed: 9-21-17

Lynn Green
LYNN GREEN, Director,
Department of Human Services
(when applicable)

Program Summary Form

Created	10/19/2016		Contract #	83689		Provider	Journey Mental Health Center, Inc						
Revised:	11/18/2016, 2/6/2017, 9/1/2017		Division:	Adult Community Services		Funding Period:	January 1, 2017 - December 31, 2017						
Contract Maximum Service Costs: Subject to the provisions specified elsewhere in this contract, the following summarizes and sets forth the rates and maximum payments available for services under this contract:													
Program Number	Program Group	Org	Obj	Program Name	SPC	# of Clients	# of Slots	Unit Cost	Unit Quantity	County Cost	Other Revenue*	Total Cost	Reporting
a	3645	3645	ACICTMHC	IZDCAA	603	110	62	178.43	850	\$ 151,593		\$ 151,593	600/610
b	3646	3646	ACIASSMT	IZATAA	603	187	92	305.15	894	\$ 272,828		\$ 272,828	600/610
c	3651	6064	ACICTMHC	CZATAA	507.00	74	N/A	77.39	832	\$ 64,354		\$ 64,354	600/610
d	3652	6064	ACICTMHC	CMATAA	604	52	N/A	77.39	221	\$ 17,072		\$ 17,072	600/610
e	3653	6065	ACICTMHC	CZDCAA	507.00	30	N/A	84.46	580	\$ 48,960		\$ 48,960	600/610
f	3654	6065	ACICTMHC	CMDCAA	604	30	N/A	84.46	286	\$ 24,114		\$ 24,114	600/610
g	10670	10670	ACICTMHC	IZOWAA	603	60	N/A	138.36	1,187	\$ 164,243		\$ 164,243	600/610
h	9190	9190	ACICLHHC	CZOPAA	507.00	20	20	117.56	917	\$ 107,860		\$ 107,860	N/A
Total										\$ 851,024.00	\$	\$ 851,024.00	

*Other Revenue include here the source and related amount for each program

2

The section below is to be used to further define the information above

- a Unit Quantity equal to amount of available funds divided by Unit Cost Unit = direct client service hour 11/18/2016 Revision Funds added to bring total cost of living adjustment to 2.0%.
- b bring total cost of living adjustment to 2.0%
- c Unit Quantity equal to amount of available funds divided by Unit Cost Unit = direct client service hour 11/18/2016 Revision Funds added to bring total cost of living adjustment to 2.0%
- d bring total cost of living adjustment to 2.0%
- e Unit Quantity equal to amount of available funds divided by Unit Cost Unit = direct client service hour 11/18/2016 Revision Funds added to bring total cost of living adjustment to 2.0%
- f bring total cost of living adjustment to 2.0%
- g CAU Assessment and Coordination services for the OWI Court Unit Quantity equal to amount of available funds divided by Unit Cost Unit = direct client service hour 11/18/2016 Revision Funds added to bring total cost of living adjustment to 2.0%
- h Contract line added to provide medication assisted therapy to opioid-dependent individuals directly upon their release from the Dane County Jail Unit Quantity equal to amount of available funds divided by Unit Cost Unit = direct client service hour 2/6/2017 Revision Increase to reflect grant revenue received 9/1/2017 Revision: Funds added from State Targeted Response Grant.

Standard Program Category (SPC) Code Description												
a Intake Assessment			c Outpatient, regular			e Outpatient, regular			g Intake Assessment			
b Intake Assessment			d Case Management			f Case Management			h Outpatient, regular			
Contract Manager(s)/Programs			Todd Campbell			Accountant(s)/Programs			Laura Yurci			

JOURNEY MENTAL HEALTH CENTER, INC.

Jail Opiate Project

Program #9190

2017 – SCHEDULE A

A. Description of Services to be Purchased

This program is intended to provide:

Program #: 9190 – Outpatient, Regular (SPC 507.00)

Outpatient treatment service means a nonresidential treatment service that provides a variety of evaluation, diagnostic, intervention, crisis, counseling, physical health services, and medical support services relating to substance abuse in order to ameliorate symptoms and restore effective functioning. Regular outpatient is less than six hours of service per person, per week.

1. Service Location

Services under this contract are provided at 49 Kessel Court, Madison, WI 53711.

2. Persons to Be Served

a. Target Population

PROVIDER will serve adults who are in need of treatment and case management for a substance use disorder that has caused serious problems in their lives. These programs provide treatment and case management specifically for opiate drug users

b. Eligibility

PROVIDER will find eligible for admission to these programs any individuals who possess the following characteristics:

- i. Adult (at least 18 years old); and
- ii. Dane County resident; and
- iii. Diagnosable Opioid Use Disorder; and
- iv. Incarcerated in the Dane County Jail for a minimum of seven days immediately before presenting for services.

