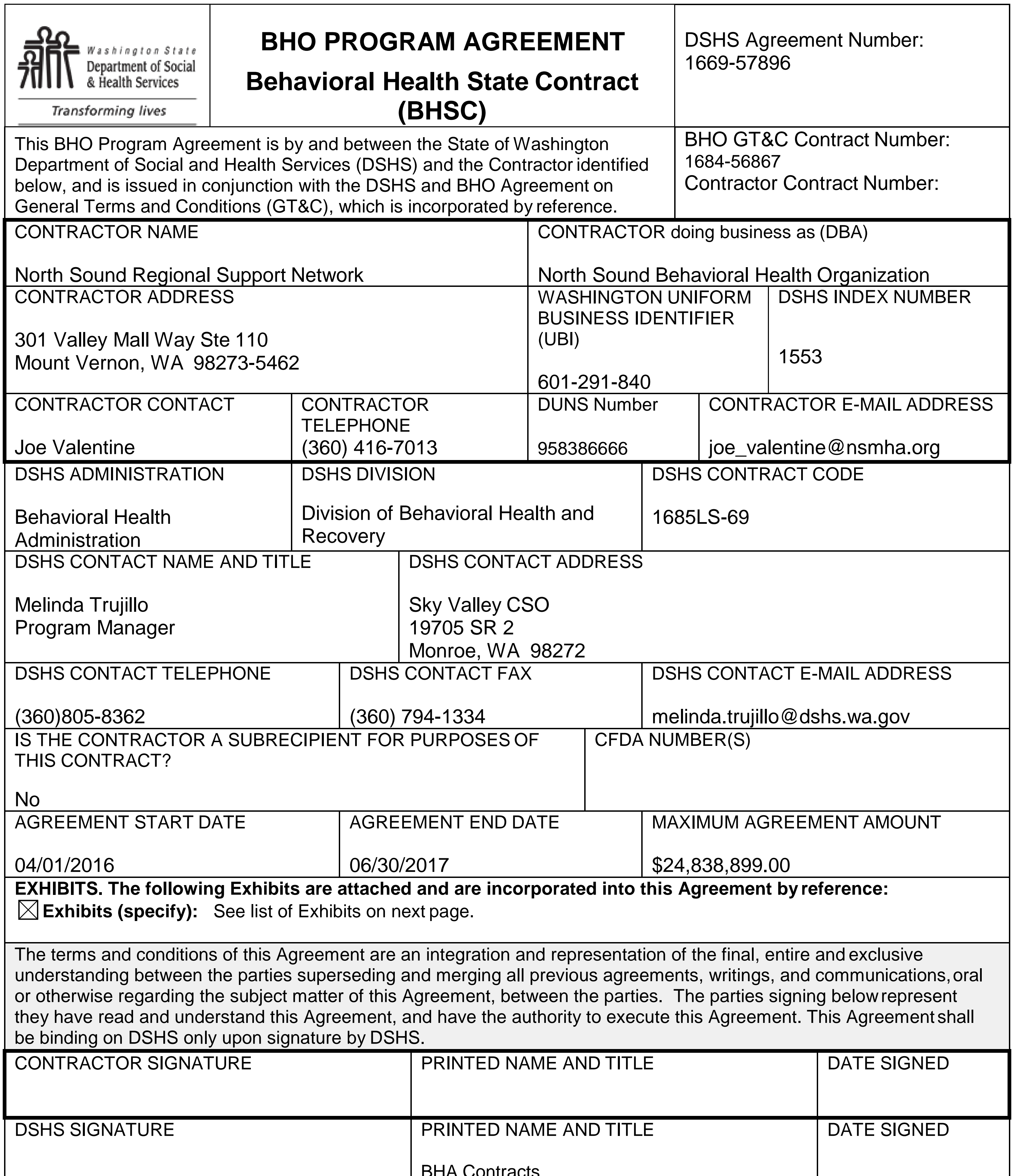

Washington State Department of Social & Health Services
Transforming lives

BHO PROGRAM AGREEMENT

Behavioral Health State Contract (BHSC)

DSHS Agreement Number: 1669-57896

This BHO Program Agreement is by and between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below, and is issued in conjunction with the DSHS and BHO Agreement on General Terms and Conditions (GT&C), which is incorporated by reference.

BHO GT&C Contract Number: 1684-56867
Contractor Contract Number:

CONTRACTOR NAME	CONTRACTOR doing business as (DBA)
North Sound Regional Support Network	North Sound Behavioral Health Organization

CONTRACTOR ADDRESS	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)	DSHS INDEX NUMBER
301 Valley Mall Way Ste 110 Mount Vernon, WA 98273-5462	601-291-840	1553

CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	DUNS Number	CONTRACTOR E-MAIL ADDRESS
Joe Valentine	(360) 416-7013	958386666	joe_valentine@nsmha.org

DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE
Behavioral Health Administration	Division of Behavioral Health and Recovery	1685LS-69

DSHS CONTACT NAME AND TITLE	DSHS CONTACT ADDRESS
Melinda Trujillo Program Manager	Sky Valley CSO 19705 SR 2 Monroe, WA 98272

DSHS CONTACT TELEPHONE	DSHS CONTACT FAX	DSHS CONTACT E-MAIL ADDRESS
(360)805-8362	(360) 794-1334	melinda.trujillo@dshs.wa.gov

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT?	CFDA NUMBER(S)
No	

AGREEMENT START DATE	AGREEMENT END DATE	MAXIMUM AGREEMENT AMOUNT
04/01/2016	06/30/2017	$24,838,899.00

EXHIBITS. The following Exhibits are attached and are incorporated into this Agreement by reference:
☒ **Exhibits (specify):** See list of Exhibits on next page.

The terms and conditions of this Agreement are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise regarding the subject matter of this Agreement, between the parties. The parties signing below represent they have read and understand this Agreement, and have the authority to execute this Agreement. This Agreement shall be binding on DSHS only upon signature by DSHS.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

DSHS SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
	BHA Contracts	

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1. PURPOSE OF PROGRAM AGREEMENT

The purpose of this Program Agreement (Agreement) is to establish and support state funded community behavioral health services.

2. DEFINITIONS

2.1. “Administration Costs” means costs for the administration of this Agreement for the general operation of the public behavioral health system. These activities cannot be identified with specific direct services or direct services support function as defined in the “BHO Fiscal Program Requirements & Revenue and Expenditure Report Instructions” administered by the DSHS, Behavioral Health Administration, Budget & Finance Division.

2.2. “Annual Revenue” means all revenue received by the Contractor pursuant to the Agreement for July of any year through June of the next year.

2.3. “ASAM” means the American Society of Addiction Medicine.

2.4. “ASAM Criteria” is used to evaluate an individuals need for treatment along six dimensions after systemically evaluating the severity and diagnosis of an individual, and then utilize a fixed combination rule to determine which of four levels of care a substance abusing patient will respond to with the greatest success. ASAM also includes the recommended duration of substance use disorder treatment based on each individual’s need.

2.5. “Assessment” means diagnostic services provided by a CDP or CDPT under CDP supervision to determine an Individual’s involvement with alcohol and other drugs. See WAC 388-877B-0500 for a detailed description of assessment requirements.

2.6. “Authorized Representative” means a person appointed by an Individual, or authorized under State or other applicable law, to act on behalf of an Individual or other party involved in an Appeal or Grievance. If the Individual gives written permission, the Authorized Representative may include a behavioral health practitioner working on behalf of the Individual.

2.7. “Available Resources” means funds appropriated for the purpose of providing community behavioral health programs: federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under RCW 71.24 or RCW 71.05 by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other behavioral health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

2.8. “Behavioral Health Advisory Council” (“BHAC”) (also referred to as "the Council") includes persons with behavioral disorders, providers, advocates, government representatives, and other private and public entities. The membership represents the state's population with respect to race, ethnicity, disability, and age, urban and rural.

2.9. “Behavioral Health Agency” (“BHA”) means an agency licensed by the State of Washington to provide mental health and/or substance use disorder treatment and is Subcontracted under this Agreement to provide services.

2.10. “Behavioral Health Administration” means the DSHS Administration governing mental health care and substance abuse services, and its employees and authorized agents.

2.11. “Behavioral Health Data Store” means the management information system maintained by DSHS that retains demographic, treatment, assessment and ancillary service data on each individual receiving publicly-funded outpatient and residential substance use disorder treatment services in Washington State, as well as data on other general services provided.

2.12. “Behavioral Health Organization” (“BHO”) means a county authority or group of county authorities or other entity recognized by the Secretary that contracts for mental health services and substance use disorder treatment services within a defined Regional Service Area.

2.13. “BHO Advisory Board” means the behavioral health advisory board appointed by each BHO, which reviews and provides comments on plans and policies related to service delivery and outcomes. The BHO must promote active engagement with persons with behavioral disorders, their families, and service providers by soliciting and using their input to improve its services, and appoints a BHO Advisory Board to fulfill this purpose.

2.14. “Budget Narrative” means a description of how costs were estimated and the justification of the needs for the cost.

2.15. “Centers for Medicare and Medicaid Services” (“CMS”) means the agency within the U. S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.16. "Certified" means the status given by DSHS to substance use disorder, mental health, and problem and pathological gambling program-specific services.

2.17. “Chemical Dependency Professional” (“CDP”) means an individual licensed through the Washington State Department of Health (DOH). A CDP is the individual with primary responsibility for implementing an individualized plan for Substance Use Disorder treatment services.

2.18. “Chemical Dependency Professional Trainee” (“CDPT”) means an individual working toward the education and experience requirements for certification as a chemical dependency professional, and who has been credentialed as a CDPT.

2.19. “Child” means a person under the age of eighteen (18) years. For persons eligible for the Medicaid program, child means a person who is under the age of twenty-one (21) years.

2.20. “Child Study and Treatment Center” (“CSTC”) means the Department of Social and Health Services’ child psychiatric hospital.

2.21. “Children’s Long Term Inpatient Program” (“CLIP”) means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from Children’s Long Term Inpatient Programs.

2.22. “Community Mental Health Agency” (“CMHA”) means an agency licensed by the State of Washington to provide mental health services and Subcontracted to provide services covered under this Agreement.

2.23. “Community Support Services” means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for persons who are mentally ill being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for children who are mentally or severely emotionally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by behavioral health organizations.

2.24. “Comprehensive Assessment Reporting Evaluation” (“CARE”) means the tool used by DSHS Aging and Long-Term Support Administration case managers to document a client’s functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a client will receive, and develop a plan of care.

2.25. “Consultation” means the clinical review and development of recommendations regarding the job responsibilities, activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

2.26. “Contractor” means a behavioral health organization recognized by the Secretary with the authority to establish and operate a community behavioral health program.

2.27. “Criminal Justice Treatment Account” (“CJTA”), means per RCW 70.96A.350, the account created by Washington State that may be expended solely for: substance use disorder treatment and treatment support services for offenders with a substance.

2.28. “Cultural Competence” means the ability to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of cultural competent care include striving to overcome cultural, language, and communications barriers, providing an environment in which individuals from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options, encouraging individuals to express their spiritual beliefs and cultural practices, and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans.

2.29. “Data” means information that is disclosed or exchanged as described by this

Program Agreement.

2.30. “Delegation Plan” means a document or an identified set of documents that show the Contractor’s compliance with the Subcontracts Section of this Agreement.

2.31. “Deliverable” means items required for submission to DSHS to satisfy the work requirements of this Agreement and are due by a particular date or on a regularly occurring schedule.

2.32. “Dependent Child” means a child under age eighteen (18) living with the parent or a person under the age of twenty-one (21) years if enrolled in school and financially supported by the parent.

2.33. “Designated Chemical Dependency Specialist" means a person designated by the Behavioral Health Organization (BHO) or by the county alcoholism and other drug addiction program coordinator designated by the BHO to perform the commitment duties described in RCW 70.96A.140 and qualified to do so by meeting standards adopted by the Department.

2.34. “Designated Mental Health Professional” (“DMHP”) means a mental health professional designated by the behavioral health organization (BHO) county or other authority authorized in rule to perform duties under the involuntary treatment act as described in RCW 10.77.010, 71.05.020, 71.24.025 and 71.34.020.

2.35. “Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition” (“DSM-5”) means the 2013 update to the American Psychiatric Association’ classification and diagnostic tool that serves as a universal authority for psychiatric diagnosis in the United States.

2.36. “Division of Behavioral Health and Recovery” (“DBHR”) means the DSHS-designated single state agency for mental health and substance use disorder treatment, authorized by RCW Chapters 71.05, 71.24, 71.34, 70.96a and 70.96b.

2.37. “DSHS Contact” means the individual identified on page one (1) of this program agreement as the designated DSHS representative for this program agreement, or the successor of that individual.

2.38. “Early Periodic Screening Diagnosis and Treatment” (“EPSDT”) means the program under Title XIX of the Social Security Act as amended for children who are under twenty-one (21) years.

2.39. “Eastern Washington BHOs” includes BHOs contracted by DSHS to provide services in the following Washington counties: Ferry, Stevens, Pend Oreille, Lincoln, Okanogan, Grant, Adams, Chelan, Douglas, Spokane, Klickitat, Yakima, Kittitas, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin, and Whitman.

2.40. “Emergent Care” means services that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.153.

2.41. “Emerging Best Practice” or “Promising Practice” means a practice that presents,

based on preliminary information, potential for becoming a research-based or consensus-based practice.

2.42. “Enrollee” means a Medicaid recipient who is enrolled in a Pre-paid Inpatient Health Plan.

2.43. “Ethnic Minority” or "Racial/Ethnic Groups" means any of the following general population groups:

2.43.1. African American;

2.43.2. An American Indian or Alaskan Native; including:

2.43.2.1. A person who is a member of or considered to be a member in a federally recognized tribe;

2.43.2.2. A person determined eligible to be found Indian by the secretary of interior;

2.43.2.3. An Eskimo, Aleut, or other Alaskan native;

2.43.2.4. A Canadian Indian, meaning a person of a treaty tribe, Metis community, or non-status Indian community from Canada;

2.43.2.5. An unenrolled Indian meaning a person considered Indian by a federally or non-federally recognized Indian tribe or off-reservation Indian/Alaskan native community organization;

2.43.3. Asian/Pacific Islander; or

2.43.4. Hispanic.

2.44. “Evaluation and Treatment” (“E & T”) means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to Individuals suffering from a mental disorder, and which is certified as such by DSHS. A physically separate and separately operated portion of a State Hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the Department or any federal agency will not require certification. No correctional institution of facility, or jail, shall be an evaluation and treatment facility within the meaning of RCW Chapter 71.05.020.

2.45. “Evidence-Based Practice” means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

2.46. “Fair Hearing” means a hearing before the Washington State Office of Administrative Hearing.

2.47. “Family” means:

2.47.1. For adult Individuals, family means those persons the Individual defines as

family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the Individual.

2.47.2. For children, family means a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the department of social and health services, or a Federally Recognized Tribe.

2.48. "Federally Recognized Tribes" ("Tribes") means self-governing American Indian and Alaska Native governments recognized under applicable federal and common law. Because of their unique sovereign status, Federally Recognized Tribes have the inherent power to make and enforce laws on their lands, and to create governmental entities.

2.49. "Global Appraisal of Individual Needs – Short Screener ("GAIN-SS") means a tool used for conducting an integrated comprehensive screening of substance use disorder and mental health issues.

2.50. "Grievance" means any expression of dissatisfaction made by or on behalf of an individual and referred to the agency or behavioral health organization (BHO), as applicable, for resolution.

2.51. "Grievance Process" is one of the processes included in the grievance system that allows an Individual to express concern or dissatisfaction about a behavioral health service.

2.52. "Grievance System" means the processes through a BHO in which an individual applying for, eligible for, or receiving behavioral health services may express dissatisfaction about services. The grievance system must be established by the BHO and meet the requirements of WAC 388-877A-0400 through 0460, and include: a Grievance Process and access to the Department's Administrative Fair Hearing process.

2.53. "Individual" means a person who applies for, is eligible for, or receives BHO-authorized behavioral health services from an agency licensed or certified by the Department as a behavioral health agency. In the case of a minor, the Individual's parent or, if applicable, the Individual's parent or custodian.

2.53.1. For the purposes of accessing the Grievance System, the definition of Individual also includes the following if another person is acting on the Individual's behalf:

2.53.1.1. The Individual's legal guardian; or

2.53.1.2. The Individual's representative if the Individual gives written permission.

2.54. "Individual Using Intravenous Drugs" means a person who has used a needle to illicitly inject drugs one or more times.

2.55. "Institute for Mental Disease" ("IMD") means, per P.L. 100-360, an institution for

mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of Individuals with mental diseases.

2.56. "International Statistical Classification of Diseases and Related Health Problems, 10th Edition" ("ICD-10") is the standard diagnostic tool for epidemiology, health management and clinical purposes and contains codes for diseases, signs and symptoms and other causes of injury or diseases.

2.57. "Involuntary Treatment Act - Mental Health" ("ITA-MH") allows for Individuals to be committed by court order to a mental hospital or institution for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of Individuals with a mental disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial detention may last up to seventy-two (72) hours, but, if necessary, Individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05.240 and 71.05.290).

2.58. "Involuntary Treatment Act – Substance Use Disorder" ("ITA-SUD") allows for Individuals to be committed by court order to an approved treatment program for a limited period of time. Involuntary civil commitments are meant to provide for the treatment of Individuals with a substance use disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. Individuals can be committed for a period of sixty (60) days unless sooner discharged if it has been determined that the likelihood of harm no longer exits or treatment is no longer adequate or appropriate per ASAM criteria, or incapacity no longer exists. A petition for recommitment can be filed for an additional period of up to ninety (90) days. (RCW 70.96A.140)

2.59. "Juvenile Drug Court" means a court that has special calendars or dockets designed to achieve a reduction in recidivism and substance abuse among nonviolent, substance abusing felony and non-felony juvenile offenders by increasing their likelihood for successful rehabilitation through early, continuous, and intense judicially supervised treatment; mandatory periodic drug testing; and the use of appropriate sanctions and other rehabilitation services.

2.60. "Level of Care Guidelines" means the criteria the BHO uses in determining the scope, duration and intensity of services to be provided.

2.61. "Less Restrictive Alternative Treatment" describes the minimum services that all individuals who are under a less restrictive order must be offered as per RCW 71.05.585 and Exhibit E of this Agreement.

2.62. "Medicaid" means the Centers for Medicare and Medicaid Services (CMS) Federal Department of Health and Human Services (DHHS) program, which is state-operated and provides medical benefits for certain indigent or low-income individuals in need of health and medical care.

2.63. “Medicaid Funds” means funds provided by the federal Centers for Medicare and Medicaid Services (CMS) Authority.

2.64. “Medical Necessity” means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that; endanger life, cause pain and suffering, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the person requesting service. “Course of treatment” may include mere observation or, where appropriate, no treatment at all.

2.65. “Mental Health Advance Directive” means written instructions such as, a living will or durable power of attorney, recognized under state law and relating to the provisions of health care if the individual is incapacitated.

2.66. “Mental Health Care Provider” (“MHCP”) means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field or A.A. level with two (2) years’ experience in the mental health or related fields.

2.67. “Mental Health Professional” means:

2.67.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in RCW 71.05 and 71.34 RCW;

2.67.2. A person who is licensed by the Department of Health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

2.67.3. A person with a master's degree or further advanced degree in counseling or one of the behavioral sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

2.67.4. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;

2.67.5. A person who had an approved waiver to perform the duties of a mental health profession prior to July 1, 2001; or

2.67.6. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the division of behavioral health and recovery.

2.68. “Mental Health Specialist means:

2.68.1. A "Child Mental Health Specialist" is defined as a mental health professional with the following education and experience:

2.68.1.1. A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

2.68.1.2. The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

2.68.2. A “Disability Mental Health Specialist” is defined as a mental health professional with special expertise in working with an identified disability group. Disabled, for purposes of this Agreement, means an Individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

2.68.2.1. If the Individual is deaf, the Specialist must be a mental health professional with:

2.68.2.1.1. Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

2.68.2.1.2. Ability to communicate fluently in the preferred language system of the Individual.

2.68.2.2. The specialist for Individuals with developmental disabilities must be a mental health professional who:

2.68.2.2.1. Has at least one (1) year’s experience working with people with developmental disabilities; or

2.68.2.2.2. Is a developmental disabilities professional as defined in RCW 71.05.020.

2.68.3. An "Ethnic Minority Mental Health Specialist" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one (1) year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

2.68.3.1. Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

2.68.3.2. A minimum of one hundred (100) actual hours (not quarters or semester hours) of specialized training devoted to ethnic minority issues and treatment.

2.68.4. A "Geriatric Mental Health Specialist" is defined as a mental health professional who has the following education and experience:

2.68.4.1. A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty (60) years of age or older; and

2.68.4.2. The equivalent of one (1) year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

2.68.5. An "Ethnic Minority Mental Health Specialist" is defined as a mental health professional who:

2.68.5.1. Has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving ethnic minority community attesting to the person 's commitment to that community; or

2.68.5.2. A minimum of one hundred actual hours (not quarters or semester hours) of specialized - training devoted to ethnic minority issues and treatment.

2.69. “Notice of Determination” means a written notice that must be provided to Individuals to inform them that services, available per the BHO’s policy and procedures, have not been authorized, and the reason for this determination. A Notice of Determination must contain the following:

2.69.1. The reason for denial or offering of alternative services.

2.69.2. A description of alternative services, if available.

2.69.3. The right to request a Fair Hearing.

2.70. “Opiate Substitution Treatment” (“OST”) means the provision of treatment services and medication management to individuals addicted to opiates.

2.71. “Patient Days of Care” includes all voluntary patients and involuntarily committed patients under RCW 71.05, regardless of where in the State Hospital they reside. Patients who are committed to the State Hospital under RCW 10.77 are not included in the Patient Days of Care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the Patient Days of Care until a petition for ninety (90) days of civil commitment under 71.05 RCW, has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the Patient Days of Care until the patient is civilly committed under RCW 71.05.

2.72. “Peer Counselor" means a person recognized by (DBHR) as a person who:

2.72.1. Is a self-identified consumer of mental health services.

2.72.2. Is a counselor registered under RCW 18.19.

2.72.3. Has completed specialized training provided by or contracted through DBHR. If the person was trained by trainers approved by the mental health division (now DBHR) before October 1, 2004, and has met the requirements of this section by January 31, 2005, the person is exempt from completing this specialized training.

2.72.4. Has successfully passed an examination administered by DBHR or an authorized contractor.

2.72.5. Has received a written notification letter from DBHR stating that DBHR recognizes the person as a "peer counselor".

2.73. "Post Stabilization Services" means covered services, related to an emergency medical condition that are provided after an Individual is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e) to improve or resolve the Individual's condition.

2.74. "Pregnant and Postpartum Women and Women with Dependent Children" ("PPW") means:

2.74.1. Women who are pregnant;

2.74.2. Women who are postpartum during the first year after pregnancy completion regardless of the outcome of the pregnancy or placement of children;

2.74.3. Women who are parenting children under the age of six (6), including those attempting to gain custody of children supervised by the Department of Social and Health Services, Division of Children and Family Services (DCFS).

2.75. "Prepaid Inpatient Health Plan" ("PIHP") for the purpose of this agreement, means an entity that:

2.75.1. Provides behavioral health services to Medicaid Enrollees, on the basis of prepaid capitation payments, or other payment arrangements that do not use Medicaid State Plan payment rates;

2.75.2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees.

2.76. "ProviderOne" means the State Medicaid Authority's Medicaid Management Information System.

2.77. "Published" means an officially sanctioned document provided by DSHS on DSHS internet or intranet websites for downloading, reading, or printing. The Contractor must be notified in writing or by e-mail when a document meets these criteria.

2.78. "Quality Assurance" means a focus on compliance to minimum requirements (e.g. rules, regulations, and Agreement terms) as well as reasonably expected levels of performance, quality, and practice.

2.79. “Quality Improvement” means a focus on activities to improve performance above minimum standards/reasonably expected levels of performance, quality, and practice.

