North Central BHO

BEHAVIORAL HEALTH ORGANIZATION
DETAILED PLAN

OCTOBER 30, 2015

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Introduction

General and Overall Transition Plan – Introduction to the Detailed Plan

The North Central Behavioral Health Organization (NCBHO) will include Chelan, Douglas and Grant Counties. Chelan and Douglas Counties comprise the Chelan-Douglas Regional Service Network (CDRSN), which operates as a two-county RSN. Grant County currently is a member of the Spokane County Regional Service Network (SCRSN), but will join with Chelan-Douglas RSN to form the NCBHO effective April 1, 2016.

CDRSN is a fully functioning RSN with the operational procedures in place to manage the North Central BHO. Under the direction of Chelan, Douglas and Grant Counties, the transition to the new BHO will need to proceed steadily to promote continuity of care for all consumers/enrollees. At the same time, all federal and State of Washington requirements must be met to address the management of effective care, the financial risk associated with the SUD benefit, and the additional members from Grant County. Attention to the information technology changes and the clinical management tasks are extremely important for the transition period and smooth operations as of April 1. While it is important to recognize there is a need for additional staff beyond current capacity, the core staff of CDRSN are critical to the successful transition given their historical knowledge of managed care operations and requirements. This foundation will be helpful to Chelan, Douglas and Grant Counties.

Grant County made the decision to align with CDRSN to form a new regional alliance for the management of services for people with mental health (MH) and substance use disorders (SUD) after an invitation from and discussion with Chelan County and Douglas County Commissioners, and stakeholder review. Grant County Commissioners want to align with health plans in the region with the goal of creating a new NCBHO that addresses the unique needs of its population and programs. At the same time, CDRSN enjoys the support of its county leaders and currently has the RSN infrastructure in place. As a result, there is agreement among the three counties that CDRSN would sign the attestations and submit the Detailed Plan. Grant County is also a key provider of mental health (MH) and substance use disorder (SUD) services. Grant County Commissioners carefully considered and appointed a Director with administrative responsibilities and extensive knowledge of legislative issues for the agency. This decision was based on the need to create an appropriate firewall between the management and delivery of Grant County's BH services and to work with the CDRSN administrator on the formation of

NCBHO. CDRSN and Grant County, with some additional assistance from SCRSN, provided information for developing the Detailed Plan.

The partners (Chelan, Douglas and Grant Counties) recognize that the development of the NCBHO reflects the unique needs of each county partner requires a longer timetable than the time remaining to meet the DSHS planned start date of April 1, 2016. Thus, there is agreement that CDRSN will provide the interim infrastructure for the BHO for the targeted start date while the planning continues to form a new BHO that recognizes and integrates the strengths of each county partner while addressing the inevitable gaps in behavioral health systems of care. Toward that goal, the following activities are ongoing or under development:

- Tamara Burns, Interim CDRSN Administrator and Gail Goodwin, Director for Grant County, meet regularly to develop the Detailed Plan and will continue to lead the staff planning process. These senior managers will be referred to as the Lead Planners for the integration of Grant County, the management of MH services and the integration of SUD services under the managed care operations of NCBHO.
- The CDRSN Governing Board, Chelan, Douglas and Grant County Commissioners will convene periodic meetings to provide guidance on the development of the NCBHO, and establish its Governing Board prior to April 2016.
- The NCBHO Governing Board will provide direction for the new BHO.

The partners recognize that the initial operations of the NCBHO will be based on CDRSN operations due to the limited time to establish a new NCBHO. As it develops, the organization will reflect the needs of all three county partners. Prior to April 1, 2016, the current staff and structure will provide continuity of care for consumers/enrollees and stability for staff and providers. New staff will be necessary to cover the additional duties related to integration of SUD services as well as to address the management of services for Grant County's population, which nearly doubles the population currently served by CDRSN. Decisions about the leadership and organizational structure will be made by the newly established Governing Board, once operational. During the transition period, the County Commissioners, CDRSN Governing Board and the Lead Planners will collaborate on implementation and development, while including input from stakeholders.

Transition Planning Goals

The Lead Planners will implement the following transition goals with the guidance of the CDRSN Governing Board and the commissioners of Chelan, Douglas and Grant Counties.