3. Federal and state requirements:

PROVIDER will comply with all federal and state requirements related to the funding source for this program including the Residential Substance Abuse Treatment Grant from the Wisconsin Department of Justice, and the State Targeted Response Grant from the Wisconsin Department of Health Services.

B. Program Evaluation

1. Goals

- a. To provide an objective and effective bridge between the justice system and the community.
- b. To minimize the risk of overdose by opiate-dependent individuals released from jail after a period of sobriety while incarcerated.

- c. To reduce the use of alcohol and other drugs among participants;
- d. To maximize the number of treatment completions by engaging clients in the treatment process;

2. Performance Indicators

- a. 50% of program participants will be compliant with medication-assisted therapy while in treatment with the PROVIDER.
- b. 60% of all clients discharged will have successfully completed treatment, in accord with the following criteria:
 - i. Clients will have stopped or reduced their usage of alcohol and or other drugs to non-problematic usage;
 - ii. Will have improved their level of functioning in at least two of the following areas:
 - (a) social and family relations;
 - (b) psychiatric/emotional;
 - (c) legal involvement;
 - (d) financial/vocational; and
 - (e) health.
 - iii. Clients will have an established involvement with a self-help group or support groups or systems.

C. Contract Requirements Specific to Programs

1. Referrals/Application Process

Referrals are accepted primarily from AIDS Resource Center of Wisconsin and from staff from the Dane County Jail. PROVIDER is the authorizing agent for services provided under this contract. An individual whose referral is received prior to release from jail shall be provided with an intake appointment within 24 hours of their release from jail.

2. Capacity/Wait List

No wait list for this program is permitted.

3. Service Methods

a. Service Definition

Services provided under the terms of this contract will include: screening, assessment/diagnosis; treatment plan development, monitoring and review, individual, group (including Cognitive Behavioral Therapy), couple and family counseling, case management, medication assisted therapy, psychiatric, crisis intervention services, education, and referral to other needed services.

b. Frequency of Contact

Each individual will have less than six hours of contact per week.

c. Nature of Contact

The majority of contact under this contract will take place in the PROVIDER's office with some contacts in the Dane County jail and/or community, and will be face-to-face between staff from the PROVIDER and each client admitted to the

program. The PROVIDER may have some contact with and on behalf of admitted clients by telephone, email, fax, and mailed correspondence.

d. Service Hours/Days

Service hours are between 8:00 a.m. and 7:00 p.m. Monday through Thursday and 8:00 a.m. to 5:00 p.m. on Friday. Scheduling accommodations for the individual client's work and family commitments are made whenever possible.

e. Length of Service

The length of a treatment episode is tailored to individual client needs, with discharge based upon completion of client-identified goals.

f. Service Area

Individuals from all of Dane County will be served.

4. Transportation

Transportation is not a covered service under this contract.

5. Service Termination

Services are terminated upon successful completion of the program, or if the client or client and therapist together determine that services should be otherwise terminated.

6. Clients to be Reported

All clients for whom a COUNTY client identification number has been assigned shall be reported. PROVIDER agrees to provide the statistical information to satisfy the requirements of the Residential Substance Abuse Treatment Grant from the Wisconsin Department of Justice.

7. Units of Service

One hour represents one unit of service.

8. Other Features and Requirements

a. Program Certification

PROVIDER shall maintain certification under State Community Substance Abuse Services Standards established by Administrative Rule DHS 75 for services provided under this contract.

b. Tuberculosis Services

- i. The PROVIDER shall directly provide or routinely make available the following TB services to each individual receiving treatment for substance abuse:
 - (a) Counseling the individual with respect to TB.
 - (b) Testing to determine whether the individual has been infected with mycobacterium TB to determine the appropriate form of treatment for the individual.

- (c) Providing for or referring the individuals infected by mycobacterium TB appropriate medical evaluation and treatment.
- ii. The PROVIDER shall implement the infection control procedures that are consistent with those established by the Wisconsin Department of Health Services to prevent the transmission of TB and that address the following:
 - (a) Screening individuals and identification of those who are at high risk of becoming infected.
 - (b) Meeting all state reporting requirements while adhering to federal and state confidentiality requirements 45 CFR parts 160 & 164 Health Insurance Portability and Accountability Act, HIPAA, including 42 CFR part 2.
 - (c) Case management activities to ensure that individuals receive such services.
- iii. The PROVIDER shall report all individuals with active TB as required by state law and in accordance with federal and state confidentiality requirements 45 CFR Parts 160 & 164 Health Insurance Portability and Accountability Act, HIPAA, including 42 CFR Part 2.