2.80. “Quality Strategy” means a documented overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of a Behavioral Health Organization’s operations.

2.81. “Recovery” means the processes by which people are able to live, work, learn, and participate fully in their communities.

2.82. “Referring BHO” means the BHO in whose region the Individual being transferred resided and/or from whom they received services prior to state hospital admission.

2.83. “Regional Service Area" means the BHO-contracted geographic region.

2.84. “Regional Support Network” (“RSN”) means a county authority or group of county authorities or other entity previously recognized by the secretary to administer mental health services in a defined region through March 31, 2016.

2.85. “Request for Service” means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an Individual or his or her Authorized Representative. For purposes of this Agreement, an EPSDT referral is only a Request for Service when the Individual or the person authorized to consent to treatment for that Individual has confirmed that they are requesting service.

2.86. “Residential Mental Health Programs" means a complete range of residences and supports authorized by resource management services and that may involve a facility, a distinct part thereof, or services supporting community living, for persons who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the Behavioral Health Organization to be at risk of becoming acutely or chronically mentally ill. “Resilience” means the personal and community qualities that enable Individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

2.87. “Routine Services” means services that are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward behavioral health. These services do not meet the definition of urgent or emergent care.

2.88. “Rural Area” means areas with a population density of at least twenty (20) and less than five hundred (500) people per square mile. “Specialized Non-Medicaid Services” means, for purposes of the BHO Transfer Protocol, IMD admissions, residential placement, and state hospital census.

2.89. “State Minimum Standards" means minimum requirements established by rules (Washington Administrative Code) adopted by the secretary and necessary to implement the delivery of behavioral health services.

2.90. “Substance Use Disorder” (“SUD”) means a problematic pattern of alcohol/drug use leading to clinically significant impairment or distress as categorized in the DSM-5.

2.91. “Substance Use Disorder Treatment Agency” (“SUDTA”) means an Agency that is licensed and certified by the State of Washington to provide Substance Use Disorder Treatment Services and subcontracted to provide services covered under this Agreement.

2.92. “Tribal Authority” means, for the purposes of behavioral health organizations and RCW 71.24.300 only, the Federally Recognized Tribes and the major Indian organizations recognized by the secretary as long as these organizations do not have a financial relationship with any behavioral health organization that would present a conflict of interest.

2.93. “Tribal Behavioral Health Program” means a behavioral health program that is overseen by a Federally Recognized Tribe within Washington State, or overseen by a Recognized American Indian Organization within Washington State.

2.94. “Urban Area” means an area that has a population density of at least five hundred (500) people per square mile.

2.95. “Urgent Care” means a service to be provided to persons approaching a behavioral health crisis. If services are not received within twenty four (24) hours of the request, the person’s situation is likely to deteriorate to the point that emergent care is necessary.

2.96. “Washington Program of Assertive Community Treatment” (“WA-PACT”) is a team-based, evidence-based mental health service delivery model that incorporates the values of Recovery and Resiliency. PACT is also a client-centered, recovery-oriented mental health service delivery model that utilizes a multi-disciplinary team approach providing services to Individuals with severe and persistent mental illnesses and co-occurring disorders.

2.97. “Western Washington BHOs” includes BHOs contracted by DSHS to provide services in the following Washington counties: San Juan, Whatcom, Island, Skagit, Snohomish, Clallam, Jefferson, Kitsap, King, Pierce, Thurston, Mason, Grays Harbor, Lewis, Pacific, Wahkiakum, and Cowlitz.

2.98. “WISe” means Wraparound with Intensive Services, a program model that includes a range of service components that are individualized, intensive, coordinated, comprehensive and culturally competent and provided in the home and community. WISe is for children, youth, and young adults up to age twenty one (21) who are experiencing mental health symptoms to a degree that is causing severe disruptions in the youth’s behavior, interfering with their functioning in family, school or with peers that requires:

2.98.1. The involvement of the mental health system and other youth, young adults, and child-serving systems and supports;

2.98.2. Intensive care collaboration; and

2.98.3. Ongoing intervention to stabilize the child, youth, young adult, and family in order to prevent a more restrictive or institutional placement.

2.99. “Young Adult” means a person from age eighteen (18) through age twenty (20).

2.100. “Youth” means a person from age ten (10) through age seventeen (17).

3. SPECIAL TERMS AND CONDITIONS

3.1. **Administrative Review Activities**.

3.1.1. The Department of Social and Health Services, Office of the State Auditor or any of their duly-authorized representatives, may conduct announced and unannounced:

3.1.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement;

3.1.1.2. Reviews regarding the quality, appropriateness, and timeliness of behavioral health services provided under this Agreement;

3.1.1.3. Audits and inspections of financial records of the Contractor or subcontractor;

3.1.1.4. Audits and inspections of any books and records of the Contractor and of any subcontractor, that pertain to the ability of the entity to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the Agreement; and

3.1.1.5. On-site inspections of any and all contractor and subcontractor locations.

3.1.2. The Contractor must notify DSHS when an entity other than DSHS performs any audit or review described above related to any activity contained in this Agreement.

3.2. **Behavioral Health Advisory Board.** The Contractor must maintain an Advisory Board that is broadly representative of the demographic character of the region. Composition of the Advisory Board and the length of terms must be submitted to DSHS upon request and meet the criteria below:

3.2.1. Representative of the geographic and demographic mix of service population;

3.2.2. At least fifty one percent (51%) of the membership is persons with lived experience, family, and/or self identifies as a person in Recovery from a behavioral health disorder;

3.2.3. Law Enforcement representation;

3.2.4. County representation, when the BHO is not a County operated BHO;

3.2.5. No more than four (4) elected officials;

3.2.6. No employees, managers or other decision makers of subcontracted agencies who have the authority to make policy or fiscal decisions on behalf of the subcontractor;

3.2.7. Three (3) year term limit, multiple terms may be served, based on rules set by the Advisory Board.

3.3. **Compliance with Additional Laws**. At all times during the term of this Agreement, the Contractor must comply with all applicable federal, State, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations, and the following, whether or not a specific citation is identified in various sections of this Agreement:

3.3.1. All applicable Office of Insurance Commissioner's statutes and regulations;

3.3.2. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement;

3.3.3. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC §1857(h)), Section 508 of the Clean Water Act (33 USC §1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, Department of Health and Human Service (DHHS), and the EPA;

3.3.4. Any applicable mandatory standards and policies relating to energy efficiency which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act;

3.3.5. Those specified in Title 18 RCW for professional licensing;

3.3.6. Reporting of abuse as required by RCW 26.44.030;

3.3.7. Industrial insurance coverage as required by Title 51 RCW;

3.3.8. Any provision of this Agreement which conflicts with State and federal statutes, or regulations, or CMS policy guidance is hereby amended to conform to the provisions of State and federal law and regulations;

3.3.9. Law enforcement or court inquiries regarding firearm permits. The Contractor shall respond in a full and timely manner to law enforcement or court requests for information necessary to determine the eligibility of a person to possess a pistol or be issued a concealed pistol license under RCW 9.41.070 or to purchase a pistol under RCW 9.41.090.

3.4. **Confidentiality of Personal Information**

3.4.1. The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307, RCWs 70.02, 71.05, 71.34, and for Individuals receiving substance use disorder treatment services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded behavioral health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement. Such purposes include, but are not limited to:

3.4.1.1. Establishing eligibility;

3.4.1.2. Determining the amount of medical assistance;

3.4.1.3. Providing services for recipients;

3.4.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan;

3.4.1.5. Assuring compliance with Federal and State laws and regulations, and with terms and requirements of the Agreement;

3.4.1.6. Improving quality.

3.4.2. The Contractor must establish and implement procedures consistent with all confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA)(45 CFR Parts 160 and 164) for medical records and any other health and enrollment information that identifies a particular individual. The contractor must include this requirement in all subcontracts.

3.4.3. In the event an Individual's picture or personal story will be distributed outside the treating agency, the Contractor shall first obtain written consent from the Individual.

3.4.4. The Contractor shall prevent inappropriate access to confidential data and/or data systems used to hold confidential client information by taking, at a minimum, the following actions:

3.4.4.1. Verify the identity or authenticate all of the system's human users before allowing them access to any confidential data or data system capabilities;

3.4.4.2. Authorize all user access to client applications;

3.4.4.3. Protect application data from unauthorized use when not in use;

3.4.4.4. Keep any sensitive data or communications private from unauthorized individuals and programs;

3.4.4.5. Notify the appropriate DSHS point of contact within five (5) business days whenever an authorized user with access rights leaves employment or has a change of duties such that the user no longer requires access. If the removal of access is emergent, include that information with the notification;

3.4.4.6. In the event of a Breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from any DSHS data system, the Contractor shall comply with all requirements of the HIPAA Security and Privacy for Breach Notifications and as otherwise required by state or federal law.

3.4.5. DSHS reserves the right at any time to conduct audits of system access and use, and to investigate possible violations of this Agreement and/or violations of federal and state laws and regulations governing access to protected health information contained in DSHS data systems.

3.4.6. The Contractor understands that DSHS reserves the right to withdraw access to any of its confidential data systems at any time for any reason.

3.5. **Governing Body.** The Contractor shall establish a Governing Body responsible for oversight of the BHO. The Governing Body can be an existing executive or legislative body within a county government. Each member of the Governing Body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests. Members of the Governing Body must act within the best interests of the Contractor and the Individuals. The Contractor must maintain membership roster(s) and by-laws of the Governing Body demonstrating compliance. The Governing Body by-laws must include:

3.5.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident;

3.5.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present; and

3.5.3. A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest.

3.6. **Limited Liability Company Obligations**. If the Contractor is incorporated as a limited liability company under Chapter 25.15 RCW, the Contractor agrees that nothing shall limit the debts, obligations, and liabilities of Contractor's member county authorities to DSHS, including, but not limited to, the requirements of county authorities under Chapter 71.24 RCW and the requirements of this Agreement regarding use of funds, reserves and fund balances. The interlocal agreement to form a multi-county BHO must comply with RCW 71.24.100 and identify the treasurer of one participating county as the custodian of funds for the BHO and that the county treasurer is responsible to DSHS for all debts, obligations, and liabilities owed to DSHS upon termination of the contract or as a result of remedial action.

3.7. **Nondiscrimination.** The Contractor shall ensure that its provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

4. PAYMENT AND FISCAL MANAGEMENT

4.1. The Contractor must ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public behavioral health system.

4.2. Special programs, for non-Medicaid funded activities are delineated in *Exhibit F – Funding*. State funds will be paid based upon the categories of services contained in *Exhibit F*.

4.2.1. Involuntary Court Costs - Funding is provided as described in *Exhibit F – Funding* for the costs of Involuntary Court costs for 180-day commitment hearings that occur at the state psychiatric hospital.

4.2.2. Special Services to Eastern State Hospital, Spokane County Regional Behavioral Organization Only - The Contractor is provided funding as contained in *Exhibit F – Funding* to implement the following services to reduce the utilization and the census at Eastern State Hospital.

4.2.2.1. High intensity treatment team for Individuals who are high utilizers of psychiatric inpatient services, including those with co-occurring disorders and other special needs.

4.2.2.2. Crisis outreach and diversion services to stabilize in the community those individuals who are at risk of requiring inpatient care or jail services.

4.2.2.3. Behavioral health services provided in nursing facilities to individuals with dementia, and consultation to facility staff treating those individuals.

4.2.2.4. Services at a sixteen (16) bed evaluation and treatment facility.

4.2.2.4.1. The Contractor shall assess the effectiveness of the above services in reducing the utilization at Eastern State Hospital, identify services that are not optimally effective, and modify those services to improve their effectiveness. The Contractor shall submit a report by April 30, 2016.

4.2.3. Evaluation and Treatment (E&T) Services - Funds provided according to *Exhibit F – Funding* must be used solely to maintain services as it works to transition services to settings eligible for federal participation for Individuals covered under the Medicaid program.

4.2.4. Housing And Recovery Through Peer Services (HARPS) - Funds provided for HARPS will include an annual payment each fiscal year as listed *Exhibit F – Funding*, and two payments for housing subsidies each fiscal year as listed in *Exhibit F*. The HARPS program requirements are in *Exhibit J*.

4.2.4.1. Additional funds for housing subsidies will be based on performance and monthly reporting. Monthly reports are due by the 15th of the following month based on the schedule provided.

4.2.5. Juvenile Drug Courts - Funds provided for Juvenile Drug Courts are listed in *Exhibit F – Funding*.

4.2.6. ITA Court Cost Charge Rates. BHOs with courts within their service areas that provide ITA proceedings and charge BHOs for ITA Court Costs must submit local ITA Court Cost Chart Rates to DBHR for inclusion into *Exhibit I, ITA Court Cost Charge Rates*. Rate changes may be submitted only up to two (2) times per calendar year.

4.2.7. BHO-Specific Funding. 5480 funding, mental health enhancement funds, detention decision review funds, additional PACT funds, etc. are listed in *Exhibit F-1 BHO-Specific Funding*. (Note: This exhibit will be unique to each BHO and contain a brief statement of work for special proviso funded projects.)

4.3. If for any reason the Contractor does not agree to continue to provide services after July 31, 2018, the Contractor must provide the appropriate notice to DSHS under the requirements of the Termination Section of the "DSHS and BHO Agreement on General Terms and Conditions" between the parties.

4.4. If the Contractor elects to use ProviderOne for inpatient claim processing, DBHR, or its designee, will bill the Contractor on a monthly basis for claims paid on behalf of the BHO. The Contractor has thirty (30) calendar days from receipt of the inpatient claim bill to pay the costs assessed.

4.5. The Contractor shall provide DSHS Aging and Disabilities Services program funds equal to the general-fund state cost of Medicaid Personal Care Services used by the Contractor for Individuals who are determined to have personal care needs, as per the CARE assessment, and the need is due solely to a psychiatric disability when such payments have been authorized by the Contractor.

4.6. DBHR will withhold fifty percent (50%) of the final payment under this Agreement until all reports and data due during this Contract period of performance are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

4.7. Each payment will be reduced by the amount paid by DBHR on behalf of the Contractor for unpaid assessments, penalties, and other payments pending a dispute resolution process. If the dispute is still pending July 1, 2018, DBHR will withhold the amount in question from the final payment until the dispute is resolved.

4.8. State Hospital reimbursement and State Hospital related payments.

4.8.1. The Contractor shall pay a reimbursement for each State Hospital Patient Day of Care that exceeds the Contractor's daily allocation of State Hospital beds identified in *Exhibit D – ESH and WSH Bed Allocations* based on a quarterly calculation of the bed usage by the Contractor.

4.8.1.1. The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of the agreed-upon allocation in *Exhibit D*.

4.8.1.2. Any changes to the allocation shall require an amendment to the Agreement, and will become effective the 1st day of the quarter following the effective date of the amendment.

4.8.1.3. State Hospital reimbursement payments will be based only on the allocation of beds contained in *Exhibit D* and any subsequent Amendments.

4.8.2. The rate of payment for reimbursement for Eastern State Hospital is $691.00.

4.8.3. The rate of payment for reimbursement for Western State Hospital is $549.00.

4.8.4. DSHS will bill the Contractor quarterly for State Hospital Patient Days of Care exceeding the Contractor's daily allocation of State Hospital beds. DSHS will assess reimbursement amounts on the Contractor based on the quarterly net census overage. DSHS will process and send bills two months after the last day of each quarter the Contractor exceeds its allocation. (For example, the July through September Quarter of usage will be billed in December.) The Contractor has thirty (30) calendar days from receipt of the reimbursement bill to pay the assessed costs or receive payment based on the following methodology:

4.8.4.1. If at the end of a Quarter, the Contractor has utilized less than the Contractor's allocation of State Hospital beds and reimbursements have been collected from other BHOs, the Contractor shall receive a payment in accordance with the following methodology which will be calculated separately for the Western and Eastern BHOs:

4.8.4.1.1. Fifty percent (50%) of the reimbursements collected by DSHS from Eastern or Western BHOs for State Hospital Patient Days of Care exceeding their quarterly allocation of State Hospital beds will be distributed to those BHOs who used fewer Patient Days of Care than their quarterly allocation of State Hospital beds;

4.8.4.1.2. Each BHO using fewer Patient Days of Care than their quarterly allocation of State Hospital beds will receive a portion of the reimbursement collected proportional to its share of the total number of Patient Days of Care that were not used at the appropriate State Hospital;

4.8.4.1.3. Payment of funds will be made approximately five (5) months after the end of the applicable quarter. (For example, October services will be billed in January and reimbursed in March.)

4.9. If the Contractor terminates this Agreement for any reason or will not be entering into any subsequent Agreements, DSHS shall require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with DSHS. Funds will be deducted from the monthly payments until all reserves and fund balances are spent. Any funds not spent for the provision of services under this contract shall be returned to DBHR within sixty (60) calendar days of the last day this Agreement is in effect.

4.10. The Contractor is required to limit Administration costs to no more than ten percent (10%) of the annual revenue supporting the public behavioral health system operated by the Contractor. Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by the DSHS Behavioral Health Administration.

4.11. The Contractor must ensure the existence of Inpatient Reserves at the percentage specified in *Exhibit F – Funding* of the Contractor's annual payment. The Inpatient Reserves are funds set aside into an account by official action of the BHO governing body. Inpatient reserve funds may only be set aside for anticipated psychiatric inpatient costs.

4.12. The Contractor may have an Operating Reserve not to exceed the percentage specified in *Exhibit F – Funding* of the maximum consideration for this Agreement. The Operating Reserves are funds set aside into an account by official action of the BHO governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of behavioral health services.

4.12.1. Transition of Regional Support Network (RSN) reserves and financial obligations

4.12.1.1. The Contractor must have a DBHR-approved process to receive unspent reserves from a RSN.

4.12.1.2. These funds must be used for payment of the RSN's outstanding financial liabilities.

4.13. All funds received from a RSN and the expenditures of those funds must be documented and made available to DBHR on demand. Financial Reporting and Certification: Financial Reports and Certifications are due quarterly, according to the following schedule:

Quarterly R & E Due Dates	
Reporting Period:	**Due Date:**
April 2016 – June 2016	August 15, 2016
July 2016 – September 2016	November 15, 2016
October 2016 – December 2016	February 15, 2017

January 2017 – March 2017	May 15, 2017
April 2017 – June 2017	August 15, 2017

4.13.1. The Contractor shall submit and certify the single Revenue, Expenditure, Reserves and Fund Balance report in compliance with BHO Fiscal Program Requirements and "Fiscal/Program Requirements Supplementary Instructions – Behavioral Health Programs", administered by DSHS/Behavioral Health Administration, Budget & Finance Division. The report must include the following:

4.13.1.1. Indication that administrative costs, as defined in the "Behavioral Health Program Revenue and Expenditure (R&E) Report Instructions" incurred by the Contractor are no more than ten (10) percent of the annual revenue supporting the public behavioral health system operated by the Contractor. Administrative costs must be measured on a State fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by DSHS;

4.13.1.2. The amounts paid to Federally Qualified Health Centers for services;

4.13.1.3. Any revenue collected by Subcontractors for services provided under this Agreement. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for services provided under this Agreement are identified, pursued, and recorded by the Subcontractor, in accordance with Medicaid being the payer of last resort;

4.13.1.4. If the Contractor is unable to provide valid certifications or if DBHR finds discrepancies in the Revenue and Expenditure Report, DBHR may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment must occur within ninety (90) calendar days of the close of the State fiscal year or within ninety (90) calendar days of the DBHR's receipt of the certification, whichever is later;

4.13.1.5. DBHR reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. DBHR agrees to notify the Contractor of any anticipated changes prior to the implementation. The Contractor may review and comment on changes before they go into effect.

5. QUALITY OF CARE

5.1. **DBHR Review Activities.** The Contractor shall participate with DBHR in review activities. Participation will include at a minimum:

5.1.1. The submission of requested materials necessary for a DBHR-initiated review within thirty (30) calendar days of the request;

5.1.2. The completion of site visit protocols provided by DBHR;

5.1.3. Assistance in scheduling interviews and agency visits required for the completion of the review.

5.2. **Fraud and Abuse.** Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable Federal or State law. Abuse means provider actions that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. The Contractor shall do the following to guard against Fraud and Abuse:

5.2.1. Create and maintain a mandatory compliance plan that includes provisions to educate staff and providers of the False Claims Act (31 U.S.C. 3729-3733) and whistle blower protections;

5.2.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards;

5.2.3. Designate a compliance officer and a compliance committee that is accountable to senior management;

5.2.4. Provide effective ongoing training and education for the compliance officer, Contractor staff, and selected staff of the BHAs;

5.2.5. Facilitate effective communication between the compliance officer, the Contractor's employees, and the Contractor's network of BHAs;

5.2.6. Enforce standards through well-publicized disciplinary guidelines;

5.2.7. Conduct internal monitoring and auditing;

5.2.8. Respond promptly to detected offenses and develop corrective action initiatives;

5.2.9. Report fraud and/or abuse information to DBHR as soon as it is discovered including the source of the complaint, the involved BHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

5.3. **Quality Improvement.** The Contractor shall provide Quality Improvement feedback to BHAs, the Advisory Board, and other interested parties. The Contractor will maintain documentation of the activities and provide the documentation to DBHR upon request.

5.4. **Quality Review Activities**

5.4.1. The Department of Social and Health Services, Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:

5.4.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement;

5.4.1.2. Audits regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement;

5.4.1.3. Audits and inspections of financial records;

5.4.2. The Contractor shall notify DBHR when an entity other than DSHS performs any audit described above related to any activity contained in this Agreement.

5.5. **Quality Review Team**. The Contractor shall establish and maintain the independence of a quality review team as set forth in WAC 388-865-0282. The Quality Review Team shall include current Individuals served by the behavioral health system, past Individuals, or Family members. The Contractor shall assure that Quality Review Teams:

5.5.1. Fairly and independently review the performance of the BHO and service providers to evaluate systemic customer service issues as measured by objective indicators of Individual outcomes in rehabilitation, Recovery, and reintegration into the mainstream of social, employment and educational choices, including:

5.5.1.1. Quality of care;

5.5.1.2. The degree to which services are Individual-focused/directed and are age and Culturally Competent;

5.5.1.3. The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and

5.5.1.4. The adequacy of the BHO's cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.

5.5.2. Have the authority to enter and monitor any agency providing services under contract with a BHO, including state and community hospitals, freestanding E & T facilities, and BHAs;

5.5.3. Meet with interested Individuals and Family members, allied service providers, including state or community psychiatric hospitals, BHO-contracted service providers, and persons that represent the age and ethnic diversity of the BHO:

5.5.3.1. Determine if services are accessible and address the needs of Individuals based on sampled individual recipient's perception of services using a standard interview protocol that will be developed by DBHR. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs (acceptability), and the benefit of the service received; and

5.5.3.2. Work with interested Individuals, service providers, the BHO, and DSHS to resolve identified problems.

5.5.4. Provide reports and formalized recommendations upon request to the DBHR, the Behavioral Health Advisory Committee, and the BHO advisory and governing boards, and ensure that input from the quality review team is integrated into the overall BHO quality management process, Ombuds services, local Individual and family advocacy groups, and provider network;

5.5.5. Receive training and adhere to confidentiality standards; and

5.5.6. Are allowed to participate in External Quality Review Organization (EQRO) activities that are performed to evaluate the Prepaid Inpatient Health Plan (PIHP) contract, upon request of the EQRO.

6. UTILIZATION MANAGEMENT

6.1. All non-Core services are to be provided within available resources. The Contractor must have policies and procedures that determine how the availability of resources for these services is determined, including how decisions are made to authorize intake evaluations or deny provision of services due to insufficient resources.

6.2. **Level of Care Guidelines.** The Contractor and its subcontractors must establish written policies and procedures for authorization of Behavioral Health services, and maintain written utilization management criteria that include Level of Care Guidelines that reflect both the Access to Care Standards for Behavioral Health Organizations and the ASAM criteria.

6.3. The Contractor's Level of Care Guidelines must be provided to DSHS upon request. DSHS reserves the right to require changes to the Contractor's Level of Care Guidelines.