- Developing a communications strategy for all levels of the managed care system: consumers/enrollees, families, providers, and counties, other stakeholders and allied systems of care, to inform them about the pending changes and assure them about continuity of care.

- All current clients and families that are currently receiving services and may be receiving services on April 1, 2016 must be identified, notified of the changes, and plans must be made to continue their care. This involves identifying: services provided, planned treatment end date, provider information, treatment location, administrative records and individual client transition plans, as needed.
    - Fortunately, CDRSN and SCRSN use the same utilization management (UM) vendor, Behavioral Healthcare Options, a subsidiary of Sierra Health Services, Inc., (and part of United HealthCare). NCBHO will contract with Behavioral Healthcare Options for UM. As a result, major changes in the UM protocol will focus on implementation of utilization criteria for SUD services consistent with the requirements of American Society for Addictions Medicine (ASAM) and DSM-5 (or ICD-10). Behavioral Healthcare Options, as an experienced managed care vendor has expertise with applying ASAM criteria and has UM staff with expertise in SUD.

- Transitioning and modifying current provider contracts held by SCRSN and CDRSN to the North Central BHO, incorporating new requirements, and transitioning current SUD provider contracts from the counties to the BHO for covered SUD services.
- Modifying the CDRSN policies and procedures to align with Grant County's policies, DSHS contract requirements and best practices in the management of SUD services. The current CDRSN policies are comprehensive and are a useful foundation on which to build the policies for the new BHO. Grant County has comprehensive provider procedures that complement the CDRSN policies. These resources, along with the policies and procedures currently in use by the Center for Alcohol and Drug Treatment will assist the Lead Planners in designing a comprehensive set of policies and procedures compliant with DSHS contract requirements for MH and SUD services.
- Implementing required Information System (IS) modifications to accommodate management of SUD providers including linkages from Grant County's system to assure accurate data transfers to the BHO and the State. Grant County will continue to use its Cerner products and CDRSN will continue to use Netsmart's Avatar program, which will have interfaces for use by Grant County to facilitate information exchange for managed care operations.
- Performing other administrative and management activities that will promote continuity for consumers/enrollees and stability for providers.

Chelan, Douglas and Grant Counties have developed a project plan that outlines all key clinical and business functions of the new BHO that will be addressed during the planning and implementation phases. There is agreement on the regional BHO functions that will be performed by the BHO and described throughout the Detailed Plan.

Regional BHO Operations	
Customer Services	Advisory Board
Compliance	Governing Board
Legal (pertaining to BHO)	Ombuds
Human Resources Management	Provider Network Management
Financial Management	Quality Improvement Oversight
Information Systems	Utilization Management
Policies and Procedures	

The areas of further review by the County Commissioners and new Governing Board include:

- Final name of the BHO. There is interest in developing a different name for the BHO.
- Reserves, rates and project funding.

BHO Organizational Structure

The detailed plan provides in Attachment 1 an interim organizational chart that addresses both a seamless transition for consumers/enrollees that will move from CDRSN and SCRSN to NCBHO on April 1, as well as the transition of consumers/enrollees with SUD whose care management will become the responsibility of NCBHO. It includes executive staff and managers of all key managed care functions.

In addition to the Governing Board, Advisory Boards and staffing, NCBHO will have several operating committees:

- A Continuous Quality Improvement Committee (QIC), inclusive of the Ombuds, the independent Quality Review Team, and other stakeholders as required by DSHS contracts, that oversees all quality initiatives of the BHO and its Behavioral Health Agencies (BHAs).
- A Compliance Committee, inclusive of information systems, service implementation, reporting requirements, and documentation requirements.
- A Provider Advisory Committee to provide input on provider operations, policies and procedures, provider training needs and network expansion.

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General and Overall Transition Plan

(160) Joint agreements of county authorities – required provisions.

The County Commissioners of Chelan, Douglas and Grant Counties are meeting in October and November to develop the Interlocal Agreement. Authorization for NCBHO as a formal organization will be addressed and the joint agreements including required provisions will be submitted by January 2016.

(161) Joint agreements of county authorities – permissive provisions.

As noted above, the County Commissioners of Chelan, Douglas and Grant Counties are meeting in October and November to develop the Interlocal Agreement. Authorization for NCBHO as a formal organization will be addressed and the joint agreements including permissive provisions will be submitted by January 2016.