6.4. The Contractor must use these policies for making decisions about scope, duration, intensity and continuation of services. The Level of Care Guidelines must include:

6.4.1. Criteria for authorization of initial routine services including outpatient and residential treatment services. These services do not meet the definition of Urgent or Emergent Care;

6.4.2. The requirement for documentation of the presence of a covered Mental Health or Substance Use Disorder diagnosis based on DSM 5;

6.4.3. The ASAM criteria for initial authorizations, continuing stay, and discharge for SUD services;

6.4.3.1. ASAM levels of care for outpatient and residential services include the following:

Level 1 Outpatient Services;

Level 2.1 Intensive Outpatient Services;

Level 3.1 Clinically Managed, Low Intensity Residential Services;

Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential Services. (This level of care not designated for adolescent populations);

Level 3.5 Clinically Managed, Medium Intensity Residential Services.

6.4.3.2. ASAM levels of care for Withdrawal Management (Detoxification Services) include the following:

Level 1 WM Ambulatory withdrawal management without extended onsite monitoring;

Level 2 WM Ambulatory withdrawal management with extended onsite monitoring;

Level 3.2 WM Clinically managed Residential Withdrawal Management;

Level 3.7 WM Medically monitored inpatient withdrawal management.

6.4.4. Access to Care Standards for BHOs for mental health services.

6.4.5. Criteria for Authorization of Routine and Inpatient care at a community psychiatric hospital.

6.4.6. Individuals cannot be required to relinquish custody of minor children in order to access residential SUD treatment services.

6.4.7. Continuing stay and discharge criteria for Routine and Inpatient Care. Mental Health - Access to Care Standards for BHOs may not be used as continuing stay and discharge criteria from Routine mental health services and psychiatric inpatient services.

6.4.8. The requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a Chemical Dependency Professional or Mental Health Professional with the appropriate clinical expertise.

6.5. **Appointment Standards**. The Contractor must comply with appointment standards that are consistent with the following:

6.5.1. The Contractor must make available crisis mental health services on a

twenty-four (24) hour, seven (7) day per week basis that may be accessed without full completion of intake evaluations and/or other screening and assessment processes;

6.5.1.1. Emergent mental health care must occur with two (2) hours of a request for mental health services from any source;

6.5.1.2. Urgent care must occur within twenty-four (24) hours of a request for mental health services from any source.

6.5.2. A routine behavioral health intake evaluation or assessment appointment must be available and offered to every Enrollee within fourteen (14) calendar days of the request, with a possible extension of up to an additional fourteen (14) calendar days, unless both of the following conditions are met:

6.5.2.1. An intake evaluation or assessment has been provided in the previous twelve (12) months that establishes medical necessity; and

6.5.2.2. The Contractor agrees to use the previous intake evaluation or assessment as the basis for authorization decisions.

6.5.3. The time period from request for behavioral health services to the first Routine Service appointment offered must not exceed twenty-eight (28) calendar days;

6.5.4. The Contractor must document the reason for any delays. This includes documentation when the Individual declines an intake appointment within the first ten (10) business days following a request or declines a Routine appointment offered within the twenty-eight (28) calendar day timeframe;

6.5.5. The Contractor must monitor the frequency of Routine appointments that occur after twenty-eight (28) calendar days for patterns and apply corrective action where needed.

6.6. **Authorization for Mental Health Services.** The Individual must be determined to have a mental health diagnosis (as defined in the current Diagnostic and Statistical Manual of Mental Illness) covered by the Access to Care Standards for public mental health services. The Individual's impairment(s) and corresponding need(s) must be the result of a mental health diagnosis. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental health diagnosis. The Individual is expected to benefit from the intervention. The Individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

6.7. **Criteria for SUD services authorization.** The Individual must be determined to have a substance use disorder diagnosis as defined in the current Diagnostic and Statistical Manual of Mental Illness covered by Washington State for public SUD services. The Individual's impairment(s) and corresponding need(s) must be the result of a SUD diagnosis. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the

presence of a SUD diagnosis. The Individual is expected to benefit from the intervention. The Individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

6.7.1. The following priority groups may be provided substance use disorder treatment Services within Available Resource for Individuals who:

6.7.1.1. Have an income level no more that 220% of the federal poverty level;

6.7.1.2. Are not Medicaid eligible;

6.7.1.3. Are uninsured;

6.7.1.4. Have insurance but are unable to meet the co-pay or deductible for the services.

6.8. **Authorization for Routine Mental Health and Substance Use Disorder Services**. The Contractor must make a determination of eligibility for an initial authorization of Routine services based on Medical Necessity.

6.8.1. Medical Necessity for Mental Health Services is based on the presence of a covered DSM 5 mental health diagnosis and application of the Mental Health Access to Care Standards for BHOs following the initiation of the intake evaluation.

6.8.2. Medical Necessity for Substance Use Disorder Treatment Services is based on the presence of a DSM 5 substance related diagnosis and application of the ASAM criteria following an Assessment.

6.8.3. Authorization and provision of services may begin once medical necessity has been established through process of beginning an intake evaluation for mental health services or completing an assessment for SUD services.

6.8.4. Notice of the authorization decision must be provided as expeditiously as the individual's health condition requires and no later than fourteen (14) calendar days after the request for authorization.

6.8.5. An extension of up to fourteen (14) additional calendar days to make the authorization decision is possible upon request by the Enrollee or the BHA or the Contractor justifies (to DSHS upon request) a need for additional information and how the extension is in the Enrollee's interest.

6.8.6. The Contractor and its subcontractors must have written policies and procedures to ensure consistent application of extensions within the service area.

6.8.7. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.

6.8.8. Authorization decisions must be expedited to no longer than three (3) business days after receipt of the request for services if either of the

following is true:

6.8.8.1. The Enrollee's presenting behavioral health condition affects their ability to maintain or regain maximum functioning;

6.8.8.2. The Enrollee presents a potential risk of harm to self of others.

6.8.9. The Contractor must designate at least one (1) Children's Care Manager that is a Children's Mental Health Specialist or is supervised by a Children's Mental Health Specialist who oversees the authorizations of Enrollees under the age of twenty-one (21) years old.

6.8.10. The Contractor must have at least one (1) Care Manager who is a licensed Chemical Dependency Professional.

6.8.11. The Contractor or formal designee must review requests for additional services to determine a re-authorization following the exhaustion of previously authorized services by the Enrollee. This must include:

6.8.11.1. An evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods or intensity of services being provided;

6.8.11.2. A method for determining if an Enrollee has met discharge criteria.

6.9. **Transition of payment for SUD Services.**

6.9.1. As of April 1, 2016, the Contractor will be responsible for payment for all services for Individuals in a course of treatment that was started under a fee for service arrangement with any DSHS-contracted provider for SUD services that are now covered by this Agreement. Beginning on April 1, 2016, the Contractor must:

6.9.1.1. Develop a safe, medically appropriate transition plan, considering the health and safety of the transitioning Individual;

6.9.1.2. Authorize and become responsible for continuing services for Individuals in a course of treatment that began prior to April 1, 2016, for up to sixty (60) calendar days after the implementation date, or until one of the following occurs based on the ASAM criteria:

6.9.1.2.1. The course of treatment is complete; or

6.9.1.2.2. The Contractor evaluates the Individual and determines that services are no longer necessary; or

6.9.1.2.3. The Contractor determines that a different course of treatment is indicated.

6.9.1.3. Authorize and become responsible for SUD Involuntary Treatment services to continue in accordance with RCW 70.96A.140 using ASAM Criteria to determine length of stay;

6.9.1.4. The Contractor must ensure that all services are delivered under a subcontract that meets all contractual requirements of this Agreement, including but not limited to Subcontractor, HIPAA, Confidentiality, and Data Security Requirements.

6.10. **Authorization for payment of Psychiatric Inpatient Services.** The Contractor must have appropriate clinical staff members available twenty-four (24) hours per day, seven (7) days per week to respond to requests for certification of psychiatric inpatient care in community hospitals. The Contractor must adhere to the requirements set forth in the Washington Apple Health Inpatient Hospital Services Provider Guide. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the Individual's health condition requires, no later than three business days following the receipt of the authorization request. Extensions of up to 14 calendar days are permitted if the Individual or provider requests an extension, or if the Contractor justifies a need for additional information and the delay is in the Individual's best interest.

6.10.1. Only a psychiatrist or doctoral-level clinical psychologist may deny a request for payment of psychiatric inpatient care.

6.10.2. If the Contractor denies payment of any portion of a psychiatric inpatient stay and the inpatient facility has a dispute, the Contractor must follow the dispute process provided in the Washington Apple Health Inpatient Hospital Services Provider Guide, see "Clinical Appeals" and "Administrative Disputes".

6.10.3. In the event that a community hospital becomes insolvent, the Contractor must continue authorized community psychiatric inpatient services for the remainder of the period for which payment has been made, as well as for inpatient admissions up until discharge.

6.11. **Authorization for Withdrawal Management Services.**

6.11.1. Initial Admissions are determined based on medical necessity and appropriateness of placement by the admitting provider. Initial authorizations have the following limitations:

6.11.1.1. Alcohol detoxification is limited to three days; and

6.11.1.2. Drug detoxification is limited to five days.

6.11.2. The Contractor must have qualified clinical staff members to respond to requests for any additional days and make referrals as necessary for continuity of care.

6.11.3. Services are to be delivered in settings that meet the requirements of WAC 388-877B for Individuals who have met the screening criteria.

6.12. **Utilization Management Plan.** The Utilization Management Plan may not be structured to encourage individuals or entities to deny, limit, or discontinue medically necessary services.

6.12.1. The Contractor must have a medical director (consultant or staff) who is qualified to provide leadership and guidance in oversight, utilization management and quality assurance planning for the behavioral health programs. These following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the medical director to oversee. Utilization reviews must address the following components:

6.12.1.1. Services requested in comparison to services identified as medically necessary;

6.12.1.2. A review of youth receiving medication without accompanying behavioral or therapeutic intervention;

6.12.1.3. Level of Care authorized for treatment based on ASAM placement criteria, mental health level access to care standards and the BHO level of care guidelines in comparison to services treatment services offered and delivered;

6.12.1.4. A review of trends and patterns identified in the Individual Service Plan which have been met, have been discontinued, or have continued need;

6.12.1.5. Patterns of denials;

6.12.1.6. Use of Evidence-Based Practices and other identified practice guidelines;

6.12.1.7. Use of discharge planning guidelines;

6.12.1.8. Community standards governing activities such as coordination of care among treating professionals;

6.12.1.9. Coordination with Federally Recognized Tribes and Recognized American Indian Organizations (RAIOs).

6.12.2. The Contractor must establish criteria for documenting and monitoring:

6.12.2.1. Consistent application of Medical Necessity criteria and Level of Care Guidelines including the use of Access to Care Standards for BHOs and ASAM Criteria;

6.12.2.2. Consistent application of criteria for authorization decisions for continuing stay and discharge;

6.12.2.3. Appropriate inclusion of providers in utilization decisions; and

6.12.2.4. Over and under-utilization of services.

6.13. **Medicaid Funded Personal Care and Related Services**: DSHS Aging and Long Term Support Administration (ALTSA), Home and Community Services (HCS) Division uses the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine personal care needs.

6.13.1. Personal care and related services authorized by HCS must not duplicate services the Contractor is required to provide.

6.13.2. Requests for information.

6.13.2.1. The Contractor or its designee must respond to requests from HCS within five (5) business days of the request.

6.13.2.2. The Contractor and the local HCS office may mutually agree in writing to extend the five (5) business day requirement.

6.13.2.3. The Contractor must have an agreement with HCS or its designee that allow it to share this information without a signed release of information from the Individual.

6.13.3. Authorization decisions must be based on the following:

6.13.3.1. A review of the request to determine if the Individual is currently authorized to receive Behavioral Health services in the Contractor's Service Area;

6.13.3.2. A verification of the need for personal care and related services is based solely on a psychiatric disability;

6.13.3.3. A review of the requested services to determine if the Individual's personal care and related services or other needs could be met through the provision of other available behavioral health services;

6.13.3.4. Services may include personal care, relief care, cluster care, nurse delegation, training required by an individual provider to continue providing personal care, or client responsibility reimbursement.

6.13.4. Authorization denials:

6.13.4.1. If the Contractor denies authorization for personal care or related services, and the Individual's diagnosis is psychiatric, a written response must be provided to HCS or its designee and must include the reason for the determination and alternative services authorized that will be used to meet the personal care needs identified in the CARE assessment;

6.13.4.2. When the Contractor denies authorization based on provision of other services, a plan (e.g. Individual Service Plan) must be developed by

the Contractor and implemented to meet the service needs identified in the CARE assessment.

6.13.5. Reporting.

6.13.5.1. The Contractor must provide the following documentation to DBHR, HCS, or its designee on request:

6.13.5.1.1. The original referral from HCS or its designee and request for authorization;

6.13.5.1.2. Any information provided by HCS or its designee including the CARE assessment;

6.13.5.1.3. A copy of the Contractor's determination and written response provided to HCS or its designee;

6.13.5.1.4. A copy of the plan developed and implemented to meet the Individual's needs through provision of other services when the personal care or other related services request has been denied based on the Contractor's determination.

7. GRIEVANCE SYSTEM

7.1. The Contractor must have a Grievance System that complies with the requirements of WAC 388-877A-0420, 0440, 0450, and 388-877-0605.

7.1.1. The Contractor must have policies and procedures addressing the grievance system, which comply with the requirements of this Agreement. These must be provided to DSHS within sixty (60) calendar days of this Agreement's Start Date. DSHS will approve, in writing, all Grievance System policies and procedures and related Notices to Individuals regarding the Grievance System.

7.1.2. An Individual applying for, eligible for, or receiving behavioral health services authorized by a BHO, the Individual's representative, or the Individual's legal guardian may access the BHO's Grievance System to express concern about their rights, services, or treatment. The Grievance System must include:

7.1.2.1. A Grievance Process;

7.1.2.2. Access to a Fair Hearing.

7.1.3. Before requesting a Fair Hearing, the Individual must exhaust the Grievance Process, subject to the rules in WAC 388-877A-0420.

7.1.4. Individuals may also use the free and confidential Ombuds services (see WAC 388-865-0250) through the BHO that contracts with the BHA at which they receive behavioral health services. Ombuds services are provided independent of BHOs and agency service providers, and are offered to

Individuals at any time to help them with resolving issues or problems at the lowest possible level during the Grievance or Fair Hearing process.

7.2. **Grievance Process.** The Contractor must ensure its Grievance Process complies with the following:

7.2.1. The Grievance Process may be used by an Individual or his or her representative to express dissatisfaction in person, orally, or in writing about any matter regarding non-Medicaid services, including: the BHA providing the behavioral health services; or the Contractor;

7.2.2. The Ombuds serving the Contractor or BHA may assist the Individual in resolving the Grievance at the lowest possible level;

7.2.3. An Individual may choose to file a Grievance with the Contractor or with the BHA, subject to the following:

7.2.3.1. Filing a Grievance with a BHA. If the Individual first files a Grievance with the BHA, and the Individual is not satisfied with the BHA's written decision on the Grievance, or if the Individual does not receive a copy of that decision from the BHA within the timelines established herein, the Individual may then choose to file the Grievance with the Contractor. If the Individual is not satisfied with the Contractor's written decision on the Grievance, or if the Individual does not receive a copy of the decision from the Contractor within the timelines established herein, the Individual can request a Fair Hearing to have the Grievance reviewed and the Contractor's decision or failure to make a timely decision about it;

7.2.3.2. Filing a Grievance with the Contractor. If the Individual first files a Grievance with the Contractor (and not the BHA), and the Individual either is not satisfied with the Contractor's written decision on the Grievance, or does not receive a copy of the decision within the timelines established herein, the Individual can request a Fair Hearing to have the Grievance reviewed and the Contractor's decision or failure to make a timely decision about it. Once an Individual receives a decision on a Grievance from a Contractor, the Individual cannot file the same Grievance with the BHA, even if that agency or its staff member(s) is the subject of the Grievance.

7.2.4. When an Individual files a Grievance, the Contractor or BHA receiving the Grievance must:

7.2.4.1. Acknowledge the receipt of the Grievance in writing within five (5) business days;

7.2.4.2. Investigate the Grievance; and

7.2.4.3. Send the Individual who filed the Grievance written notification describing the decision within ninety (90) calendar days from the date the Grievance was filed.

7.2.5. The Contractor or BHA receiving the Grievance must ensure the following:

7.2.5.1. That other people, if the Individual chooses, are allowed to participate in the Grievance process;

7.2.5.2. The Individual's right to have currently authorized behavioral health services continued pending resolution of the Grievance;

7.2.5.3. That a Grievance is resolved even if the Individual is no longer receiving behavioral health services;

7.2.5.4. That the persons who make decisions on a Grievance:

7.2.5.4.1. Were not involved in any previous level of review or decision-making; and

7.2.5.4.2. Are MHPs or CDPs who have appropriate clinical expertise if the Grievance involves clinical issues.

7.2.5.5. That the Individual and, if applicable, the Individual's representative receive written notification containing the decision within ninety (90) calendar days from the date a Grievance is received by the Contractor or BHA. This timeframe can be extended up to an additional fourteen (14) calendar days:

7.2.5.5.1. If requested by the Individual or the Individual's representative; or

7.2.5.5.2. By the Contractor or BHA when additional information is needed and the Contractor can demonstrate that it needs additional information and that the added time is in the Individual's interest.

7.2.5.6. That written notification includes:

7.2.5.6.1. The decision on the Grievance;

7.2.5.6.2. The reason for the decision; and

7.2.5.6.3. The right to request a Fair Hearing and the required timeframe to request the hearing.

7.2.6. That full records of all Grievances and materials received or compiled in the course of processing and attempting to resolve the Grievance are maintained and:

7.2.6.1. Kept for six (6) years after the completion of the Grievance process;

7.2.6.2. Made available to DSHS upon request as part of the state Quality Strategy;

7.2.6.3. Kept in confidential files separate from the Individual's clinical record; and

7.2.6.4. Not disclosed without the Individual's written permission, except to DSHS or as necessary to resolve the Grievance.

7.3. **Continuation of Services**.

7.3.1. During the Grievance Process, the Contractor must continue the Individual's authorized services if all of the following conditions are met:

7.3.1.1. Resources are available for the services, as determined by the Contractor's policies for determination of available resources;

7.3.1.2. The Grievance involves the termination, suspension, or reduction of a previously authorized course of treatment;

7.3.1.3. The services were provided by an authorized BHA;

7.3.1.4. The Individual requests a continuation of services;

7.3.1.5. The Individual is currently receiving services at the time of the request.

7.4. **Recordkeeping and Reporting Requirements.**

7.4.1. The Contractor must maintain records of Grievances and Fair Hearings originating at or handled by a BHA, Ombuds or Contractor.

7.4.2. The Contractor must incorporate the results of Grievances and Fair Hearings and address any trends in its quality improvement plan.

7.4.3. The Contractor must submit Individual-level quarterly grievance reports for children/youth referred to WISe in a format required by DSHS that contains at least the following:

7.4.3.1. Individual's full name;

7.4.3.2. Date of birth;

7.4.3.3. P1 or the Behavioral Health Data Store identifier; and

7.4.3.4. Date and type of Grievance (per WAC 388-877A-0410).

7.4.4. The Contractor must submit quarterly aggregate reports for all non-WISe referral Grievances in a format provided by DSHS and accompanied by a brief report identifying trends and plans for improvement.

7.4.5. Quarterly Grievance reports are due as follows:

Quarterly Grievance Report Schedule	
Period Covered	**Due Date**

April 1 – June 30, 2016	July 30, 2016
July 1 – September 30, 2016	October 31, 2016
October 1 – December 31, 2016	January 31, 2017
January 1 – March 31, 2017	April 30, 2017
April 1 – June 30, 2017	July 30, 2017

7.4.6. Reports that do not meet the Grievance System reporting requirements will be returned to the Contractor for correction. Corrected reports must be resubmitted to DSHS within thirty (30) calendar days.

8. SUBCONTRACTS.

8.1. All Subcontracts and amendments must be in writing and made available, in the requested format, upon request to DBHR. Subcontracts must specify all duties, responsibilities and reports delegated under this Agreement and require adherence with all federal and state laws that are applicable to the Subcontractor.

8.2. **Delegation.** A Subcontract does not terminate the legal responsibility of the Contractor to perform the terms of this Agreement. The Contractor must monitor functions and responsibilities performed by, or delegated to, a Subcontractor on an ongoing basis.

8.2.1. The responsibilities of the Quality of Care section of this Agreement may not be delegated to a contracted network BHA.

8.2.2. The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit a BHO-contracted, licensed provider from subcontracting with other appropriately licensed provider(s) so long as the sub-contracting provision of this Agreement are met.

8.2.3. Prior to any new delegation of any responsibility or authority described in the Care Management, Authorization Standards and Quality of Care sections of this Agreement through a Subcontract or other legal Agreement, the Contractor must use a delegation plan.

8.2.4. The Contractor must only contract with DSHS licensed service providers for the provision of direct services per RCW 71.24.045 and WAC 388-865-0284. Unless a county is a licensed service provider and the Contractor is contracting for direct services, the Contractor must not provide BHO funds to a county that is a participant in the BHO Agreement without a delegation of duties agreement. The agreement must identify the specific duties from the Contractor's BHO Program Agreement – Prepaid Inpatient Health Plan (PIHP) or this BHO Program Agreement – Behavioral Health State Contract (BHSC) that are being delegated. The requirements for delegation stated within this Agreement must be met.

8.2.5. The Contractor must maintain and make available to DSHS all delegation plans with current Subcontractors. The delegation plans must include the following:

8.2.5.1. An evaluation of the prospective Subcontractor's ability to perform delegated activities;

8.2.5.2. A detailed description of the proposed subcontracting arrangements, including:

8.2.5.2.1. Name, address, and telephone number of the Subcontractor(s);

8.2.5.2.2. Specific contracted services;

8.2.5.2.3. Compensation arrangement; and

8.2.5.2.4. Monitoring plan.

8.2.5.3. The required Subcontract language that specifies the activities and responsibilities delegated and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is not adequate.

8.2.6. Within thirty (30) calendar days of execution of this Agreement, the Contractor must submit a list of subcontractors and their delegated services in a format approved by DBHR.

8.3. **Required Provisions.** Subcontracts must require Subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activities performed under this Agreement.

8.3.1. All Subcontracts must be in writing and specify all duties, responsibilities and reports delegated under this Agreement and require adherence with all federal and state laws that are applicable to the Subcontractor.

8.3.2. Subcontracts must require adherence to any applicable terms in the Americans with Disabilities Act.

8.3.3. Subcontracts for the provision of mental health services must require compliance and implementation of the Mental Health Advance Directive statutes.

8.3.4. Subcontracts must require Subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel, and records.

8.3.5. For Subcontractors providing WISe, the Subcontractor must adhere to the most current version of the WISe Manual and participate in all WISe-related quality activities.

8.3.6. Subcontracts for the provision of behavioral health services must require Subcontractors to provide Individuals access to translated information and

interpreter services as described in the Information Requirements section of this Agreement.

8.3.7. Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.

8.3.8. Subcontracts must require Subcontractors to participate in training when requested by DBHR. Requests for DBHR to allow an exception to participation in required training must be in writing and include a plan for how the required information is provided to targeted Subcontracted staff.

8.3.8.1. Annually, all community behavioral health employees who work directly with Individuals must be provided with training on safety and violence prevention topics described in RCW 49.19.030.

8.3.9. Subcontracts must require compliance with Washington State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and the DSHS Behavioral Health Data Store Data Dictionary.

8.3.10. Subcontracts must define a clear process to be used to revoke delegation, impose corrective action, or take other remedial actions if the Subcontractor fails to comply with the terms of the Subcontract.

8.3.11. Subcontracts must require that the Subcontractor correct any areas of deficiencies in the Subcontractor's performance that are identified by the Contractor or DBHR as part of a Subcontractor review.

8.3.12. Subcontracts for the provision of behavioral health services must require best efforts to provide written or oral notification no later than fifteen (15) business days after termination of a clinician to Individuals currently open for services who have received a service from the affected clinician in the previous sixty (60) calendar days. Notification must be verifiable in the Individual medical record at the BHA.

8.3.13. Subcontracts must require that the subcontracted BHAs comply with the Contractor's policy and procedures and timeframes as described in the Services section of this Agreement.

8.3.14. Subcontracts for the provision of behavioral health services must require that the Subcontractor implement a Grievance Process that complies with the Grievance Section of this Agreement.

8.3.15. The BHO must provide information about the Grievance System to all BHAs and Subcontractors at the time they enter into a contract.

8.3.15.1. A condition of the Subcontract will be that all BHAs and other Subcontractors will abide by all Grievance and Fair Hearing decisions.

8.3.16. Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Agreement.

8.3.17. GAIN-SS.

8.3.17.1. Subcontracts for the provision of behavioral health services must require the use of the GAIN-SS and assessment process that includes use of the quadrant placement. In addition, the Subcontract must contain terms requiring corrective action if the Integrated Co-Occurring Disorder Screening and Assessment process is not implemented and maintained throughout the Contract period of performance.

8.3.17.2. If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, this information must be considered in the development of the treatment plan including appropriate referrals.

8.3.17.3. Documentation of the quadrant placement is required during the Assessment/Admission process and again upon discharge is input into the Behavioral Health Data Store.

8.3.18. Subcontracts for the provision of behavioral health services must require Subcontractors to re-submit data when rejected by DBHR due to errors. The Subcontract must require the data to be re-submitted within thirty (30) calendar days of when the error report was produced.

8.3.19. Subcontracts for the provision of mental health services must require that the Subcontractor must respond in a full and timely manner to law enforcement inquiries regarding an Individual's eligibility to possess a firearm under RCW 9.41.040(2)(a)(ii).

8.3.20. Subcontracts must require that potential Medicaid Enrollees are offered assistance with accessing enrollment into health plans if the potential Enrollee is uninsured at the time they present for services.

8.4. **Subcontractor Reviews.** The Contractor must conduct periodic reviews of its Subcontractors. The Contractor must review each Subcontractor at least once per contract period, and must initiate corrective action when necessary. All collected data including monitoring results, agency audits, sub-contract monitoring activities, Individual Grievances and service verification must be incorporated into this review. This review must be included in the Contractor's ongoing quality management program.

8.4.1. The Contractor must ensure that periodic Subcontractor reviews do not duplicate monitoring conducted by DBHR's contracted External Quality Review Organization, or DSHS.

8.4.2. This review may be combined with a formal review of services performed pursuant to the Prepaid Inpatient Health Plan Agreement between the Contractor and DSHS.

8.4.3. The periodic review must be based on the specific delegation agreement with each Subcontractor, and must at least address the following:

8.4.3.1. Traceability of Services – The Contractor must ensure that medical necessity is established and documented, and that the Access to Care Standards for BHOs have been met and the American Society of Addiction Medicine (ASAM) Criteria have been applied appropriately. Once medical necessity has been established and documented, the Contractor must monitor client records to ensure that authorized services are appropriate for the diagnosis that the treatment plan reflects the identified needs, and that progress notes support the use of each authorized State Plan service. The Contractor must also monitor Individual records to ensure an appropriate 180-day review is conducted to update the service plan, diagnostic information and provide justification for level of continued treatment;

8.4.3.2. Timeliness of Services – The Contractor must ensure that Individuals receive services in a timely manner. The Contractor must monitor and, if necessary, measure the timeliness of services rendered to Individuals according to the following guidelines:

8.4.3.2.1. Emergent Mental Health Services = two (2) hours from request;

8.4.3.2.2. Urgent Mental Health Services = twenty-four (24) hours from request;

8.4.3.2.3. Initial Psychiatric Inpatient Certification = twelve (12) hours from request;

8.4.3.2.4. Crisis and Telephone Service = 24/7/365 availability. Phones answered by live person;

8.4.3.2.5. Post-discharge services = Individuals need to receive an outpatient mental health service within seven (7) calendar days of discharge from a psychiatric inpatient or residential substance use disorder treatment stay;

8.4.3.2.6. Routine Intake Evaluation or Assessment for Behavioral Health services = fourteen (14) calendar days from Request;

8.4.3.2.7. First Routine Service = twenty-eight (28) calendar days from request;

8.4.3.2.8. If behavioral health services are not rendered within these guidelines, the Contractor should monitor the reason and appropriateness of the delay as documented in the clinical record. This can include documentation that there were no appropriate Available Resources as allowed under this Agreement or that the Individual did not meet the definition of a priority group for substance use disorder treatment as defined in this Agreement.

8.4.4. Special Populations – The Contractor must ensure that Individuals who

self-identify as having specialized cultural, ethnic, linguistic, disability, or age related needs have those needs addressed.

8.4.5. Coordination of Primary Care – The Contractor must ensure that Individuals with complex medical needs and who have no assigned primary care provider (PCP) are assisted in obtaining a PCP. For Individuals who already have a PCP, the Contractor must coordinate care as needed. The Contractor must also ensure that coordination for those with complex medical needs is tracked through the treatment plan and progress notes.

8.4.6. Grievances –the Contractor must ensure that network providers have a process in place for reporting, tracking, and resolving customer expressions of dissatisfaction (i.e., Grievances). The Contractor must monitor and report Grievances documented at the provider level, as well as those documented in the Ombuds records. The Contractor must also monitor the frequency and type of Individual Grievances to ensure that systematic issues are appropriately addressed.

8.4.7. Critical Incidents – The Contractor must ensure that network providers follow requirements for reporting to the Contractor and managing critical incidents. The Contractor must track and monitor the incidents that occur within its provider network, and determine if the incidents are responded to in an appropriate and timely manner. If a pattern that suggests a systemic issue is identified, the Contractor must monitor the provider’s actions toward resolving the issue.

8.4.8. Information Security – The Contractor must ensure that network providers and other contractors actively follow federal regulations for managing personal health information (HIPAA / HI-TECH), and appropriately report any violations.

8.4.9. Disaster Recovery Plans – The Contractor must ensure that Individual service and electronic data can be recovered following a natural disaster or computer systems failure. The Contractor must monitor each provider’s Disaster Recovery and Business Continuity Plan to ensure that they are periodically tested and updated. The Contractor must also monitor each provider’s natural disaster plan to ensure continuation of services and consistency in care to Individuals.

8.4.10. Fiscal Management – the Contractor must monitor and document the provider’s cost allocations, revenues, expenditures and reserves in order to ensure that funds under this Contract are being spent appropriately under WAC 388-865-0270.

8.4.11. Licensing and Certification Issues – The Contractor must have the responsibility for the oversight of their providers, including but not limited to ensuring licenses and certifications are current and that any findings during any review are corrected.

8.5. **Changes in Provider Network.** A significant change in the provider network is defined as the termination or addition of a Subcontract with an entity that provides

behavioral health services or the closing of a Subcontractor site that is providing services under this Agreement. The Contractor must notify DSHS and impacted Individuals sixty (60) calendar days prior to the end date of any of its Subcontracts with entities that provide direct services or entering into new Subcontracts with entities that provide direct service. This notification must occur prior to any public announcement of this change.

8.5.1. If either the Contractor or the Subcontractor terminates a Subcontract in less than sixty (60) calendar days or a site closure occurs in less than sixty (60) calendar days, the Contractor must notify DSHS as soon possible and prior to a public announcement.

8.5.2. If DSHS issues a stop placement of Individuals in a subcontracted treatment facility upon finding that a facility is not in substantial compliance with provisions of any WAC related to substance use disorder treatment, the Contractor must work with the subcontracted Contractor to transition care of any impacted Individuals.

8.5.3. The Contractor must notify DSHS, in writing, of any other changes in capacity that results in the Contractor being unable to meet any of the time and distance standards as required in this Agreement. Events that affect capacity include: decrease in the number or frequency of a required service; employee strike or other work stoppage related to union activities; or any changes that result in the Contractor being unable to provide timely, Medically Necessary services.

8.5.4. If any of the events described in this section occur, the Contractor must submit a plan to DSHS Contact on Page One of this Agreement, in writing, that includes at least:

8.5.4.1. Notification to Ombuds services;

8.5.4.2. Crisis services plan;

8.5.4.3. Client notification plan;

8.5.4.4. Plan for provision of uninterrupted services;

8.5.4.5. Plan for retention and/or transfer of clinical records;

8.5.4.6. Any information released to the media.

8.6. **Credentialing**

8.6.1. The Contractor must use only BHAs that are licensed and/or certified by DSHS.

8.6.2. The Contractor must have written policies that require monitoring of provider credentials, including maintenance of their Washington State issued license or certification and any findings or concerns about the

agency or any of its employees that is identified by either DSHS or the Washington State Department of Health.

8.6.3. The Contractor must require criminal history background checks for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults.

8.7. **Data Verification**

8.7.1. The Contractor must maintain and either provide to Subcontractors, or require Subcontractors to also maintain, a health information system that complies with the requirements of 42 CFR §438.242 and provides the information necessary to meet the Contractor's obligations under this Agreement.

8.7.2. The Contractor must have in place mechanisms by which to verify that the health information received from Subcontractors is complete, accurate, and timely.

8.8. **Data Certification.**

8.8.1. The Contractor must comply with the required format provided in the Encounter Data Transaction Guide published by DSHS. Data includes encounters documenting services paid for by the Contractor and delivered to Individuals through the Contractor during a specified reporting period as well as other data per the Data Dictionary and Service Encounter Reporting Instructions (SERI). DSHS collects and uses this data for many reasons such as: federal reporting (42 CFR 438.242(b) (1)); rate setting and risk adjustment; service verification, managed care quality improvement program; utilization patterns and access to care; DSHS hospital rate setting; and research studies.

8.8.2. Annual Data Certification: The Contractor must certify that the health information received from Subcontractors was verified using the same or similar methodology as described in the PIHP Agreement. The Contractor's certification statement must also indicate that the health information received from Subcontractors is complete and accurate.

9. INDIVIDUAL RIGHTS AND PROTECTIONS

9.1. The Contractor and subcontractors must comply with any applicable Federal and State laws that pertain to individual rights and require that its staff takes those rights into account when furnishing services to Individuals. Any changes to applicable law must be implemented within ninety (90) calendar days of the effective date of the change.

9.2. The Contractor must require that Behavioral Health Professionals, including MHPs, MHCPs and CDP/CDPTs, acting within the lawful scope of their practice, are not prohibited or restricted from advising or advocating on behalf of an Individual with respect to:

9.2.1. The Individual's behavioral health status;

9.2.2. Receiving all information regarding behavioral health treatment options including any alternative or self-administered treatment, in a Culturally Competent manner;

9.2.3. Any information the Individual needs in order to decide among all relevant behavioral health treatment options;

9.2.4. The risks, benefits, and consequences of behavioral health treatment (including the option of no behavioral health treatment);

9.2.5. The Individual's right to participate in decisions regarding his or her behavioral health care, including the right to refuse behavioral health treatment and to express preferences about future treatment decisions;

9.2.6. The Individual's right to be treated with respect and with due consideration for his or her dignity and privacy;

9.2.7. The Individual's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

9.2.8. The Individual's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164;

9.2.9. The Individual's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the BHO, BHA, CDP/CDPT or MHCP treats the Individual.

9.3. The Contractor must provide or purchase age, linguistic and Culturally Competent behavioral health services for Individuals.

9.4. Individual service plans must be developed in compliance with WAC 388-877-0620.

9.4.1. The Contractor must require that Individuals are included in the development of their individualized service plans, Mental Health Advance Directives and crisis plans.

9.4.1.1. This must include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings).

9.4.1.2. At a minimum, treatment goals must include the words of the Individual receiving services and documentation must be included in the clinical record, as part of the 180 day progress review, describing how the Individuals sees progress.

9.5. **Ombuds.** The Contractor must provide a behavioral health Ombuds as described in WAC 388-865-0250 and RCW 71.24.

9.5.1. The Contractor must provide the names of and contact information for all Ombuds within its Regional Service Area to the DBHR by April 30, 2016, and within ten (10) business days of hearing of any changes of Ombuds or contact information.

9.5.2. An entity or Subcontractor independent of the BHO Administration must employ the Ombuds and provide for the following:

9.5.2.1. Separation of personnel functions (e.g. hiring, salary and benefits determination, supervision, accountability and performance evaluations);

9.5.2.2. Independent decision making to include all investigation activities, findings, recommendations and reports.

9.6. **Advance Directives.** The Contractor must maintain written policies and procedures for Advance Directives that meet the current requirements of RCW 71.32 (changes must be included within ninety (90) calendar days of the effective date of any changes to the RCW).

9.6.1. The Contractor must inform all Individuals of their right to a Mental Health Advance Directive and must provide technical assistance to those who express an interest in developing and maintaining one. This requirement includes Individuals diagnosed with a Substance Use Disorder as per RCW 71.32, which states that "Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions.

9.6.2. The Contractor must inquire whether Individuals have active Medical Advance Directives, and must provide those who express an interest in developing and maintaining Medical Advance Directives with information about how to initiate a Medical Advance Directive.

9.6.3. The Contractor must not establish any conditions of treatment or in any way discriminate against an Individual based on the existence or absence of an Advance Directive.

9.6.4. The Contractor must provide training to its staff on policies and procedures regarding Advance Directives.

9.6.5. The Contractor must require subcontractors to maintain current copies of any Medical and/or Mental Health Advance Directives in Individuals' clinical records.

9.6.6. The Contractor and its subcontractors must provide written information to Individuals that includes:

9.6.6.1. A description of their rights for a Mental Health Advance Directive under current RCW 71.32 (changes must be included within 90 days of the effective date of any changes to the RCW);

9.6.6.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of a Mental Health Advance Directive as a matter of Conscience; and

9.6.6.3. Information regarding how to file a Grievance concerning noncompliance with a Mental Health Advance Directive with the Washington State Department of Health.

9.7. **Information Requirements.** The Contractor must provide information to Individuals consistent with WAC 388-877-0650. The Contractor must maintain written policy and procedures addressing all information requirements, and must:

9.7.1. Provide interpreter services for Individuals who speak a primary language other than English for all interactions between the Individual and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a Grievance or Fair Hearing;

9.7.2. The Contractor and affiliated service providers must post a multilingual notice in each of the DSHS-prevalent languages (Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese, Arabic, Amharic, Punjabi, and Ukrainian) that advises Individuals information is available in other languages and how to access this information;

9.7.3. The Contractor and affiliated service providers must post a translated copy of the Statement of Individual Participant Rights, as detailed in WAC 388-877-0600(1) in each of the DSHS-prevalent languages;

9.7.4. The Contractor must provide written translations of generally available materials including, at minimum, applications for services, and consent forms in each of the DSHS-prevalent languages that are spoken by five percent (5%) or more of the population of the State of Washington based on the most recent U.S. census. DSHS has determined based on this criteria that Spanish is the currently required language. The Contractor must maintain availability of translated documents at all times for the Contractor and its contracted BHAs to distribute.

9.7.4.1. Materials may be provided in English if the Individual's primary language is other than English but the Individual can understand English and is willing to receive the materials in English. The Individual's consent to receiving information and materials in English must be documented in the Individual's record.

9.7.4.2. For Individuals whose primary language is not translated, the requirement may be met by providing the information through audio or video recording in the Individual's primary language, having an interpreter read the materials in the Individuals primary language or providing materials in an alternative format that is acceptable to the Individual. If one of these methods is used it must be documented in the Individual's record.

9.7.5. Ensure that MHPs, MHCPs and CDP/CDPTs have an effective mechanism to communicate with Individuals with sensory impairments.

9.7.6. The Contractor must post a translated copy of the Individual rights as provided by DBHR in each of the DSHS-prevalent languages.

9.7.7. Upon an Individual's request, the Contractor must provide:

9.7.7.1. BHA licensure, certification and accreditation status;

9.7.7.2. Information that includes but is not limited to, education, licensure, and Board certification or re-certification or registration of MHPs, MHCPs and CDP/CDPTs.

9.8. **Customer Services**.

9.8.1. The Contractor must provide Customer Services that are customer-friendly, flexible, proactive, and responsive to Individuals, families, and stakeholders. The Contractor must provide a toll-free number for Customer Service. A local telephone number may also be provided for those Individuals within the local calling area.

9.8.2. At a minimum, Contractor Customer Services staff must:

9.8.2.1. Promptly answer telephone calls from Individuals, Family members and stakeholders from 8 a.m. until 5 p.m. Monday through Friday, holidays excluded;

9.8.2.2. Respond to Individuals, Family members and stakeholders in a manner that resolves their inquiry. Staff must have the ability to respond to those with limited English proficiency or hearing loss;

9.8.2.3. Customer Services staff must be trained on how to refer these calls to the appropriate party. Logs must be kept that, at a minimum, track the date of the initial call, type of call and date of attempted resolution. This log will be provided to DBHR for review upon request.

10. CARE MANAGEMENT

10.1. Care Management is a set of clinical management oversight functions that must be performed by the Contractor. Care Management functions, except individual service plans and co-occurring disorder assessments, must be not delegated to a network BHA. Care Management activities must be performed by a Mental Health Professional for mental health services and by a CDP/CDPT for substance disorder services.

10.2. **Individual Service Plans.** Individual Service Plans must be developed in compliance with WAC 388-877-0620.

10.2.1. The Contractor must require that Individuals are actively included in the development of their individualized service plans, Mental Health Advance

Directives, and crisis plans. This must include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings).

10.2.2. At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record, describing how the Individual sees progress.

10.2.3. Individual Service Plans must address the overall identified needs of the Individual, including those that best met by another service delivery system, such as education, primary medical care, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections and juvenile justice as appropriate. The Contractor must ensure there is coordination with the other service delivery systems responsible for meeting identified needs.

10.3. **Coordination with other BHOs.** The Contractor must follow the guidelines set forth in *Exhibit B, BHO Transfer Protocol*, as applicable.

10.4. **Evidence-Based Practices:** The Contractor will participate with DSHS to increase the use of research and Evidence-Based Practices, with a particular focus on increasing these practices for children and youth as identified through legislative mandates. This includes:

10.4.1. Participation in state-sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT/CBT) and CBT-Plus (TF-CBT/CBT+) Evidence-Based Practices including those for which state subsidy of training costs is not available. The Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice in at least one site within the Contractor's service area;

10.4.2. Participation in state-sponsored efforts to ensure that the sites offering the TF-CBT/CBT+ Evidence-Based Practice are operated as trauma-informed systems of care;

10.4.3. The Contractor must track Evidence-Based and research-based practices following guidelines published by the Washington State Institute of Public Policy (WSIPP).

10.5. **Children's Mental Health.**

10.5.1. Contractors who implement WISe as part of their service delivery must adhere to the most current version of the WISe Manual and meet the requirements of the WISe Quality Management Plan.

10.5.2. Contractors not yet implementing WISe as part of their service delivery must incorporate and disseminate the Washington State Children's Behavioral Health Principles as guidelines for providing care to children, youth and their families.

10.6. **Transition Age Youth.**

10.6.1. The Contractor must maintain a process for addressing the needs of Transition Age Youth (ages 16 - 21) in their care/treatment plans. The Process must contain or address:

10.6.1.1. A comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports, and outcomes;

10.6.1.2. Individual behavioral health needs in the context of a Transition Age Youth, which include supported transition to meaningful employment, post-secondary education, technical training, housing, community supports, natural supports, and cross-system coordination with other system providers;

10.6.1.3. For youth who require continued services in the adult behavioral health system, the process must include identification of transitional services that allow for consistent and coordinated services and supports for young people and their parents;

10.6.1.4. Developmentally and culturally appropriate adult services that are relevant to the Individual or population.

10.7. **State Hospitals.** The Contractor must abide by the current Western and Eastern State Hospital/Behavioral Health Organization/Home and Community Services Agreement for Home and Community Services Placements from Western and Eastern State Hospitals.

10.7.1. The Contractor must participate with DSHS, the Division of Home and Community Services (HCS), and other BHOs to develop a common operating agreement. The agreement must be completed within ninety (90) calendar days of contract execution and be maintained and updated or reviewed at least annually.

10.7.1.1. In the event an agreement cannot be executed by that date, DSHS may require the Contractor to follow procedures that meet the intended goals of such an agreement.

10.7.1.2. Upon implementation of the agreement, the Contractor must comply with its terms.

10.7.1.3. The agreement must address the following topics:

10.7.1.3.1. Referrals for service to/from the Contractor and DSHS-HCS services;

10.7.1.3.2. Exchange of information needed for treatment and placement planning;

10.7.1.3.3. Timelines for activities to occur;

10.7.1.3.4. Procedures to assist in the diversion of patients from State Hospitals especially those with dementia and similar diagnoses;

10.7.1.3.5. Procedures for evaluating the operation of the agreement and for addressing problems.

11. BEHAVIORAL HEALTH DATA MANAGEMENT

11.1. **Data Submission and Error Correction.** The Contractor must provide DSHS with all data described in DSHS "Service Encounter Reporting Instructions" and the "Data Dictionary," and encounters must be submitted as described in DSHS "Encounter Data Reporting Guide".

11.1.1. The Contractor must report encounters electronically to ProviderOne within thirty (30) calendar days of the close of each calendar month in which the encounters occurred.

11.1.2. The Contractor must submit all other required data about Individuals to the DSHS Behavioral Health Data Store within thirty (30) calendar days of collection or receipt from subcontracted providers.

11.1.3. Upon receipt of data submitted, both ProviderOne and DSHS Behavioral Health Data Store generate error reports. The Contractor must have in place documented policies and procedures to assure that data submitted and rejected due to errors are corrected and resubmitted within thirty (30) calendar days of when the error report was produced.

11.1.4. The Contractor must require Subcontractors to resubmit data rejected due to errors. The Subcontractor must resubmit corrected data within thirty (30) calendar days of when an error report was produced.

11.1.5. The Contractor must attend meetings and respond to inquiries to assist in DSHS decisions about changes to data collection and information systems to meet the terms of this Agreement. This may include requests to add, delete or change data elements that may include projected cost analysis.

11.1.6. The Contractor must implement changes documented in DSHS "Service Encounter Reporting Instructions", the "Data Dictionary" and DSHS "Encounter Data Reporting Guide" within one hundred twenty (120) calendar days from the date published. When changes on one document require changes to the other, DSHS will publish all affected documents concurrently.

11.1.6.1. In the event that shorter timelines for implementation of changes under this section are required or necessitated by either a court order or agreement resulting from a lawsuit or legislative action, DSHS will provide as much notice as possible of the impending changes and provide specifications for the changes as soon as they are available. The Contractor will implement the changes required by the timeline established in the court order, legal agreement or legislative action. To the extent possible, DSHS will work through its stakeholder groups to implement any change as necessary.

11.1.7. The Contractor must implement changes to the content of national standard

code sets (such as Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), Place of Service code sets) per the instructions and implementation schedule or deadline from the issuing organization. If the issuing organization does not provide an implementation schedule or deadline, the Contractor shall implement the changes within one hundred twenty (120) calendar days.

11.1.8. When DBHR makes changes referenced in this Section (Behavioral Health Data Management), the Contractor must send at least one test batch of data containing the required changes. The test batch must be received no later than fifteen (15) calendar days prior to the implementation date.

11.1.8.1. The test batch must include at least one hundred (100) transactions that include information effected by the change.

11.1.8.2. The processed test batch must result in at least eighty percent (80%) successfully posted transactions or an additional test batch is required.

11.1.9. The Contractor must respond to requests from DBHR for information not covered by the data dictionary in a timeframe determined by DBHR that will allow for a timely response to inquiries from CMS, the legislature, DSHS, and other parties.

11.1.10. No BHO encounter transaction shall be accepted for initial entry or data correction after one year from the date of service, except by special exception.

11.2. **Business Continuity and Disaster Recovery.** The Contractor must demonstrate a primary and backup system for electronic submission of data requested by DSHS. This must include the use of the Inter-Governmental Network (IGN), Information Systems Services Division (ISSD) approved secured Virtual Private Network (VPN) or other ISSD- approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on DSHS approval.