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Transition and Coordination of Services Plan

Transitioning to Integrated Care

(280) Primary care and coordination of health care services

Chelan-Douglas Regional Support Network (CDRSN) and its subcontractors all participate in an allied system coordination planning. This system coordination plan is designed to formalize processes of collaboration in order to effectively serve multi-system individual consumers. The policies and procedures for allied system coordination form the basis for linkages of consumers/enrollees having MH and/or SUD conditions with primary care. A specific policy outlines coordination of care with primary care providers and emergency rooms. The Lead Partners are reviewing and will finalize the policy for the NCBHO. Thus, North Central BHO (NCBHO) will adopt these policies and procedures, which are currently under review by the Lead Planners, effective April 1, 2016.

The policies acknowledge that physical disorders can impede recovery progress and that MH and SUD disorders may complicate the ability of the consumer/enrollee to adhere to medical treatment plans. The presence of co-morbid medical conditions for people with MH and SUD also requires special focus on their specific health needs. In order to address these issues, NCBHO will foster communication and coordination of care with the consumer's Primary Care Provider and local emergency room (ER) staff.

NCBHO will provide a care manager who in cooperation with the assigned Behavioral Health Agency (BHA)[1] staff, will assist the consumer's primary care provider in developing or adjusting the consumer's treatment plan in order to effectively identify and address mental health and SUD symptoms that may complicate the consumer's recovery. NCBHO, in cooperation with the BHA staff, will collaborate with the consumer's primary care provider to exchange information relating to past, present and current treatment interventions so that all involved providers have a comprehensive case overview of the individual consumer and both BH and physical health care needs. Consumer information exchanged will include: medical history and physical, demographic information, assessments, treatment plans, progress notes, diagnosis, pharmacology, and social assessments.

[1] Behavioral Health Agency is used throughout this document for MH and SUD service providers.

The NCBHO care manager, the assigned BHA staff and primary care physician will update information when there is a change in the treatment plan or general condition of the consumer.

If the consumer does not have a current source of primary care, NCBHO, in cooperation with the assigned BHA staff will assist them by referring them to the appropriate insurance or Managed Care Organization (MCO). Assistance in completing the application will be provided if needed.

NCBHO care managers and the assigned BHA or crisis response staff will collaborate with ER staff to identify the unique reasons the consumer uses the ER. The care manager and the assigned network provider direct service staff or crisis response staff will assist the ER staff to identify resources, remove barriers and solve problems. The care manager and the BHA staff or crisis response staff will also assist the emergency room staff with the development of a treatment plan that will provide a more effective course of treatment for the consumer.

Transitioning SUD Services into Managed Care

(19) Comprehensive program of treatment.

SUD System of Care: The NCBHO system of care for SUD treatment has a full continuum of the required State Plan and ASAM levels of care. The region is fortunate to have a residential treatment facility and a withdrawal management unit within its boundaries, and outpatient treatment for youth, pregnant and parenting women and adults. While these services are available, there are challenges related to the large rural area of the region and NCBHO will need to use out-of-region providers for some services when current services reach capacity and for medical detox.

Incorporating public and private resources: The Lead Planners are in the early stages of reviewing their counties' respective strategic plans for addressing SUD conditions. They recognize the need for additional service sites, staffing and funding. Strategies to align with health system partners have been underway as demonstrated by the MOUs that CDRSN has developed with all health plans in the region. The approach to working with allied system partners articulated in CDRSN's policies and procedures and the experience of Grant Integrated Services in this area demonstrates the capacity to collaborate and leverage resources whenever possible.

SUD Challenges and Emerging Treatments: The Lead Planners and providers are in the process of cataloguing all existing evidence based practices and emerging treatments in the region to address needs. Similar to all regions, the increased and less expensive availability of heroin, the use of methamphetamine, other stimulants and marijuana benefit from specific interventions. While CDRSN has experienced some leveling off of IV use, Grant County has experienced an

increase. The need for effective interventions for methamphetamine use across the region remains a challenge. As noted in Item 273, *Delivery Network,* the need for additional outreach to engage youth and their families to address marijuana and other substance use is targeted by the Lead Planners. The goal is to expand the known therapies, such as MAT, the Matrix Model, which provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) abusers in treatment and helping them achieve abstinence, cognitive–behavioral therapy, Multidimensional Family Therapy, Functional Family Therapy, and Motivational Interviewing.