11.2.1. The Contractor must create and maintain a business continuity and disaster recovery plan that ensures timely reinstitution of the behavioral health data system following total loss of the primary system or a substantial loss of functionality. The plan must be in written format, have an identified update process (at least annually) and a copy must be stored off site.

11.2.2. The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must be submitted by January 1 of each year of this Agreement. The certification must indicate that the plans are up to date, the system and data backup and recovery procedures have been tested, and copies of the Contractor and Subcontractor plans are available for DSHS or the contracted EQRO to review and audit. The plan must address the following:

11.2.2.1. A mission or scope statement;

11.2.2.2. An appointed Information Services Disaster Recovery Staff;

11.2.2.3. Provisions for Backup of Key Personnel; Identified Emergency Procedures; visibly listed emergency telephone numbers;

11.2.2.4. Procedures for allowing effective communication; Applications Inventory and Business Recovery priority; Hardware and software vendor list;

11.2.2.5. Confirmation of updated system and operations documentation; Process for frequent backup of systems and data;

11.2.2.6. Off-site storage of system and data backups; Ability to recover data and systems from backup files;

11.2.2.7. Designated recovery options which may include use of a hot or cold site;

11.2.2.8. Evidence that disaster recovery tests or drills have been performed.

11.3. **Information System Security and Protection of Confidential Information**

11.3.1. The Contractor must comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et.seq., and 45 CFR Parts 160, 162 and 164.

11.3.2. The Contractor must ensure that confidential information provided through or obtained by way of this Agreement or services provided, is protected in accordance with *Exhibit A - Data Security Requirements* of the *DSHS and BHO Agreement on General Terms and Conditions*.

11.3.3. The Contractor must maintain a statement on file for each individual service provider and Contractor staff who has access to the Contractor's behavioral health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality.

11.3.4. The Contractor must take appropriate action if a Subcontractor or Contractor employee wrongly releases confidential information.

12. REPORTING REQUIREMENTS

12.1. **Duplicative Reports and Deliverables.** If this Agreement requires a report or other Deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties the Contractor may provide one (1) report or Deliverable that contains the information required by both Agreements.

12.2. **Evaluations.** Evaluations under this Agreement must be done by inspection or other means to measure quality, appropriateness, and timeliness of services, and to

determine whether the Contractor and its Subcontractors are providing service to Individuals in accordance with the requirements set forth in this Agreement and applicable State and federal regulations.

12.3. **Incident Reporting.** The Contractor must maintain policies and procedures regarding mandatory incident reporting and referrals consistent with all applicable state and federal laws. The policies must address the Contractor's oversight and review of the requirements in this Section.

12.3.1. The Contractor must have a designated incident manager responsible for meeting the requirements under this section.

12.3.2. The Contractor must report and follow up on all incidents involving Individuals using the Behavioral Health and Recovery Incident Reporting System at https://fortress.wa.gov/dshs/mhdirhrsa/Login.aspx. Access to the Incident Reporting System is restricted to authorized users only. Those needed access to the System may contact the Incident Reporting Manager (incidentmanager@dshs.wa.gov). If the Incident Reporting System is unavailable for use, a DBHR standardized form with instructions will be provided. Incident Reports must contain the following:

12.3.2.1. A description of the incident;

12.3.2.2. The date and time of the incident;

12.3.2.3. Incident location;

12.3.2.4. Incident type;

12.3.2.5. Names and ages, if known, of all Individuals involved in the incident;

12.3.2.6. The nature of each Individual's involvement in the incident;

12.3.2.7. The service history with the Contractor, if any, of Individuals involved;

12.3.2.8. Steps taken by the Contractor to minimize harm; and

12.3.2.9. Any legally required notifications made by the Contractor.

12.3.3. The Contractor must report and follow-up on the following incidents. In addition, the Contractor must use professional judgment in reporting incidents not listed herein.

12.3.3.1. Category One Incidents: the Contractor must report and also notify the DBHR Incident Manager by telephone or email immediately upon becoming aware of the occurrence of any of the following Category One incidents involving any Individual that was or Individuals that were served within 365 calendar days of the incident:

12.3.3.1.1. Death or serious injury of patients, Individuals, staff, or public citizens at a DSHS facility or a facility that DSHS licenses, contracts with, or certifies;

12.3.3.1.2. Unauthorized leave of a mentally ill offender or a sexual violent offender from a mental health facility or a Secure Community Transition Facility. This includes Evaluation and Treatment centers (E&T), Crises Stabilization Units (CSU), and Triage Facilities that accept involuntary Individuals;

12.3.3.1.3. Any violent act to include rape or sexual assault, as defined in RCW 71.05.020 and RCW 9.94A.030, or any homicide or attempted homicide committed by an Individual;

12.3.3.1.4. Any event involving an Individual or staff that has attracted, or that in the professional judgment of the Incident Manager, is likely to attract media attention.

12.3.3.2. Category Two Incidents: the Contractor must report within one (1) business day of becoming aware that any of the following Category Two Incidents has occurred, involving an Individual:

12.3.3.2.1. Alleged abuse or neglect of an Individual of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another Individual;

12.3.3.2.2. A substantial threat to facility operation or to an Individual's safety resulting from a natural disaster (to include earthquake, volcanic eruption, tsunami, fire, flood, an outbreak of communicable disease, etc.);

12.3.3.2.3. Any breach or loss of Individual data in any form that is considered as reportable in accordance with the Health Insurance Portability and Accountability Act (HIPAA) shall be reported as directed in the DSHS and BHO Agreement on General Terms and Conditions, HIPAA Compliance section, Breach Notification subsection;

12.3.3.2.4. Any allegation of financial exploitation as defined in RCW 74.34.020;

12.3.3.2.5. Any attempted suicide that requires medical care that occurs at a facility that DSHS licenses, contracts with, and/or certifies;

12.3.3.2.6. Any event involving an Individual or staff, likely to attract media attention in the professional judgment of the Incident Manager;

12.3.3.2.7. Any event involving: a credible threat towards a staff member that occurs at a DSHS facility, a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. A credible threat towards staff is defined as "A

communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's Family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan";

12.3.3.2.8. Any incident that was referred to the Medicaid Fraud Control Unit by the Contractor or its Subcontractor;

12.3.3.2.9. A life safety event that requires an evacuation or that is a substantial disruption to the facility.

12.3.4. **Comprehensive Review.** DSHS may require the Contractor to initiate a comprehensive review of an incident.

12.3.4.1. The Contractor will fully cooperate with any investigation initiated by DSHS and provide any information requested by DSHS within the timeframes specified within the request.

12.3.4.2. If the Contractor does not respond according to the timeframe in DSHS' request, DSHS may obtain information directly from any involved party and request their assistance in the investigation.

12.3.4.3. DSHS may also review or may require the Contractor to review incidents that involve Individuals who have received services from the Contractor more than 365 calendar days prior to the incident.

12.3.5. **Incident Review and Follow-up.** the Contractor must review and follow-up on all incidents reported. The Contractor will provide sufficient information, review, and follow-up to take the process and report to its completion. An incident will not be categorized as complete until the following information is provided:

12.3.5.1. A summary of any incident debriefings or review process dispositions;

12.3.5.2. Whether the Individual is in custody (jail), in the hospital, or in the community, and if in the community whether the Individual is receiving services. If the Individual cannot be located, the Contractor must document the steps the Contractor took to attempt to locate the Individual by using available local resources;

12.3.5.3. Documentation of whether the Individual is receiving or not receiving behavioral health services from the Contractor at the time the incident is being closed;

12.3.5.4. In the case of death of the Individual, the Contractor must provide either a telephonic verification from an official source or via a death certificate;

12.3.5.5. In the case of telephonic verification, the Contractor must document the date of the contact and both the name and official duty title of the person verifying the information;

12.3.5.6. If this information is unavailable, the attempt to retrieve it must be documented.

12.4. **Information Requests.** The Contractor must maintain information necessary to promptly respond to written requests by a DBHR Director, Office Chief, or his or her designee. The Contractor shall submit information detailing the amount spent throughout its Service Area on specific items upon request by a DBHR Director, or an Office Chief.

12.5. **Reviews.** The Contractor and its Subcontractors must cooperate in all reviews, including but not limited to, surveys, and research conducted by DSHS or other Washington State Departments.

12.6. **WISe Reporting (Children's Mental Health).**

12.6.1. Contractors who implement WISe as part of their service delivery must report on actions taken in response to WISe Quality Management Plan reports and associated outcomes.

12.6.1.1. The Contractor must develop and implement a plan to achieve Wraparound with Intensive Services (WISe) capacity targets.

12.6.1.2. The Contractor must meet identified cumulative quarterly targets outlined in *Exhibit H – Estimated WISe Capacity Expansion*.

12.6.2. The Contractor must submit a bi-monthly progress report to begin on the month following Agreement execution to DBHR at WISeSupport@dshs.wa.gov by 5:00 p.m. on the final day of that month, containing the following:

12.6.2.1. The current WISe service capacity for the region;

12.6.2.2. The increase or decrease in WISe capacity compared to the previous progress report;

12.6.2.3. If the Contractor experiences a decrease, the Contractor shall include an explanation for the decrease along with an action plan for bringing the Contractor back into compliance;

12.6.2.4. If the Contractor has an identified action plan from the previous progress report, the Contractor shall identify what action items were accomplished;

12.6.3. The Contractor must identify challenges in meeting their service capacity targets and identify strategies to address those challenges.

12.7. **No Beds Available** for Persons Meeting Mental Health Detention Criteria - Report.

12.7.1. The BHO must ensure that their DMHPs make a report to DSHS when he or she determines an Individual meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710 and there are not any beds available at the evaluation and treatment facility, the Individual has not been provisionally accepted for admission by a facility, and the Individual cannot be served on a single bed certification or less restrictive alternative.

12.7.2. Starting at the time when the DMHP determines an Individual meets detention criteria, the investigation has been completed and when no bed is available, the DMHP must submit a completed report to the DSHS Contact listed on page one (1) within twenty-four (24) hours.

12.7.3. The notification report must contain at a minimum:

12.7.3.1. The date and time that the investigation was completed;

12.7.3.2. The identity of the responsible BHO;

12.7.3.3. A list of facilities which refused to admit the Individual;

12.7.3.4. Identifying information for the Individual, including age or date of birth; and

12.7.3.5. Other reporting elements deemed necessary or supportive by DSHS.

12.7.4. The BHO receiving the notification report must attempt to engage the Individual in appropriate services for which the Individual is eligible and report back within seven (7) days to DSHS.

12.7.5. BHOs are required to implement an adequate plan to provide evaluation and treatment services, which may include the development of less restrictive alternatives to involuntary treatment, or prevention programs reasonably calculated to reduce demand for evaluation and treatment.

12.7.6. DSHS will initiate corrective action when appropriate to ensure an adequate plan is implemented. Corrective actions may include remedies under RCW 43.20A.894, including requiring expenditure of reserve funds. DSHS may initiate corrective action plans for those BHOs lacking an adequate network of evaluation and treatment services to ensure access to treatment.

13. SERVICES

13.1. **Co-Occurring Disorder Screening and Assessment**: The Contractor must maintain the implementation of the integrated, comprehensive screening and assessment process for substance use disorder and mental disorders as required by RCW 70.96C.010. Failure to maintain the Screening and Assessment process will result in remedial actions up to and including financial penalties as described in Section 17 Remedial Actions.

13.1.1. The Contractor must attempt to screen all Individuals aged thirteen (13) and above through the use of the DBHR-provided GAIN-SS during:

13.1.1.1. All new intakes;

13.1.1.2. The provision of each crisis episode of care including ITA investigations services, except when:

13.1.1.2.1. The service results in a referral for an intake assessment;

13.1.1.2.2. The service results in an involuntary detention under RCW 71.05, RCW 71.34 or RCW 70.96B;

13.1.1.2.3. The contact is by telephone only;

13.1.1.2.4. The professional conducting the crisis intervention or ITA investigation has information that the Individual completed a GAIN-SS screening within the previous twelve (12) months.

13.1.1.3. The GAIN-SS screening must be completed as self-reported by the Individual and signed by that Individual on the DBHR-GAIN-SS form. If the Individual refuses to complete the GAIN-SS screening or if the clinician determines the Individual is unable to complete the screening for any reason this must be documented on the DBHR-GAIN-SS form;

13.1.1.4. The results of the GAIN-SS screening, including refusals and anywhere the Individual was unable to complete, must be reported to DBHR through the Behavioral Health Data Store;

13.1.1.5. The Contractor must complete a co-occurring mental health and substance abuse disorder assessment, consistent with training provided by DBHR and outlined in SAMHSA Publication Substance Abuse Treatment For Persons With Co-Occurring Disorders, A Treatment Improvement Protocol TIP 42, to determine a quadrant placement for the Individual when the Individual scores a two (2) or higher on either of the first two (2) scales (ID Screen & ED Screen) and a two (2) or higher on the third (3rd) (SD Screen).

13.1.1.5.1. The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities.

13.1.1.5.2. The quadrant placements are defined as:

13.1.1.5.2.1. Less severe mental health disorder / less severe substance disorder;

13.1.1.5.2.2. More severe mental health disorder / less severe substance disorder;

13.1.1.5.2.3. Less severe mental health disorder / more severe substance disorder;

13.1.1.5.2.4. More severe mental health disorder / more severe substance disorder. The quadrant placement must be reported to DBHR through the Behavioral Health Data Store.

13.2. **Core Mental Health Services**. The Contractor must provide the following services as described below and prioritize such services above any other services unless otherwise specified in this Agreement.

13.2.1. Crisis Mental Health Services: The Contractor must provide twenty-four (24) hour, seven (7) day per week crisis mental health services to Individuals who are within the Contractor's Service Area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the Individual's ability to pay. Crisis mental health services may include each of the following:

13.2.1.1. Crisis Services: Evaluation and treatment of mental health crisis to all Individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, the outcome of which decides whether possible bad consequences will follow. Crisis services must be available on a twenty-four (24) hour basis. Crisis services are intended to stabilize the Individual in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the Individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services must be provided by or under the supervision of a Mental Health Professional;

13.2.1.2. Stabilization Services: Services provided to Individuals who are experiencing a mental health crisis. These services are to be provided in the Individual's own home, or another home-like setting, or a setting which provides safety for the Individual and the Mental Health Professional. Stabilization services must include short-term (less than two (2) weeks per episode) face-to-face assistance with life skills training and with the understanding of medication effects and side effects. This service includes: a) follow up to crisis services; and b) other Individuals determined by a Mental Health Professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services. This service may include cost for room and board;

13.2.1.3. Involuntary Treatment Act Services - Mental Health: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of Individuals in accordance with RCW 71.05, RCW 71.24.300, and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act

Services when a Designated Mental Health Professional (DMHP) determines an Individual must be evaluated for involuntary treatment. The decision-making authority of the DMHP must be independent of the BHO administration. ITA services continue until the end of the involuntary commitment;

13.2.1.4. Freestanding Evaluation and Treatment Services: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Washington State Department of Health and certified by DSHS to provide Medically Necessary evaluation and treatment to the Individual who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals, and discharge planning involving the Individual, Family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The Individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented. This service is provided for Individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self, due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the Individual does not allow him/her to be managed at a lesser level of care. This service does not include cost for room and board. DSHS must authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

13.2.2. Crisis mental health services may be provided without an intake evaluation or screening process. The Contractor must provide:

13.2.2.1. Emergent Care within two (2) hours of the request received from any source for crisis mental health services;

13.2.2.2. Urgent Care within twenty-four (24) hours of the request received from any source for crisis mental health services.

13.2.3. The Contractor must provide access to all components of the Involuntary Treatment Act to Individuals who have mental disorders in accordance with state law (RCW 71.05 and RCW 71.34) and without regard to ability to pay.

13.2.4. The Contractor must incorporate the statewide Designated Mental Health Professionals (DMHP) Protocols listed on the DBHR intranet into the practice of Designated Mental Health Professionals.

13.2.5. The Contractor must have policies and procedures for crisis and mental health ITA services that implement the following requirements:

13.2.5.1. No DMHP or crisis intervention worker must be required to respond to a private home or other private location to stabilize or treat an Individual in crisis, or to evaluate an Individual for potential detention under the state's involuntary treatment act, unless a second trained individual accompanies them;

13.2.5.2. The clinical team supervisor, on-call supervisor, or the individual professional acting alone based on a risk assessment for potential violence, must determine the need for a second individual to accompany them;

13.2.5.3. The second individual may be a law enforcement officer, a Mental Health Professional, a mental health paraprofessional who has received training required in RCW 49.19.030, or other first responder, such as fire or ambulance personnel;

13.2.5.4. No retaliation may be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone;

13.2.5.5. The Contractor must have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations;

13.2.5.6. Every Mental Health Professional dispatched on a crisis visit, must have prompt access to information about any history of dangerousness or potential dangerousness on the Individual they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response;

13.2.5.7. Every Mental Health Professional who engages in home visits to Individuals or potential Individuals for the provision of crisis services must be provided by the Contractor or Subcontractor with a wireless telephone or comparable device for the purpose of emergency communication.

13.2.6. Psychiatric Inpatient Services: Community Hospitals and Evaluation and Treatment Facilities. The Contractor must:

13.2.6.1. Develop, maintain or purchase ITA certified treatment beds to meet the statutory requirements of RCW 71.24.300(6)(c);

13.2.6.2. Provide or purchase psychiatric inpatient services for the following:

13.2.6.2.1. Individuals who agree to be admitted voluntarily when it is determined to be Medically Necessary;

13.2.6.2.2. Individuals who are involuntarily detained in accordance with RCW 71.05 or RCW 71.34, and who are either eligible under

MCS, or who are not eligible for any other medical assistance program that would cover this hospitalization;

13.2.6.2.3. Individuals at least twenty-two (22) years of age and under sixty-five (65) years of age who are Medicaid-Individuals and are admitted to a residential facility that is classified as an IMD as defined in [42 CFR 435.1010](42 CFR 435.1010).

13.2.7. Implementation of Court Decision Detention of D.W., et al. The BHO must make use of Detention of D.W., et al funding for only the following expenses:

13.2.7.1. Operating funds have been provided for the E & T facilities listed in *Exhibit G – Additional Bed Capacity*, as part of the expansion of E & T capacity resulting from the Court Decision Detention of D.W., et al. E & T services in those facilities may be accessed by all BHOs based on the admission policies and procedures of the operating BHO.

13.2.8. Community Hospital Authorization Process: The Contractor must adhere to the requirements set forth in the Community Psychiatric Inpatient Process as provided by DBHR.

13.2.8.1. The Contractor must have appropriate clinical staff members available twenty-four (24) hours per day, seven (7) days per week to respond to requests for authorization of psychiatric inpatient care in community hospitals. The Contractor must adhere to the requirements set forth in the Washington Apple Health Inpatient Hospital Services Provider guide. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the Individual's health condition requires and no later than three (3) business days following the receipt of the authorization request. Extensions of up to fourteen (14) calendar days are permitted if the Individual or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the Individual's best interest. Authorization decisions for psychiatric inpatient care must be made within one (1) hour of the initial call.

13.2.8.2. A Notice of Determination must be provided if certification is denied for the admission.

13.2.9. Psychiatric Inpatient Services - State Hospitals: All individuals admitted to a State Hospital are assigned to a responsible BHO.

13.2.9.1. If the Contractor disagrees with the BHO/Individual assignment, it must request a reassignment within thirty (30) calendar days of admission. If a request to change the assignment is made within thirty (30) calendar days of admission and the request is granted, the reassignment will be retroactive to the date of admission.

13.2.9.2. If a request comes in after the 30th calendar day of admission and is granted, the effective date of the reassignment will be based on the

date DSHS receives the reassignment request form. All reassignment requests are to be made using the Hospital Correction Request Form. The form is attached to the State Hospital/BHO Working Agreement. This process must be described in the working Agreement between the Contractor and the State Hospital.

13.2.10. For each assigned individual the BHO must:

13.2.10.1. Ensure Individuals are medically cleared, if possible, prior to admission to a State Psychiatric Hospital;

13.2.10.2. Respond to State Hospital census alerts by using best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services;

13.2.10.3. The Contractor or its designee must monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320;

13.2.10.4. The Contractor or its designee must offer mental health services to assist with compliance with LRA requirements;

13.2.10.5. The Contractor or its designee must respond to requests for participation, implementation, and monitoring of Individuals receiving services on Conditional Releases (CRs) consistent with RCW 71.05.340. The Contractor or designee must provide mental health services to assist with compliance with CR requirements;

13.2.10.6. The Contractor or designee must ensure provision of mental health services to Individuals on a Conditional Release under RCW 10.77.150;

13.2.10.7. For conditional releases under RCW 10.77, Individuals in transitional status in Pierce or Spokane County will transfer back to the responsible BHO upon completion of transitional care. Individuals discharged to a BHO other than the responsible BHO will be done so according to the Inter-BHO agreement described in the State Hospital Working Agreement;

13.2.10.8. Maintain or develop a written working agreement with the State Hospital in its Service Area within ninety (90) calendar days of the effective date of this Agreement. The Agreements must include:

13.2.10.8.1. Specific roles and responsibilities of the parties related to transitions between the community and the hospital;

13.2.10.8.2. A process for the completion and processing of the Inter-BHO Transfer Request Form for Individuals requesting placement outside of the BHO of residence;

13.2.10.8.3. Collaborative discharge planning and coordination with cross-system partners;

13.2.10.8.4. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.

13.2.10.9. The Contractor must coordinate with the Department of Social and Health Services, Home and Community Services (HCS) regional office to support the placement of Individuals discharged or diverted from State Hospitals into HCS placements. In order to accomplish this, the Contractor must:

13.2.10.9.1. Whenever possible, prior to referring an Individual with a diagnosis of dementia for a ninety (90) calendar day commitment to a State Psychiatric Hospital;

13.2.10.9.2. Ensure that a request for a CARE assessment is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all Individuals who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE assessments for Individuals who have been detained to an E&T or in another setting;

13.2.10.9.3. Request and coordinate with HCS, a scheduled CARE assessment for such Individuals. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the State Hospital;

13.2.10.9.4. For Individuals (both those being discharged and those being diverted) whose CARE assessments indicate likely functional and financial eligibility for long-term care services:

13.2.10.9.4.1. The Contractor will coordinate with HCS placement activities with one entity designated as being responsible for those activities. This designation must be documented in writing and agreed upon by both the Contractor and HCS. If such designation is not made the responsibility is the Contractor's;

13.2.10.9.4.2. The responsible entity will establish and coordinate a placement or discharge planning team that includes Contractor staff, HCS assessors, and other community partners, as necessary, to develop a plan of action for finding a safe, sustainable placement;

13.2.10.9.4.3. The Contractor will ensure coordination and communication will occur between those participants

involved in placement activities as identified by the discharge planning team.

13.2.10.9.5. If a placement has not been found for an Individual referred for long-term care services within thirty (30) calendar days, the designated entity will convene a meeting to review the plan and to make adjustments as necessary. Such review meetings will occur at least every thirty (30) calendar days until a placement is affected;

13.2.10.9.6. When Individuals being discharged or diverted from State Hospitals are placed in a long-term care setting, the Contractor must:

13.2.10.9.6.1. Coordinate with HCS and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the DBHR website;

13.2.10.9.6.2. When the Individual meets access to care criteria, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

13.2.11. Children's Long-Term Inpatient Programs (CLIP). The Contractor must coordinate with the Children's Long-term Inpatient ("CLIP") Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor must enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

13.2.11.1. The Contractor must integrate all regional assessment and CLIP referral activities, including the following:

13.2.11.1.1. Create and maintain a local process to assess the needs of children being considered for voluntary admission and coordinate referrals to the CLIP Administration;

13.2.11.1.2. When an Individual under age eighteen (18) is committed for 180 calendar days under RCW 71.34, the Contractor must assess the child's needs prior to the admission to the CLIP facility. The Contractor must provide a designee who collaborates with the CLIP Administration for children subject to court-ordered involuntary treatment. A representative designated by the Contractor will share the community and/or Family recommendations for CLIP program assignment of committed adolescents;

13.2.11.1.3. Assess the needs of juveniles transferred for evaluation purposes by the Rehabilitation Administration (RA), or under RCW 10.77 to the Child Study and Treatment Center;

13.2.11.1.4. Ensure that all required CLIP application materials, including community/Family CLIP placement recommendations are submitted to the CLIP Administration prior to consideration of voluntary referrals;

13.2.11.1.5. The Contractor must provide the legal guardian and youth aged thirteen (13) and over with a written copy of the CLIP Administration Appeal Process when the BHO denies a voluntary application for CLIP services.

13.2.11.2. After CLIP Admission, the Contractor must provide Rehabilitation Case Management, which includes a range of activities by the Contractor's or BHA's liaison conducted in or with a facility for the direct benefit of the admitted youth. This liaison is the primary case contact for CLIP programs responsible for managing Individual cases from pre-admission through discharge. The Contractor's liaison or designated BHA must participate in treatment and discharge planning with the CLIP treatment team.

13.2.11.3. Review for prior authorization recommendations for short-term/acute hospitalization when it is determined by the CLIP program that this is required.

13.2.12. Inpatient Coordination of Care

13.2.12.1. The Contractor must ensure that contact with the inpatient staff occurs within three (3) business days of an authorized voluntary or involuntary admission. The Contractor's liaison or BHA must participate throughout the admission in treatment and discharge planning with the hospital staff.

13.2.12.2. The Contractor or its designee must provide to the inpatient unit any available information regarding the Individual's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.

13.2.12.3. The Contractor's liaison or designated BHA must participate in treatment and discharge planning with the inpatient treatment team.

13.2.12.4. The Contractor's liaison or designated BHA must participate throughout the inpatient admission to assist with appropriate and timely discharge for all Individuals regardless of diagnosis.

13.2.12.5. The assigned BHA must offer, at minimum, one follow–up service within seven (7) calendar days from discharge to an Individual who has been authorized for an inpatient admission or involuntarily committed.

13.2.13. Ancillary Costs: With the funds provided under this Agreement the Contractor must prioritize payments for expenditures associated with providing Medically Necessary crisis and residential services for Medicaid

Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver. Costs include, but are not limited to, room and board in hospital diversion settings or in a residential or freestanding Evaluation and Treatment facilities and Administrative Costs related to the Involuntary Treatment Act.

13.2.14. Residential Mental Health Programs: Residential settings and programs must be available and provided based on the Individual's needs and within Available Resources per the Contractor's policies and procedures. The Contractor must maintain Level of Care Guidelines that detail when an Individual may receive Residential services. This plan may include memorandums of understanding or contracts to purchase or provide a residential program outside of the Contractor's Service Area when an Individual requires a level of residential support which is not available within the Contractor's Service Area. Residential programs and settings may include the following:

13.2.14.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers;

13.2.14.2. Supervised living such as residential programs developed to serve Individuals diagnosed with a major mental illness in nursing homes, boarding homes or adult Family homes;

13.2.14.3. Supported housing services such as intensive services provided to maintain Individuals in unlicensed individual or group home settings including transitional or permanent housing.

13.2.15. The Contractor must maintain the ability to provide Individuals with an intake evaluation at his or her residence, including adult Family homes, assisted living facilities or skilled nursing facilities, including to Individuals discharged from a State Hospital or evaluation and treatment facilities to such placements when the Individual requires an on-site service due to medical needs.

13.2.16. The Contractor must maintain the ability to provide services to Individuals in their residence, including adult Family homes, assisted living facilities and skilled nursing facilities when required due to medical needs.

13.3. **Core Substance Use Disorder Services.** The Contractor must provide access to all components of the Involuntary Treatment Act to Individuals who have a substance abuse disorder in accordance with RCW 70.96A.080 and without regard to ability to pay.

13.3.1. Involuntary Commitment Act - Substance Use Disorder: Includes all services and administrative functions required for the evaluation for involuntary commitment of Individuals in accordance with RCW 70.96A.140. This includes all clinical services, costs related to court processes and transportation. The decision-making authority of the CDP/CDPT must be independent of the BHO administration. ITA services continue until the end of the involuntary commitment.

13.3.1.1. Residential Treatment (in support of ITA): Services that are provided to an Individual in a twenty-four (24) hour per day supervised facility that includes room and board in accordance with WAC 388-877B. Services include individual and group counseling, education and related activities.

13.3.2. Ancillary Costs: With the funds provided under this Agreement, the Contractor must prioritize payments for expenditures associated with providing Medically Necessary residential services for Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver. Costs include, but are not limited to, room and board in a residential treatment facility and administrative costs related to the Involuntary Treatment Act.

13.3.3. Withdrawal Management: Services that are provided to an Individual to assist in the process of withdrawal in a safe an effective manner in accordance with ASAM criteria.

13.4. **Services in Support of Core Services.** When the Contractor has Available Resources, the Contractor must provide services necessary to the facilitation of providing or preventing Core Services to members of priority groups (RCW 71.24). The Contractor must have policies and procedures that determine how the availability of resources for these services is determined, including how decisions are made to authorize intake evaluations or deny provision of services due to insufficient resources.

13.4.1. Within Available Resources and pursuant to the Contractor's policies and procedure, the Contractor may use the funds provided under this Agreement to do any of the following:

13.4.1.1. Provide or purchase any other clinically appropriate outpatient or residential services to a non-Medicaid Individual. For Substance Use Disorder treatment services these must be based on the priority groups in Section 6.5.1. of this Agreement;

13.4.1.2. Provide or purchase clinically appropriate outpatient services to Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver;

13.4.1.3. Provide assistance with transportation;

13.4.1.4. Provide assistance with application for entitlement programs;

13.4.1.5. Purchase services for Individuals on spend-down when they become temporarily ineligible for Medicaid;

13.4.1.6. Provide Training for Peer Counselors when the training meets the following requirements:

13.4.1.6.1. The Contractor must submit Peer Counselor Training Applications to DBHR no later than thirty (30) calendar days prior to attendance at the training;

13.4.1.6.2. Each participant is over age eighteen (18) and meets the WAC 388-865-0150 definition of Individual, unless DBHR approval for exception has been obtained in writing prior to attendance at the training. Only participants with a DBHR-approved Peer Counselor Training Application may sit for the Peer Counselor Examination;

13.4.1.6.3. Training is structured in compliance with the BHO Guidelines for Peer Counseling Training according to guidelines provided by DBHR. The guidelines define BHO, DBHR, and applicant/participant responsibilities.

13.4.1.7. Within available resources Recovery Support Services can be provided to assist Individuals and their families to become stable and maintain long term Recovery from SUD.

13.4.1.8. Recovery plans must be completed in coordination with the Individual in treatment and/or their family and the Chemical Dependency Professional (CDP) or a Chemical Dependency Professional Trainee (CDPT) under the clinical supervision of a CDP, to include:

13.4.1.8.1. Individual assessment and level of care that considers:

13.4.1.8.1.1. The needs of the Individual and/or their families;

13.4.1.8.1.2. The extent to which there are Recovery Support Services, health and human services, and housing; and

13.4.1.8.1.3. The extent of available resources.

13.4.1.8.2. The plan must demonstrate shared decision-making;

13.4.1.8.3. The plan must also document progress and final interview at the time of program discharge;

13.4.1.8.4. Services will be nonclinical in nature and may include: Employment Services, Housing Services, self-help and support groups, life skills, spiritual and faith-based support, education assistance services, and parent/family education.

14. COMMUNITY COORDINATION

14.1. The Contractor must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested to do so by DBHR. The Contractor must:

14.1.1. Attend DBHR-sponsored training regarding the role of the public behavioral health system in disaster preparedness and response;

14.1.2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration;

14.1.3. Provide Disaster Outreach in Contractor's Service Area in the event of a disaster/emergency. For purposes of this section, "Disaster Outreach" means contacting Individuals in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster. This also includes a determination if additional mental health services and resources are needed as a result of a disaster;

14.1.4. There are two (2) basic approaches to the outreach process: mobile; (going to person to person) and community settings (e.g. temporary shelters, disaster assistance sites, disaster information forums). The Outreach Process must include the following:

14.1.4.1. Locating Individuals in need of disaster relief services;

14.1.4.2. Assessing their needs;

14.1.4.3. Engaging or linking Individuals to an appropriate level of support or disaster relief services;

14.1.4.4. Providing follow-up behavioral health services when clinically indicated;

14.1.4.5. Disaster Outreach can be performed by trained volunteers, peers and/or persons hired under a federal Crisis Counseling Program Grant. These persons should be trained in disaster crisis outreach, which is different than traditional mental health crisis intervention;

14.1.4.6. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs;

14.1.4.7. Provide DBHR with the name and contact information for person(s) coordinating the BHO disaster/emergency preparedness and response upon request;

14.1.4.8. Provide information and preliminary disaster response plans to DBHR within seven (7) calendar days following a disaster/emergency or upon request.

14.1.4.9. Partner in disaster preparedness and response activities with DBHR and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations. This must include:

14.1.4.9.1. Participation when requested in local and regional disaster planning and preparedness activities; and

14.1.4.9.2. Coordination of disaster outreach activities following an event.

14.2. For Individuals enrolled with Developmental Disabilities Administration (DDA), formerly hospitalized at WSH or ESH, currently living in the community, who are in the contracted service area the Contractor must:

14.2.1. Participate in quarterly community comprehensive reviews. Each review must be conducted using the DSHS, DDA Comprehensive Review Tool. This tool is incorporated by reference and is available on the DBHR Intranet;

14.2.2. Work directly with Regional (DDA) representatives in coordinating and conducting these reviews. The Contractor representative and the Regional DDA Quality Assurance Manager will be “lead staff” for Regional Review Teams (RRTs). In addition to coordinating for, and participating in these reviews the “lead staff” will be responsible for preparing and submitting final reports from the reviews to the DSHS Contact on Page one of this Agreement.

14.2.2.1. Develop a corrective action plan to address findings based on the results of a review. Require Subcontractors to respond to any identified deficiencies and to develop and implement the corrective action plan. Document completion of corrective action on the Comprehensive Review Tool.

14.2.2.2. The completion of the review, including documentation of the completion of required corrective action must be submitted to the identified DBHR Program Administrator no later than the final calendar day of the quarter in which the review was conducted.

15. TRIBAL RELATIONSHIPS.

15.1. The Contractor must designate a specific person who will be the main BHO contact for tribal communication/service coordination. The contractor must report the name and contact information to the DBHR Tribal Liaison. DBHR will provide the name and contact information to local Tribes, and RAIOs. .

15.2. Tribal Coordination Implementation Plan.

15.2.1. The Contractor must develop or attempt to develop a Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan in partnership with each Federally Recognized Tribe and RAIO within its service area as defined in this Agreement. The Contractor must provide documentation of attempts to develop a plan if any Federally Recognized Tribe or RAIO declines to participate. The Contractor must work with each Federally Recognized Tribe or RAIO to submit the matrix below for each Federally Recognized Tribe or RAIO listed on or before July 1, 2016, and by March 1 on every subsequent year. The

DBHR Tribal Liaison is available to assist in the partnership and creation of the matrix between the Contractor and the Federally Recognized Tribes and RAIOs within its service area.

15.2.2. If a Federally Recognized Tribe or RAIO declines to participate, the documentation must be attached to the matrix. The documentation must include the date of the decline, method of communication for the decline (email, telephone, or in-person), and contact information of the person at the Federally Recognized Tribe or RAIO who was delegated authority by the Federally Recognized Tribe or RAIO's governing body to make the decision to decline. The Tribal and RAIO Coordination Implementation Plan must be updated annually and submitted by March 1 of every year, even if a Tribe or RAIO has declined the previous year.

15.2.3. The Federally Recognized Tribes and/or RAIOs are defined in the following documents:

15.2.3.1. The Bureau of Indian Affairs Service List;

15.2.3.2. The Governor's Office of Indian Affairs map of Federally Recognized Tribes of Washington State;

15.2.3.3. The DSHS 7.01 Policy, which identifies the Federally Recognized Tribes and/or Recognized American Indian Organizations (RAIOs). https://www.dshs.wa.gov/sites/default/files/SESA/oip/documents/DSHS-AP-07-01.pdf

15.2.4. A Tribal Planning Checklist is attached as *Exhibit A* to assist with developing the Tribal and RAIO Coordination Implementation Plan. The Contractor shall consider the planning checklist in developing the Tribal and RAIO Coordination Implementation Plan. The DBHR Tribal Liaison is available to assist the Contractor with the creation of the Coordination Implementation Plan.

15.2.5. As part of the Tribal and RAIO Coordination Implementation planning, the Contractor must extend an invitation to those Federally Recognized Tribes and RAIOs within the Contractor's service area to participate as members of the Contractor's Governing and/or Advisory Board, according to RCW 71.24.300 (http://app.leg.wa.gov/RCW/default.aspx?Cite=71.24.300). Any issues that arise from this invitation must be detailed in the plan, including a timeline to address these issues and expected outcomes. This includes any Governing Board by-laws or other local rules or regulations that would need to be changed to accommodate Tribal representation occurring.

Tribal and RAIO Coordination Implementation Plan and Progress Report For Behavioral Health Organizations Due to DBHR on or before March 1 of each year	
Implementation Plan	**Progress Report**

(1) Goals/ Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Fiscal Year

15.3. Subcontracts with Federally Recognized Tribes and Recognized American Indian Organizations to provide behavioral health services must include the Special Terms and Conditions as laid out in the Centers for Medicare & Medicaid Services Model BHO Addendum for Indian Behavioral Health Care Providers.

15.3.1. If the Contractor chooses to enter into a Subcontract with a Federally Recognized Tribe the subcontract must include one (1) of the following:

15.3.1.1. General Terms and Conditions that are modeled on the DSHS and Indian Nation Agreement General Terms and Conditions;

15.3.1.2. General Terms and Conditions modeled on the Intergovernmental Agreement for Social and Health Services between Tribes and The Washington State Department of Social and Health Services;

15.3.1.3. General Terms and Conditions that were developed through a process facilitated by the DBHR Tribal Liaison;

15.3.1.4. General Terms and Conditions that were developed between the Federally Recognized Tribe and the Contractor. In this case, a written statement must be provided to the DBHR Tribal Liaison from each party that verifies both are in Agreement with the content in the General Terms and Conditions. The written statement must come from the Tribe's governing body.

15.3.2. If the Contractor chooses to enter into a Subcontract with a RAIO, the subcontract must include one (1) of the following:

15.3.2.1. General Terms and Conditions that were developed through a process facilitated by the DBHR Tribal Liaison;

15.3.2.2. General Terms and Conditions that were developed between the RAIO and the Contractor. In this case a written statement must be provided to the DBHR Tribal Liaison from each party that verifies both are in Agreement with the content in the General Terms and Conditions. The written statement from the RAIO must come from the RAIO's governing body.

15.3.3. Any Subcontracts with Federally Recognized Tribes and RAIOs must be consistent with the laws and regulations that are applicable to the Federally Recognized Tribe or RAIO. The Contractor must work with each Federally Recognized Tribe and RAIO to identify those areas that place legal requirements on the Federally Recognized Tribe and RAIO that are not applicable and refrain from passing these requirements on to Federally Recognized Tribes or RAIOs.

15.3.4. The DBHR Tribal Liaison will be available for technical assistance.

15.3.5. The Contractor shall have a policy and procedure that requires efforts to recruit and maintain Ethnic Minority Mental Health Specialists – Native Americans (as defined in the State Medicaid Plan) from each Federally Recognized Tribe or RAIO within the Contractor's service area for use in specialist consults whenever possible.

15.3.6. In the event the subcontracted provider is aware that the Individual receiving behavioral health services is a Federally Recognized Tribal Member, or receiving behavioral health services from a Tribal Behavioral Health Program, and the Individual or their legal representative consents, efforts must be made to notify the BHO and Tribal Authority or RAIO to assist in discharge planning and transition for the Individual. If the Individual chooses to be served only by the Tribal Behavioral Health Program, and is not under a Less Restrictive Alternative order requiring them to receive treatment from a BHO provider, a referral to a contracted network BHA is not required.

15.4. If an Individual is a Tribal Member of a Federally Recognized Tribe and is referred to or presents for non-crisis services and the Individual or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the Individual. If the Individual chooses to be served only by the Tribal Behavioral Health Program, and is not under a Less Restrictive Alternative order requiring them to receive treatment from a BHO provider, a referral to a contracted network BHA is not required.

15.5. Tribal Coordination Plan for Crisis, Voluntary Inpatient and Involuntary Commitment Evaluation Services.

15.5.1. The Contractor must work with the DBHR Tribal Liaison to develop and maintain a tribal crisis coordination plan. The plan shall outline details for providing crisis, ITA-MH and ITA-SUD evaluations, voluntary inpatient authorization and discharge planning services on Tribal Lands within the BHO service area. A draft of the plan must be submitted to the DBHR Tribal Liaison by July 29, 2016.

15.5.2. The plan shall be developed in partnership with the affected Federally Recognized Tribal and RAIO entities within the BHO region.

15.5.3. The plan shall identify a procedure and timeframe for evaluating its efficacy and a procedure and timeframe for modification to the satisfaction of all parties at least once per year.

15.5.4. If the BHO and the Federally Recognized Tribal or RAIO entity are not able develop a plan or the Tribe or RAIO does not respond to the request, DBHR will work with the Tribe and/or RAIO and BHO to reach an understanding. These meetings will be conducted in a manner which comports with the DSHS government-to-government relationship with Washington State Federally Recognized Tribes, and the collaborative relationship with RAIOs. If a Tribe or RAIO declines to develop a plan, documentation of attempts to engage must be attached to the plan. The documentation must include the date of the decline, method of

communication for the decline (email, telephone, or in-person), and contact information of the person at the Federally Recognized Tribe or RAIO who was delegated authority by the Federally Recognized Tribe or RAIO's governing body to make the decision to decline.

15.5.4.1. Those Federally Recognized Tribes, whose Tribal lands lie within multiple BHOs, may develop joint plans with those BHOs. If a BHO has multiple Tribal lands within its service region, one plan may be developed for all Tribes if all parties agree.

15.5.4.2. The plan must include a procedure for crisis responders and DMHPs (non-Tribal) to access Tribal lands to provide requested services, including crisis response, and ITA evaluations.

15.5.4.3. Any notifications and authority needed to provide services including a plan for evening, holiday and weekend access to Tribal lands if different than business hours.

15.5.4.4. A process for notification of Tribal authorities when crisis services are provided on Tribal land, especially on weekends, holidays and after business hours. This must identify the essential elements included in this notification, who is notified and timeframe for the notification.

15.5.4.5. A description of how non-Tribal crisis responders and DMHPs will coordinate with Tribal behavioral health providers and/or others identified in the plan for, including a description of how service coordination and debriefing with Tribal behavioral health providers will occur after a crisis service has occurred.

15.5.4.6. The plan must include the process for determining when a non-Tribal DMHP is requested and a timeframe for consulting with Tribal behavioral health providers regarding the determination to detain or not for involuntary commitment.

15.5.4.7. Include a planned response to Tribal ITA court orders for Substance Use Disorder Treatment ITA Evaluation Services.

15.5.4.8. The plan shall include procedures for coordination and implementation of ITA mental health and ITA substance use disorder evaluations on Tribal lands, including whether or not non-Tribal DMHPs may conduct ITA evaluations on Tribal lands.

15.5.4.9. If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom Individuals will be transported to non-Tribal lands for ITA mental health and ITA substance use disorder evaluations and detentions.

15.5.4.10. If DMHP evaluations cannot be conducted on Tribal Land, the plan shall specify how and by whom Individuals will be transported off of Tribal Land to the licensed Evaluation and Treatment facility.

15.5.5. The plan shall specify where Individuals will be held and under what authority, if no E&T beds are available.

15.5.6. Voluntary Hospital Payment Authorization

15.5.6.1. The plan will include specifics as to how the BHO would like Tribal behavioral health providers to request voluntary psychiatric hospitalization and substance use residential payment authorizations for Medicaid-eligible Individuals.

15.5.6.2. The BHO shall provide to the Federally Recognized Tribes information on how to request for voluntary payment authorization, appeals and expedited appeals. The plans must reiterate that only a psychiatrist or a doctoral level psychologist may issue a denial and that denials may only be issued by the BHO and not the crisis provider.

15.5.7. Inpatient Discharge Planning. The plan shall address procedures and protocols for coordinating discharge planning and discharge activities with Tribal behavioral health providers. The plan shall address hospitals, free-standing evaluation and treatment centers, and substance use disorder residential facilities.

15.5.8. The plan shall address a process for identifying the Tribal behavioral health provider as the liaison for inpatient coordination of care when the Individual is an identified Tribal member and has not expressed a preference regarding involvement by the Tribe in their care. This includes all liaison activities required in this Section.

16. SPECIAL PROJECTS

16.1. **Jail Coordination Services –** Are to be provided within the identified resources in *Exhibit F – Funding*.

16.1.1. The Contractor must coordinate with local law enforcement and jail personnel. This must include the development or maintenance of Memoranda of Understanding (MOU) with local county and city jails in the Contractors' Service Area.

16.1.1.1. The MOU must identify the process and procedures to be implemented when the local jails contract the placement of offenders in other jurisdictions, such as tribal jails or those in other counties. The MOU must detail a referral process for persons who are incarcerated and have been diagnosed with a mental illness or identified as in need of mental health services. It must also include a process to include services to offenders placed in an out-of-jurisdiction contract facility.

16.1.1.2. The Contractor must identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.

16.1.1.3. The Contractor must accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority groups as defined in [RCW 71.24](). The Contractor must conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.

16.1.1.4. The Contractor must develop and execute a memorandum of understanding agreement with local DSHS Community Services Offices (CSOs) for expedited application or reinstatement of medical assistance for Individuals in jails, prisons, or IMDs. The Contractor must assist Individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

16.1.1.5. Pre-release services must include:

16.1.1.5.1. Mental health screening for Individuals who display behavior consistent with a need for such screening or who have been referred by jail staff or officers of the court;

16.1.1.5.2. Mental health intake assessments for persons identified during the mental health screening as a member of the priority groups as defined in RCW 71.24;

16.1.1.5.3. Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration;

16.1.1.5.4. Other prudent pre-release (including pre-trial) case management and transition planning.

16.1.1.6. Provision of direct mental health services to Individuals in jails with no mental health staff.

16.1.1.7. Implement intensive post-release outreach to ensure best possible follow-up with the CSO and appointments for mental health and other services (e.g. substance abuse) engagement with mental health services to stabilize Individuals in the community.

16.1.2. If the Contractor has provided the jail services above the Contractor may use Jail Coordination Services funds to facilitate any of the following activities if there are sufficient resources:

16.1.2.1. Daily cross-reference between new booking and the BHO database to identify newly booked persons known to the BHO;

16.1.2.2. Development of individual alternative service plans (alternative to the jail) for submission to the courts;

16.1.2.3. Interlocal Agreements with juvenile detention facilities;

16.1.2.4. Provision of up to a seven (7) day supply of medications prescribed for the treatment of mental health symptoms following the release from jail;

16.1.2.5. Training to local law enforcement and jail services personnel.

16.2. **Expanded Community Services (ECS)** The ECS funding provided in *Exhibit F* – As applicable, funding is provided for the provision of enhanced community support services for long term State Hospital patients whose treatment needs constitute substantial barriers to community placement.

16.2.1. The Contractor must provide or maintain community residential and support services for Individuals with treatment needs that constitute substantial barriers to community placement. The Individual must no longer need an inpatient Level of Care and be determined clinically ready for discharge.

16.2.2. The Contractor must screen all new referrals for ECS using the state-developed ECS screening form. Individuals are determined to be eligible for services under ECS by the Contractor. Additional Individuals may be identified during this contract period to participate in ECS if there is capacity.

16.2.3. Prior to placement of a new ECS Individual, the Contractor must convene and participate in a team of community professionals who will become familiar with the Individual and treatment plan. This includes:

16.2.3.1. Assessment of the Individual's strengths, preferences and needs;

16.2.3.2. Arrangement of a safe, clinically-appropriate, and stable residence;

16.2.3.3. Assessment and planning for other needed medical, behavioral, and social services;

16.2.3.4. Prior to placement into the community a complete written comprehensive transition plan must be developed. The process to develop the plan must include the participation of the Individual and focus on the Individual's strengths and needs;

16.2.3.5. The Contractor must utilize the ECS transition guidelines developed by the ECS Implementation Committee or other comparable local tools to assure transition needs of ECS Individuals will be met;

16.2.3.6. The Contractor must provide for face-to-face visits to the identified ECS Individual during the last months of hospitalization. The purpose of the visits is to assess the Individual mental health needs and any other service needs.

16.2.4. The Contractor must provide the minimum number of ECS days of service listed in *Exhibit F – Funding* during this Agreement period. ECS days of service include any day an ECS Individual is living outside of a State Hospital and being supported by the BHO in community residential or other

supported living setting. ECS days of service do not include days in which an Individual is residing in a State Hospital, in jail or in a Department of Corrections facility. The Contractor will monitor Subcontractors receiving ECS funds to ensure compliance with meeting the required days of service and must make available reports to demonstrate this upon request.

16.3. **Washington Program of Assertive Treatment (WA-PACT)** – (For the initial WA-PACT participating BHOs ONLY) In accordance with the original WA-PACT Initiative, WA-PACT teams are intended as an appropriate treatment approach for Individuals with a current diagnosis of a severe and persistent mental illness who are experiencing severe symptoms and have significant impairments. These Individuals must also have demonstrated a combination of continuous high service needs and functional impairments, and have not shown to benefit significantly from other outpatient programs currently available. The Contractor must:

16.3.1. Maintain a WA-PACT team in accordance with the original WA-PACT initiative and detailed in the Washington State PACT Program Standards. The Contractor must follow the standards for full or half-teams, as identified below:

WA-PACT BHO	TEAM
North Central Washington BHO	1/2 Team
Greater Columbia BHO	One Full Team
King County BHO	Two Full Teams
North Sound BHO	One Full Team
Salish BHO	1/2 Team
Optum Pierce BHO	One Full Team
Spokane County Regional BHO	One Full Team
Thurston Mason BHO	1/2 Team

16.3.2. Require that the primary Individuals served by the WA-PACT team(s) are Individuals who demonstrate or have demonstrated a Medical Necessity for inpatient psychiatric hospitalization. In addition, priority must be given to referrals from current State Hospital Individuals who are ready for discharge and meet criteria for admission into PACT teams as delineated in the current Washington State PACT Program Standards;

16.3.3. Admit Individuals in accordance with the current Washington State PACT Program Standards to maintain the Individual's participation at a minimum monthly average of thirty-seven (37) Individuals for half teams and eighty (80) Individuals for full teams;

16.3.4. Maintain capacity for priority re-admission for discharged Individuals who need re-admission to the PACT team to maintain stability within the community. These Individuals must meet Medical Necessity requirements for this Level of Care;

16.3.4.1. In the case of emergent re-admission, the overall maximum team capacity may be exceeded.

16.3.5. Incorporate stakeholder involvement in the implementation of the WA-PACT by development of Stakeholder Advisory Groups;

16.3.5.1. The Contractor may determine whether the Stakeholder Advisory Group is included within the BHO Advisory Board or is managed by the WA-PACT provider. If the Stakeholder Advisory Group is managed by the provider, the Contractor must have a representative attend all Stakeholder Advisory Group meetings.

16.3.5.2. If the Stakeholder Advisory Group is separate from the BHO Advisory Board, the Contractor must maintain and make available to DBHR upon request membership rosters of participants on the WA-PACT Stakeholder Advisory Group. The roster must identify each Individual serving as a member, the stakeholder group represented, and the duration of their terms. The revised Washington State PACT Program Standards requires a representation of at least fifty-one percent (51%) Individual and Individual Family members.

16.3.5.3. Stakeholder Advisory Groups must meet at least quarterly throughout this Agreement.

16.3.6. Require in subcontracts for WA-PACT providers to attend and participate in DBHR-required training and technical assistance activities. Contractor must monitor WA-PACT provider attendance and maintain documentation of monitoring efforts;

16.3.7. Any exception to the staffing pattern required by the current Washington State PACT Program Standards and the Contractor's approved staffing pattern must be submitted to DBHR for prior approval;

16.3.8. The Contractor must have teams which comport with the current Washington State PACT Program Standards identified staffing patterns;

16.3.9. Non-Medicaid funds for the WA-PACT program will be provided in accordance Exhibit F – Funding. The Contractor will provide all medically necessary Medicaid WA-PACT services as described in the revised Washington State PACT Program Standards to Medicaid Individuals in the WA-PACT program;

16.3.9.1. The Contractor must submit outcome data quarterly on Individuals served by the WA-PACT teams in a format provided by DBHR. Reports must be submitted to DBHR within sixty (60) calendar days of

the end of the quarter. The Contractor must also submit to DBHR any other data or reports as required under this Agreement.

16.3.10. Performance/Fidelity.

16.3.10.1. The Contractor must cooperate with fidelity monitoring by providing to DBHR representatives, upon request, access to all BHO WA-PACT program documentation, Subcontractor facilities, BHO and Subcontractor staff, and records related to this program for review. In addition, Contractor and Subcontractor staff must facilitate and support interviews. The Contractor must be subject to corrective actions as described in the Remedial Action section of this Agreement for failure to adequately meet fidelity requirements as determined by DBHR reviews.

16.3.10.2. WA-PACT Teams must admit Individual in accordance with the Published WA-PACT Program Standards. The Contractor must maintain minimum targets of actively enrolled for WA-PACT teams as identified in the WA-PACT Fidelity Protocols. The active enrollment target must be maintained by the final day of the period in accordance with the schedule in the WA-PACT Fidelity Protocols. Failure to meet targets will subject the Contractor to corrective actions as described in the Remedial Action Section of this Agreement.

16.4. **Additional PACT** (Great Rivers BHO ONLY). **Development of a ½ PACT Team.** The BHO will receive a one-time payment in the amount of $750,000 for implementation and planning activities in the development of a ½ Program for Assertive Community Treatment (PACT) team (see *Exhibit F-1, BHO-Specific Funding*).

16.4.1. The Contractor shall designate and identify a PACT Implementation Project Director and any other key BHO personnel who will be involved in local PACT implementation planning. The director and any key staff shall be identified no later than April 15, 2016.

16.4.2. Participate regularly in statewide PACT implementation planning meetings, training, and activities coordinated by DBHR.

16.4.3. Identify and contract with a provider agency for the provision of PACT services. This process shall be in accordance with the Contractor's procurement policies.

16.4.4. Submit to DBHR by June 1, 2016, a plan for implementation of the ½ PACT team. The plan shall include:

16.4.4.1. A timeline for implementation, with a targeted service start date no later than August 1, 2016;

16.4.4.2. The location of the ½ PACT team;

16.4.4.3. Proposed budget for the ½ PACT team.

16.5. **Specific Eligibility and/or Funding Requirements for Criminal Justice Treatment Account Services.** Criminal Justice Treatment Account (CJTA) (RCW 70.96A, RCW 70.96A.055: Drug Courts, RCW 2.28.170; Drug Courts) and Drug Court funding. Drug court funding is provided to the following counties Clallam, Cowlitz, King, Kitsap, Pierce, Skagit, Spokane, and Thurston/Mason. The Contractor must ensure the provision of substance use disorder treatment and support services detailed below and in accordance with RCW 70.96A and RCW 2.28.170.

16.5.1. The BHO must coordinate with the local legislative authority for the county or counties in its regional service area in order to facilitate the planning requirement as described in RCW 70.96A.350.

16.5.1.1. The plan must:

16.5.1.1.1. Describe in detail how substance use disorder treatment and support services will be delivered within the region;

16.5.1.1.2. Address the CJTA Account Match Requirement by providing a local participation match of all DSHS-provided criminal justice awards;

16.5.1.1.3. Include details on special projects such as best practices/treatment strategies, significant underserved population(s), or regional endeavors, including the following:

16.5.1.1.3.1. Describe the project and how it will be consistent with the strategic plan;

16.5.1.1.3.2. Describe how the project will enhance treatment services for offenders;

16.5.1.1.3.3. Indicate the number of offenders who were served using innovative funds;

16.5.1.1.3.4. Detail the original goals and objectives of the project.

16.5.2. Completed plans must be submitted to DSHS for review and approval. Once approved, the Contractor must implement its plan as written.

16.5.2.1. The plan is due October 1, 2016, and subsequent plans will be submitted on a biennial basis due October 1.

16.5.3. CJTA Funding Guidelines

16.5.3.1. If CJTA funds are managed by a Drug Court, then it is eligible for a dollar-for-dollar participation match for services to Individuals who are receiving services under the supervision of a drug court.

16.5.3.2. If CJTA funds are managed in accordance with RCW 2.28.170, then the BHO is responsible for match.

16.5.3.3. No more than ten percent (10%) of the total CJTA funds may be used for the following support services combined:

16.5.3.3.1. Transportation;

16.5.3.3.2. Child Care Services.

16.5.3.4. At a minimum thirty percent (30%) of the CJTA funds for special projects that meet any or all of the following conditions:

16.5.3.4.1. An acknowledged best practice (or treatment strategy) that can be documented in published research;

16.5.3.4.2. An approach utilizing either traditional or best practice approaches to treat significant underserved population(s);

16.5.3.4.3. A regional project conducted in partnership with at least one other entity serving the service area;

16.5.3.4.4. Services eligible to be provided through CJTA funds are defined in the *SUD Services Descriptions and Service Matrix (available upon request);*

16.5.3.4.5. CJTA Special Projects. DSHS retains the right to request progress reports on CJTA special projects.

16.6. **Juvenile Drug Court.** (King County, North Sound, and Great Rivers BHOs ONLY) The Contractor must maintain a juvenile drug court (JDC) and provide the following for each participant:

16.6.1. A substance use disorder assessment. DBHR prefers the GAIN-I assessment tool;

16.6.2. Behavioral health treatment and counseling as appropriate which may include Evidence-Based Practices such as Functional Family Therapy and Aggression Replacement Training;

16.6.3. A comprehensive case management plan which is individually tailored, Culturally Competent, developmentally and gender appropriate and which includes educational goals that draws on the strengths and addresses the needs of the Individual;

16.6.4. Drug testing, scheduled and at random, to support the treatment plan and monitor compliance with the plan;

16.6.5. Tracking of attendance and completion of activities, and imposing appropriate incentives for compliance and sanctions for lack of compliance;

16.6.6. Engagement of the community to broaden the support structure and better ensure success, such as such as referrals to mentors, support groups, pro-social activities, etc.

16.7. **Assisted Outpatient Treatment – Least Restrictive Alternative Treatment**

16.7.1. The Contractor must provide specified services to persons ordered by the court to Less Restrictive Alternative (LRA) treatment who:

16.7.1.1. Are enrolled in Medicaid and meet the Access to Care Standards for BHOs; or

16.7.1.2. Are not enrolled in Medicaid and do not have other insurance to pay for services, if the BHO has adequate available resources to provide the services.

16.7.2. The Contractor must follow AOT caseload and treatment guidelines for Care Coordinators and AOT response times guidelines during and immediately following periods of hospitalization or incarceration. Guidelines must be within the DBHR-required range of guidelines.

16.7.3. LRA treatment must be administered by a provider that is certified or licensed to provide or coordinate the full scope of services required under the less restrictive alternative order and that has agreed to assume this responsibility.

16.7.4. Duration of LRA Orders. When entering an LRA order for a person eligible for up to 180 days of involuntary mental health treatment, a court may enter an order for up to one year of treatment, rather than for up to 180 days, if the Individual's previous commitment term was for inpatient treatment in a state hospital. Subsequent orders are for up to 180 days.

16.7.5. Enforcement of LRA Orders and Early Release. Facilities and agencies overseeing treatment and DMHPs are authorized to take Responsive Actions to enforce compliance with an LRA or conditional release order.

17. REMEDIAL ACTIONS

17.1. DSHS may initiate remedial action if it is determined that any of the following situations exist:

17.1.1. A problem exists that negatively impacts Individuals receiving services;

17.1.2. The Contractor has failed to perform any of the behavioral health services required in this Agreement;

17.1.3. The Contractor has failed to develop, produce, and/or deliver to DSHS any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement;

17.1.4. The Contractor has failed to perform any administrative function required under this Agreement. For the purposes of this section, “administrative function” is defined as any obligation other than the actual provision of mental health services;

17.1.5. The Contractor has failed to implement corrective action required by the State and within DSHS-prescribed timeframes.

17.2. DSHS may impose any one or more of the following remedial actions in any order:

17.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to DSHS within thirty (30) calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Agreement. DSHS may extend or reduce the time allowed for corrective action depending upon the nature of the situation;

17.2.1.1. Corrective action plans must include:

17.2.1.1.1. A brief description of the situation requiring corrective action;

17.2.1.1.2. The specific actions to be taken to remedy the situation;

17.2.1.1.3. A timetable for completion of the actions;

17.2.1.1.4. Identification of individuals responsible for implementation of the plan.

17.2.1.2. Corrective action plans are subject to approval by DSHS, which may:

17.2.1.2.1. Accept the plan as submitted;

17.2.1.2.2. Accept the plan with specified modifications;

17.2.1.2.3. Request a modified plan;

17.2.1.2.4. Reject the plan.

17.2.2. Any corrective action plan that was in place as part of a previous SMHC Agreement must be applied to this Agreement in those areas where the Contract requirements are substantially similar;

17.2.3. Withhold up to five percent (5%) of the next monthly capitation payment and each monthly capitation payment thereafter until the situation has been resolved. DSHS, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved;

17.2.4. Increase Withholdings identified above by up to an additional three percent (3%) for each successive month during which the remedial situation has not been resolved;

17.2.5. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which DSHS provides incentives;

17.2.6. Terminate for Default as described in the “DSHS and BHO Agreement on General Terms and Conditions”.

Exhibit A

Tribal Planning Checklist

This checklist is provided to assist the assigned employees in key identified positions in developing the Implementation Plan. This exercise can help identify areas that need to be improved upon.

☐ 1. Have you scheduled regular meetings with the Federally Recognized Tribes to discuss Policy 7.01 Implementation Plan and/or Progress Report? When and how often do you meet?

☐ 2. Have your Administration, Region, Division, Program, Contractors or Grantees met with the Tribes and Recognized American Indian Organizations in your area and identified issues that need to be addressed? What were the topics of the issues? What were the agreeable solutions?

☐ 3. Have you included Tribal and Recognized American Indian Organizations contacts in your information sharing, problem-solving and planning activities? Who are your contacts at the Tribe?

☐ 4. Have you notified Tribes and Recognized American Indian Organizations of funding opportunities, RFP's, available grants, or training opportunities from DSHS? What were they?

☐ 5. Do you have any special/pilot projects that include tribal participation or need to have tribal and Recognized American Indian Organizations participation? What are they?

☐ 6. Are your employees trained to address culturally sensitive issues or have access to culturally relevant resources?

☐ 7. Is your program/division able to respond to current needs of the tribes and Recognized American Indian Organizations? How is this achieved?

☐ 8. Did your program or division provide training to the Tribes and Recognized American Indian Organizations? To which Tribes and Recognized American Indian Organizations did you provide this? What kind of training was provided?

☐ 9. Was technical assistance provided to the Tribes and Recognized American Indian Organizations? If yes, in what capacity?

☐ 10. Do you have Local Area Agreements or current working agreements with the Tribes? What are they? Are they current?

☐ 11. Do you contract directly with the Tribes? What are these contracts?

☐ 12. Do you have a plan for recruiting Native American providers, contractors, or employees?

☐ 13. Did you inform and seek input from the Office of Indian Policy (OIP) when developing policies and procedures that will have a unique effect on Tribes or Recognized American Indian Organizations?

☐ 14. Do you have issues or concerns that require assistance from the Office of Indian Policy? Have you discussed these issues with OIP?

Exhibit B
BHO Transfer Protocol

1. **Purpose.** The purpose of this BHO Transfer Protocol is to establish an agreed-upon process by which Individuals can be transferred from one BHO to another to ensure:

   1.1. A seamless transition for the Individual with no more than minimal interruption of services.

   1.2. The Individual receives care that better meets his or her needs.

   1.3. The Individual has the opportunity to be closer to Family and/or other important natural supports.

   1.4. The Individual has access to Medicaid covered services.

2. **BHOs acknowledge and agree that:**

   2.1. Medicaid Enrollees are entitled to Medicaid covered services in the community where they live.

   2.2. Individuals who participate in behavioral health services have the right to freely move to the community of their choosing.

   2.3. There are circumstances when a BHO (referring BHO) wishes to place an Individual in another BHO's region (receiving BHO) to better meet the needs of that Individual, or moving to another BHO's region would allow the Individual to be closer to Family and/or other important natural supports.

   2.4. Some Individuals require specialized, non-Medicaid services to meet their needs.

   2.5. Due to the scarcity of specialized, non-Medicaid services, these may not be immediately available upon the request of the transferring Individual.

   2.6. The receiving BHO assumes immediate financial risk for crisis services and Medicaid covered services at the time of transfer.

   2.7. The referring BHO will continue the financial responsibility for "specialized non-Medicaid services" provided to the Individual for the duration of time as determined by the number of risk factors identified at the time of transfer.

Number of Risk Factors	Duration
One risk factor	6 months
Two risk factors	9 months
Three or more risk factors	12 months

2.8. After completion of the risk factor time frame, the receiving BHO will assume all financial responsibility for the Individual.

2.9. The referring BHO will retain the Individual on their State Hospital census until the Individual is discharged. The referring BHO will accept on their census any Individual placed in the receiving BHO who returns to the State Hospital during the period of financial responsibility as defined above.

2.10. This protocol is intended to ensure a seamless transition for Individuals with no more than minimal interruption of services.

3. Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol.

3.1. If a Medicaid Enrollee re-locates to a region outside of their current BHO they are entitled to an intake assessment in the new region and are then provided all medically necessary mental health services required in the Contractor's BHO Program Agreement (PIHP) contract, based on the BHO's level of care guidelines and clinical assessment.

3.2. Each BHO will establish a procedure to obtain information and records for continuity of care for Enrollees transferring between BHOs.

3.3. All Medicaid Enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the PIHP. The availability of Specialized Non-Medicaid Services cannot be the basis for determining if the Enrollee is offered an intake for services in the desired community of their choice.

3.4. There are circumstances when moving between BHOs is necessary to better meet the needs of the Individual, or moving to another BHO would allow the Individual to be closer to Family and/or other natural supports.

3.5. The receiving BHO will provide assistance to the Enrollee to update the Enrollee's residence information for Medicaid Benefits.

3.6. When an Individual is re-locating and may benefit from specialized non-Medicaid services beyond medically necessary services required in the PIHP, the BHOs agree to the following protocol:

3.6.1. The placement is to be facilitated by the joint efforts of both BHOs.

3.6.2. The referring BHO will provide all necessary clinical information along with the completed Inter-BHO transfer form.

3.6.3. The receiving BHO will acknowledge the request within three (3) business days.

3.6.4. The receiving BHO will follow established procedures for prioritizing the referred Individual and must offer an intake assessment to the Individual for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.

3.6.5. The placement may not be completed without written approval on the inter-BHO transfer form from both BHO administrators, or their designees.

3.6.6. The receiving BHO must make a placement determination within two (2) weeks of receiving all necessary information/documentation from the referring BHO. The Individual and the referring BHO will receive information regarding the placement policy of the receiving BHO for the specialized non-Medicaid service.

3.6.7. Placement will only occur when the specialized non-Medicaid service becomes available. If the specialized non-Medicaid service is not available at the time of the intended transfer, the receiving BHO will notify the referring BHO and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring BHO will keep the Individual and others involved in the Individual's care informed about the status of the transfer.

3.6.8. Payment responsibility for Individuals transferring between BHOs will be described in this protocol and specified on the inter-BHO transfer form.

3.6.9. Uniform Transfer Agreement - Eastern and Western State Hospital Inter-BHO Transfer Protocol.

3.6.10. This section describes the inter-BHO transfer process for Individuals preparing for discharge from a State Hospital, and who require specialized non-Medicaid resources.

3.6.11. Generally, Individuals are discharged back to the BHO in whose region they resided prior to their hospitalization (designated by the State Hospitals as the "BHO of responsibility").

3.6.12. For all Individuals in a State Hospital (regardless of risk factors) who intend to discharge to another BHO, an Inter-BHO transfer request is required and will be initiated by the BHO of responsibility (hereinafter referred to as the referring BHO).

3.6.13. The financial benefits section at the State Hospital will provide assistance to the Individual to update the Individual's residence information for Medicaid Benefits.

3.6.14. The placement is to be facilitated through the joint efforts of the State Hospital social work staff and the BHO liaisons of both the Referring BHO and Receiving BHO.

3.6.15. A Request for Inter-BHO Transfer form and relevant treatment and discharge information is to be supplied by the Referring BHO to the Receiving BHO via the liaisons.

3.6.16. The Referring BHO will remain the primary contact for the State Hospital social worker and the Individual until the placement is completed.

3.6.17. The Receiving BHO will supply the State Hospital social worker with options for community placement at discharge.

3.6.18. Other responsible agencies must be involved and approve the transfer plan and placement in the Receiving BHO when that agency's resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).

3.6.19. Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the Individual, State Hospital social worker or representative of the State Hospital treatment team, liaisons, the mental health care provider from the referring BHO, and other responsible agencies.

3.6.20. Once the discharge plan has been agreed upon, the Request for Inter-BHO transfer will be completed within two (2) weeks. The Receiving BHO has two (2) weeks to complete and return the form to the Referring BHO. This process binds both the Referring and Receiving BHOs to the payment obligations as detailed above.

3.6.21. If RSNs cannot come to an agreement within 7 calendar days of the Patient being identified as ready for discharge, DBHR will make the decision on behalf of the RSNs.

Exhibit C

This Exhibit C left intentionally blank.

Exhibit D

ESH and WSH Bed Allocations

Effective 4/1/2016

BHO NAME	PROPOSED BED ALLOCATIONS
North Central Washington BHO	24
Greater Columbia BHO	68
Spokane County Regional BHO	100
ESH Totals	**192**

BHO NAME	PROPOSED BED ALLOCATIONS
King County BHO	234
North Sound BHO	119
Salish BHO	33
Optum Pierce BHO	94
SW Washington FIMC (Fully Integrated Managed Care)	40
Thurston Mason BHO	34
Great Rivers BHO	33
WSH Totals	**587**

Exhibit E

Assisted Outpatient Treatment – Least Restrictive Alternative Treatment

1. Definitions.

1.1. “Assisted Outpatient Treatment” or “AOT” means an order for Less Restrictive Alternative Treatment for up to ninety days from the date of judgement. AOT must not order inpatient treatment.

1.2. "Care Coordinator" means a clinical practitioner who coordinates the activities of LRA treatment. The Care Coordinator coordinates activities with the designated mental health professionals necessary for enforcement and continuation of LRA orders and is responsible for coordinating service activities with other agencies and establishing and maintaining a therapeutic relationship with the Individual on a continuing basis.

1.3. “In Need of Assisted Outpatient Treatment (AOT)” means that a person, as a result of a mental disorder:

1.3.1. Has been committed by a court to detention for involuntary mental health treatment at least twice during the preceding 36 months; or, if currently committed, has been committed at least once during the 36 months preceding the date of initial detention of the current commitment cycle;

1.3.2. Is unlikely to voluntarily participate in AOT without an order for LRA treatment in view of the person’s treatment history or current behavior;

1.3.3. Is unlikely to survive safely in the community without supervision;

1.3.4. Is likely to benefit from LRA treatment;

1.3.5. Requires LRA treatment to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time. (Time spent in a mental health facility or in confinement as a result of a criminal conviction is excluded from 36 month calculation); and

1.3.6. When DMHP conducts investigation for likelihood of serious harm or grave disability, if DMHP determines individual is in need of AOT.

1.4. “Involuntary Outpatient Evaluation” means an evaluation conducted by any combination of licensed professionals authorized to petition for involuntary commitment under RCW 71.05.230 and that includes involvement or consultation with the agency or facility providing monitoring or services under the proposed LRA Treatment order. The evaluation must analyze the Individual’s condition and determine whether or not that condition is caused by a mental disorder and results in a

likelihood of serious harm, results in the Individual being gravely disabled, or results in the Individual being in need of assisted outpatient mental health treatment.

1.5. "LRA Treatment" means a program of individualized treatment in a less restrictive setting that includes the following services:

1.5.1. Assignment of a Care Coordinator;

1.5.2. An intake evaluation with the provider of the LRA treatment;

1.5.3. A psychiatric evaluation;

1.5.4. Medication management;

1.5.5. A schedule of regular contacts with the provider of LRA Treatment for the duration of the order;

1.5.6. A transition plan addressing access to continued services at the expiration of the order;

1.5.7. An individual crisis plan; and

1.5.8. After the first month, an evaluation to determine medical necessity for AOT.

1.5.9. LRA Treatment may additionally include requirements for an Individual to participate in the following services:

1.5.9.1. Psychotherapy;

1.5.9.2. Nursing;

1.5.9.3. Substance abuse counseling;

1.5.9.4. Residential treatment; and

1.5.9.5. Support for housing, benefits, education, and employment.

1.6. "Less Restrictive Alternative Treatment Provider" means a provider agency that is licensed by DBHR to monitor, provide/coordinate the full scope of services required for LRA Treatment, agrees to assume this responsibility, and houses the Care Coordinator.

1.7. "Peer Support Services" includes those services that serve to validate Individuals' experiences, provide guidance and encouragement to Individuals to take responsibility for and actively participate in their own recovery, and help Individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce Individuals' self-imposed stigma. Such services also include counseling and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness.

1.8. "Person-Centered Treatment Plan" is the culmination of a continuing process involving each Individual, their family and/or natural supports in the community, and the Less

Restrictive Alternative Treatment team, which individualizes service activity and intensity to meet the Individual's specific treatment, rehabilitation, and support needs. The written treatment plan documents the Individual's strengths, resources, self-determined goals, and the services necessary to help the Individual achieve them. The plan also delineates the roles and responsibilities of the team members who will work collaboratively with each Individual in carrying out the services.

1.9. "Responsive Actions" may include, but are not limited to:

1.9.1. Counseling, advising, or admonishing the person as to their rights and responsibilities under the order and offering compliance incentives;

1.9.2. Increasing the intensity of services through more frequent provider contacts, referral for assessment for assertive community services, or by other means;

1.9.3. Requesting a court hearing for review and modification of the order;

1.9.4. Causing the person to be transported by a peace officer, DMHP, or other means to the facility providing services or to another facility for up to 12 hours to determine whether modification, revocation, or commitment proceedings are appropriate. Detention is intended to occur only after a pattern of noncompliance or failure of reasonable attempts at engagement and is only permitted upon a clinical determination that temporary detention is appropriate; and

1.9.5. Initiating revocation proceedings if the Individual is on an LRA. Revocation must be based on violation of LRA orders conditions, not violations of AOT conditions.

1.10. "Service Coordination" is a process of organization and coordination within the transdisciplinary team to carry out the range of treatment, rehabilitation, and support services each Individual expects to receive per his or her written Person-Centered Treatment Plan and that are respectful of the Individual's wishes. Service coordination also includes coordination with community resources, including Consumer self-help and advocacy organizations that promote recovery.

2. **Statement of Work.** The Contractor must provide for the services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth herein.

2.1. Care Coordinator Caseload Size. The case mix must be such that the Care Coordinator can manage and have flexibility to be able to provide the intensity of services required for each Individual, according to the Medical Necessity of each Individual.

2.1.1. LRA Treatment must have the capacity to provide multiple contacts per week with Individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in a living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week, and depend on Individual need and a mutually agreed upon plan between Individuals and program staff. Many, if not all, staff must share responsibility for addressing the needs of all Individuals requiring frequent contact.

2.1.2. LRA Treatment must have the capacity to rapidly increase service intensity to an Individual when his or her status requires it or an Individual requests it.

2.1.3. Operating as a continuous treatment service, LRA Treatment must have the capability to provide comprehensive treatment, rehabilitation, and support services.

2.2. LRA Treatment must have a response contact time of no later than seven calendar days:

2.2.1. Upon commencement of the order for the Individual to receive services; or

2.2.2. Upon discharge from hospitalization and/or incarceration (whichever is later).

2.3. Services must minimally include the following:

2.3.1. Hospital Liaison Role. The RSN's hospital liaison must actively coordinate the transition of Individuals from Hospital/Evaluation and Treatment Center discharge to LRA Treatment in order to minimize gaps in care.

2.3.2. Service Coordination. Service coordination must incorporate and demonstrate basic recovery values. The Individual will have ownership of his or her own treatment, will be expected to take the primary role in Person-Centered Treatment Plan development, and will play an active role in treatment decision-making.

Each Individual will be assigned a Care Coordinator who coordinates and monitors the activities of the Individual's participation in LRA Treatment. The primary responsibilities of the Care Coordinator are to work with the Individual to write a Person-Centered Treatment Plan, provide individual supportive counseling, offer options and choices in the Person-Centered Treatment Plan, ensure immediate changes are made as the Individual's needs change, and advocate for the Individual's treatment needs, rights, and preferences. Service coordination also includes coordination with community resources, including Consumer self-help and advocacy organizations that promote recovery.

2.3.3. Crisis Assessment and Intervention. Crisis assessment and intervention must be provided 24 hours per day, seven days per week through the RSN's crisis system. Services must be coordinated with the assigned Care Coordinator. These services include telephone and face-to-face contact.

Each Individual receiving LRA Treatment must have an individualized, strengths-based crisis plan. As with the treatment planning process, the Individual will take the lead role in developing the crisis plan.

2.3.4. Medication Prescription, Administration, Monitoring and Documentation. The LRA Treatment physician or psychiatric ARNP must:

2.3.4.1. Establish a clinical relationship with each Individual.

2.3.4.2. Assess each Individual's mental illness symptoms and provide verbal and written information about mental illness. The physician or psychiatric ARNP will review that information with the Individual, and, as appropriate, with the Individual's family members or significant others.

2.3.4.3. Make an accurate diagnosis based on direct observation, available collateral information from the family and significant others and the comprehensive assessment.

2.3.4.4. In collaboration with the Individual, assess, discuss and document the Individual's mental illness symptoms and behavior in response to medication and monitor and document medication side effects. Review observations with the Individual.

2.4. Services may include the following, as determined by medical necessity:

2.4.1. Education Services. Supported education related services are for Individuals whose high school, college or vocational education could not start or was interrupted. Services include providing support to enrolling and participating in educational activities.

2.4.2. Vocational Services. These services may include work-related services to help Individuals value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers.

2.4.3. Activities of Daily Living Services. Services to support activities of daily living in community-based settings include individualized assessment, problem solving, skills training/practice, sufficient side-by-side assistance and support, modeling, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), environmental adaptations to assist to gain or use the skills required to access services, and provide direct assistance when necessary to ensure that Individuals obtain the basic necessities of daily life.

2.4.4. Social and Community Integration Skills Training. Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skill training and include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure Individuals' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support.

2.4.5. Peer Support Services. These include services to validate Individuals' experiences and to guide and encourage Individuals to take responsibility for and actively participate in their own recovery, as well as services to help Individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce Individuals' self-imposed stigma. Peer Support and Wellness Recovery Services include:

2.4.5.1. Peer counseling and support services, including those which:

2.4.5.1.1. Promote self-determination; and

2.4.5.1.2. Encourage and reinforce choice and decision-making.

2.4.5.2. Introduction and referral to Individual self-help programs and advocacy organizations that promote recovery.

2.4.5.3. “Sharing the journey” (a phrase often used to describe Individuals’ sharing of their recovery experience with other peers).

2.4.5.4. The Peer Specialist will serve as a consultant to the LRA Treatment team to support a culture of recovery in which each Individual’s point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, support, and community activities.

2.4.6. Substance Use Disorder Treatment. If clinically indicated, the Care Coordinator may refer the individual to a DBHR-licensed SUD treatment program. The Care Coordinator shall use a LRA/AOT referral form, as provided by DBHR.

Exhibit F
Funding

North Sound BHO
April 2016 – June 2017

	Per month Apr-Jun 2016	Total Apr-Jun 2016	Per month FY17	Total FY17	Total 15 Month
Non-Medicaid State	$1,458,024	$4,374,072	$1,281,948	$15,383,376	$19,757,448
Dedicated Marijuana Acct (DMA)	$74,295	$222,885	$94,216	$1,130,592	$1,353,477
Criminal Justice Tx Acct (CJTA)	$60,787	$182,361	$60,819	$729,828	$912,189
State Drug Court (CJTA)	$7,189	$21,567	$7,189	$86,268	$107,835
Jail Services	$31,897	$95,691	$31,897	$382,764	$478,455
Expanded Community Svs (ECS)	$15,625	$46,875	$15,625	$187,500	$234,375
Prog for Assertive Community Tx (PACT)	$28,958	$86,874	$28,958	$347,496	$434,370
Additional PACT	$0	$0	$0	$0	$0
ITA 180-Day Commitment Hearings	$0	$0	$0	$0	$0
Detention Decision Review	$6,003	$18,009	$6,003	$72,036	$90,045
Assisted Outpatient Treatment	$20,625	$61,875	$20,625	$247,500	$309,375
5480 - ITA Non-Medicaid	$39,726	$119,178	$39,726	$476,712	$595,890
Total	**$1,743,129**	**$5,229,387**	**$1,587,006**	**$19,044,072**	**$24,273,459**

One-time Payment	
Housing Services (HARPS)	$190,440

Quarterly Payments – Additional Housing (HARPS) Services	
April – June 2016	$75,000
July – September 2016	$75,000
October - December 2016	$75,000
January – March 2017	$75,000
April – June 2017	$75,000
Total	**$375,000**

Reserves

Operating Reserves	Inpatient Reserves
2.3%	13.3%

Exhibit F-1

North Sound BHO-Specific Funding

Funding Type	Project
1450 Funds	LRA Treatment/Assisted Outpatient
5480 Funds	Implement and Maintain a Geriatric Care Transitions Team
5480 Funds	Increase Crisis Response Capacity
MH Enhancement	Implement and Maintain a HARPs Project
SBC Funds	Operate an Evaluation and Treatment Center

Exhibit G
Additional Bed Capacity

Facility Name	City	County/BHO	# of Beds
Recovery Innovations E & T	Lakewood	Pierce / Optum BHO	**16**
Telecare	Sedro Wooley	Snohomish / North Sound BHO	**16**
Total			**32**

Exhibit H

Projected WISe Capacity Expansion

2/1/2016

BHO:	FY 2016	FY 2017			
	START OF Q4 [Apr. 2016]	START OF Q1 [Jul. 2016]	START OF Q2 [Oct. 2016]	START OF Q3 [Jan. 2017]	START OF Q4 [Apr. 2017]
North Central WA BHO	20	30	30	60	60
Great Rivers BHO	70	70	70	90	90
Greater Columbia BHO	250	250	250	300	300
King Co. BHO	200	300	400	450	450
North Sound BHO	190	250	250	290	290
Optum Pierce BHO	200	200	250	290	290
Salish BHO	70	80	80	120	120
Spokane County Regional BHO	150	150	190	250	250
Thurston-Mason BHO	150	150	150	150	150

Based on "Addendum to 'Initial Estimates of WISe Utilization at Full Implementation'", dated February 25, 2015

Exhibit I

ITA Court Cost Charge Rates

County	ITA Court Cost
Benton County	$360
Clallam County	$0
Franklin County	$430
Jefferson County	$0
Kitsap County	$0
Pierce County	$1,124
Skagit County	$950
Snohomish County	$680
Whatcom County	$439
Yakima County	$465

Information for counties not listed has not yet been received.

Exhibit J

Housing and Recovery Through Peer Services (HARPS)

(Great Rivers, Greater Columbia and North Sound BHOs ONLY)

1. **Background.**

1.1. The Adult Behavioral Health System - Making the Case for Change report (DBHR 2013) identified the intersection between behavioral health problems and homelessness.

1.1.1. Homelessness is traumatic, cyclical, and puts people at risk for Mental Health and Substance Use Disorders. Homelessness also interferes with one's ability to receive services, including services for behavioral health conditions, and jeopardizes the chances for successful Recovery.

1.1.2. Compared to DSHS clients overall, homeless children and adults were significantly more likely to have a Mental Health Disorder (50% increase for children/youth; 23% increase for adults) and three times as likely to have a Substance Use Disorder (Ford Shah, Black, and Felver, 2012a).

1.1.3. DSHS Research and Data Analysis (RDA) (Report #1490) identified that 4,720 of the 9,909 individuals exit chemical dependency residential facilities are homeless in a 12-month period following exit (48%) 516 of 1792 individuals exiting state mental health hospitals (note -this does not include E&Ts or local hospitals) are homeless within a 12-month period following exit (29%).

1.2. In the winter of 2012, DBHR was chosen by the Substance Abuse Mental Health Services Administration (SAMHSA) for a Chronic Homeless Policy Academy. The policy academy provides assistance to four states with high rates of chronic homelessness: California; Washington; Louisiana; and Georgia. Each state receives support and coaching from a faculty team, led by federal staff, with access to technical assistance and planning tools. The policy academy (also known as Housing 3000) became a subcommittee of the Interagency Council on Homelessness and developed a strategic plan to reduce chronic homelessness in Washington State. One of the strategies of the plan includes developing pilot projects for individuals exiting state hospitals and residential chemical dependency treatment agencies.

1.3. In 2013 the Legislature adopted two bills, Second Substitute Senate Bill 5732 and Engrossed Substitute House Bill 1519, which require the state to establish outcome expectations and performance measures in its purchasing of medical, behavioral, long-term care, and social support services. In 2014, the Legislature adopted 2SSB 6312 directing DSHS to integrate chemical dependency purchasing primarily with managed care contracts administered by BHOs, exempting the Criminal Justice Treatment Account, by April 1, 2016. Within funds appropriated by the legislature for this purpose, behavioral health organizations shall develop the means to serve the needs of people with mental disorders residing within the boundaries of their regional service area. Elements of the program may include:

1.3.1. Crisis diversion services;

1.3.2. Evaluation and treatment and community hospital beds;

1.3.3. Residential treatment;

1.3.4. Programs for intensive community treatment;

1.3.5. Outpatient services;

1.3.6. Peer support services;

1.3.7. Community support services;

1.3.8. Resource management services; and

1.3.9. Supported housing and supported employment services.

1.4. In the original budget for this project, three (3) supportive housing pilot projects were funded to assist individual's transition from institutional settings into permanent supportive housing, provide the basis for supportive housing services, and provide integration opportunities between substance abuse treatment services and BHOs. Each Team consists of:

1.4.1. 1 FTE MA Professional - $66,000*

1.4.2. 2 FTE Certified Peer Counselors - $36,000* each

1.4.3. 20% Benefits

1.4.4. 15% Administration

1.4.5. Total Team Costs: $190,440

*costs based on Behavioral Health Data Book 2013 Median Salaries by type - Area 1

2. Principles of Evidence-based Permanent Supportive Housing.

Permanent Supportive Housing (PSH) is decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord-tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences. PSH makes housing affordable to someone on SSI, (either through rental assistance or housing development). It provides sufficient wraparound supports to allow people with significant support needs to remain in the housing they have chosen. Dimensions of PSH EBP include:

2.1. Choice in housing and living arrangements

2.2. Functional separation of housing and services

2.3. Decent, safe, and affordable housing

2.4. Community integration and rights of tenancy

2.5. Access to housing and privacy

2.6. Flexible, voluntary, and Recovery-focused services

2.7. Even though HARPS will not require high fidelity PSH EBP, we encourage sites to become familiar with the dimensions of PSH EBP. A link to the SAMHSA PSH toolkit can be found at http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

3. HARPS Priority Populations:

3.1. Individuals who are Co-Occurring (Mental Health & Substance Abuse) who meet Access to Care Standards for BHOs, or

3.2. Individuals who experience mental health issues and who meet Access to Care Standards for BHOs, or

3.3. Individuals who experience substance abuse issues and who do not meet Access to Care Standards for BHOs

3.4. Who are released from or at risk of entering:

3.5. Psychiatric Inpatient settings, or

3.6. Substance Abuse Treatment Inpatient settings

3.7. Who are Homeless/At Risk of homelessness

3.8. Broad definition of homeless (couch surfing included)

4. Peer Services.

4.1. The HARPs program will build from the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH is designed to transform service delivery by promoting sustainable access to evidence based Permanent Supportive Housing. PORCH provides consumers with meaningful choice and control of housing and support services, utilizes Peer Housing Specialists, reduces homelessness and supports the Recovery and resiliency of individuals with serious mental illness. https://www.dshs.wa.gov/sesa/rda/research-reports/permanent-options-recovery-centered-housing.

4.2. SAMPLE Job Description: Peer Support Specialist II

4.2.1. Principal Duties and Responsibilities

Provide peer counseling and support with an emphasis on enhancing access to and retention in permanent supported housing. Draw on common experiences as a peer, to validate clients' experiences and to provide guidance and encouragement to clients to take responsibility and actively participate in their own Recovery. Serve as a mentor to clients to promote hope and empowerment. Provide education and advocacy around understanding culture-wide stigma and discrimination against people with mental illness and develop strategies to eliminate stigma and support client participation in consumer self-help programs and consumer advocacy organizations that promote Recovery. Teach symptom-management techniques and promote personal growth and development by assisting clients to cope with internal and external stresses. Coordinate services with other Mental Health and allied providers.

4.2.2. Housing

Assist clients to find and maintain a safe and affordable place to live, apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating, and procuring necessities (telephone, furniture, utility hook-up). Identify the type and location of housing with an exploration of access to natural supports and the avoidance of triggers (such as a neighborhood where drug dealing is prolific if the peer has a history of substance abuse). Provide practical help and supports, mentoring, advocacy, coordination, side-by-side individualized support, problem solving, direct assistance and supervision to help clients obtain the necessities of daily living including medical and dental health care; legal and advocacy services; financial support such as entitlements (SSI, SSDI, veterans' benefits); housing subsidies (HUD Section 8); money- management services (e.g., payee services); and transportation.

4.2.3. Employment

Assist with referrals to job training and DVR. Perform mentoring, problem solving, encouragement and support on and off the job site. Provide work-related supportive services, such as assistance securing necessary clothing and grooming supplies, wake-up calls, and transportation.

4.2.4. Activities of Daily Living Services

Provide ongoing assessment, problem solving, side-by-side services, skill teaching, support (prompts, assignments, encouragement), and environmental adaptations to assist clients with activities of daily living Assist and support clients to organize and perform household activities, including house cleaning and laundry. Assist and support clients with personal hygiene and grooming tasks. Provide nutrition education and assistance with meal

planning, grocery shopping, and food preparation. Ensure that clients have adequate financial support (help to gain employment and apply for entitlements). Teach money-management skills (budgeting and paying bills) and assist clients in accessing financial services (e.g., professional financial counseling, emergency loan services). Help clients to access reliable transportation (obtain a driver's license and car and car insurance, arrange for cabs, use public transportation, find rides). Assist and support clients to have and effectively use a personal primary care physician, dentist, and other medical specialists as required.

4.2.5. Social and Interpersonal Relationships and Leisure Time

Provide side-by-side support, coaching and encouragement to help clients socialize (going with a client to community activities, including activities offered by consumer-run peer support organizations). Assist clients to plan and carry out leisure time activities on evenings, weekends, and holidays. Organize and lead individual and group social and recreational activities to help clients structure their time, increase social experiences, and provide opportunities to practice social skills.

4.2.6. Education, Experience, and Knowledge Required

Certified Peer Counselor or complete certification within six months of employment. Good oral and written communication skills. Must have a strong commitment to the right and the ability of each person with a severe mental illness to live in normal community residences; work in market jobs; and have access to helpful, adequate, competent, and continuous supports and services. It is essential the peer specialist have skills and competence to establish supportive trusting relationships with persons with severe and persistent mental illnesses and respect for clients' rights and personal preferences in treatment is essential.

5. HARPS Housing Bridge Subsidy Guidelines.

5.1. The budget for the HARPS pilot project estimates up to 1,000 individuals total across the three sites exiting residential treatment facilities, state hospitals, E&T's, local psychiatric hospitals could receive up to 3 months of housing 'bridge' subsidy. The 'bridge' subsidy may include application fees, security deposits, utilities assistance, and rent.

5.2. Of these 1,000 individuals approximately 200 will receive supported housing services from pilot sites teams each year. This assumes that three teams will support an active caseload of 50 individuals at any one time and assumes turnover of thirty five percent (35%) per year.

5.3. Transitional housing/Bridge subsidy (Estimated at $500/per person/3 months). Allowable expenses for HARPS Housing Bridge Subsidy:

5.3.1. Monthly rent and utilities, and any combination of first and last months' rent for up to three (3) months. Rent may only be paid one month at a time, although rental arrears, pro-rated rent, and last month's may be included with the first month's payment.

5.3.2. Rental and/or utility arrears for up to three months. Rental and/or utility arrears may be paid if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit.

5.3.3. Security deposits and utility deposits for a household moving into a new unit.

5.3.4. HARPS rent assistance may be used for move-in costs including but not limited to deposits and first months' rent associated with housing, including project- or tenant-based housing.

5.3.5. Application fees, background and credit check fees for rental housing.

5.3.6. Lot rent for RV or manufactured home.

5.3.7. Costs of parking spaces when connected to a unit.

5.3.8. Landlord incentives (provided there are written policies and/or procedures explaining what constitutes landlord incentives, how they are determined, and who has approval and review responsibilities).

5.3.9. Reasonable storage costs.

5.3.10. Reasonable moving costs such as truck rental and hiring a moving company.

5.3.11. Hotel/Motel expenses for up to 30 days if unsheltered households are actively engaged in housing search and no other shelter option is available.

5.3.12. Temporary absences. If a household must be temporarily away from his or her unit, but is expected to return (e.g., participant violates conditions of their DOC supervision and is placed in confinement for 30 days or re-hospitalized), HARPS may pay for the households rent for up to 60 days. While a household is temporarily absent, he or she may continue to receive HARPS services.

5.4. HARPS Reporting. A monthly report format (see separately attached Excel Spreadsheet “HARPS Subsidy Log 2.15”) will be submitted to DBHR HARPS Program Manager or DBHR SH/SE Behavioral Health Program Administrator by the 15th of the following month through secure email or SFTP server.

5.5. Data Reporting: Encounters (codes identified in the Service Encounter Reporting Instructions (SERI) as well as an identified Program Code (See Data Dictionary) will be tracked for individuals receiving supportive housing services by the team. DBHR will work with each BHO to develop the codes or modify existing codes. Service Descriptions include:

5.5.1. Housing Stability. Includes activities for the arrangement, coordination, monitoring, and delivery of services related to meeting the housing needs of individuals exiting inpatient settings and helping them obtain housing stability. Services and activities may include developing, securing, and coordinating services including:

5.5.1.1. SSI/SSDI through SSI/SSDI Outreach, Access, and Recovery (SOAR)

5.5.1.2. Affordable Care Act activities that are specifically linked to the households stability plan;

5.5.1.3. Activities related to accessing Work Source employment services;

5.5.1.4. Monitoring and evaluating household progress;

5.5.1.5. Assuring that households' rights are protected; and

5.5.1.6. Developing an individualized housing and service plan, including a path to permanent housing stability subsequent to assistance.

5.6. Housing search and placement. Includes services or activities designed to assist households in locating, obtaining, and retaining suitable housing. Services or activities may include: tenant counseling, assisting households to understand leases, securing utilities, making moving arrangements, representative payee services concerning rent and utilities, and mediation and outreach to property owners related to locating or retaining housing.