(23) Review of admission and inpatient treatment of minors – determination of medical necessity – department review – minor declines necessary treatment – at-risk youth petition – costs – public funds.

NCBHO will institute policies and procedures by April 1, 2016 for the review of the admission and the inpatient treatment of minors when minors are admitted under *RCW 70.96A.245*. This rule allows a parent to bring, or authorize another person/agent to bring, his or her minor child to a certified treatment program and request that a chemical dependency assessment be conducted by a professional person to determine whether the minor is chemically dependent and in need of inpatient treatment. The consent of the minor is not required for admission, evaluation, and treatment if the parent brings the minor to the program.

The procedures will address the requirement to review and determine medical necessity for minors admitted to SUD inpatient facilities, incorporating the following steps:

- NCBHO will request the provider to contact the crisis team inclusive of the chemical dependency professional (CDP) to participate in the review and help determine if a lower level of care would meet the youth's needs. If there is agreement that an alternative to inpatient care is available, the inpatient provider and crisis provider will facilitate the transfer to the appropriate level of care.
- If the minor is admitted to a facility under RCW 70.96A.245, a NCBHO care manager/CDP will contact the facility within five working days of the date the minor is brought to the facility to determine if inpatient services are medically necessary, which includes review of the:
  - Clinical status of the minor.
  - Clinical expertise of the treatment provider to meet the youth's needs.
  - Safety of the minor.
  - Likelihood the minor's chemical dependency recovery will deteriorate if released from inpatient treatment.
  - Wishes of the parent/guardian.
- If the NCBHO care manager/CDP, in consultation with a psychiatrist, determines it is no longer a medical necessity for the minor to receive inpatient treatment, the care manager shall immediately notify the parent/guardian and the professional person in

charge. The professional person in charge shall release the minor to the parent/guardian within twenty-four hours of receiving notice unless additional time is requested by the professional or parent/guardian for the purpose for filing an at-risk youth petition. The youth will be referred and connected to a BHA for outpatient services.

(25) Voluntary treatment of individuals with a substance use disorder.

Current provider contracts require providers to engage consumers in voluntary treatment and to voluntarily sign all treatment plans. NCBHO will also insert the following *RCW 70.96A.110* requirements into provider network contracts to address the voluntary treatment of individuals with a substance use disorder.

- An individual with a substance use disorder may apply for voluntary treatment directly to an approved treatment program. If the proposed patient is a minor or an incompetent person, he or she, a parent, a legal guardian, or other legal representative may make the application.
- Subject to rules adopted by the Secretary, the administrator in charge of an approved treatment program may determine who shall be admitted for treatment. If a person is refused admission to an approved treatment program, the administrator, subject to rules adopted by the Secretary, shall refer the person to another approved treatment program for treatment, if possible and appropriate.
- If a patient receiving inpatient care leaves an approved treatment program, he or she shall be encouraged to consent to appropriate outpatient treatment. If it appears to the administrator in charge of the treatment program that the patient is an individual with a substance use disorder who requires help, the department may arrange for assistance in obtaining supportive services and residential programs.
- If a patient leaves an approved public treatment program, with or against the advice of the administrator in charge of the program, the discharging program may make reasonable provisions for his or her transportation to another program or to his or her home. If the patient has no home, he or she should be assisted in obtaining shelter. If the patient is less than fourteen years of age or an incompetent person, the request for discharge from an inpatient program shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he or she was the original applicant.
- NCBHO will develop policies and procedures for these requirements by April 1, 2016 and will incorporate the requirements into its quality improvement program and consumer satisfaction initiatives.

(26) Treatment program and facilities – admissions – peace officer duties – protective custody.

To meet these requirements, NCBHO will:

- Develop and maintain a provider network that includes approved substance use disorder treatment facilities capable of accepting persons incapacitated or gravely disabled by alcohol or other drugs and who are in a public place or who have threatened, attempted, or inflicted physical harm on themselves, or another, and have been taken into protective custody by a peace officer or staff designated by the county.
- Ensure that providers contracted to accept individuals taken into protective custody are aware of, and have policies and procedures in place that meet, the requirements of *RCW.96A.120 (3), (4), (5), (6) and (8)*, pertaining to provision of assessment, treatment, and information and referral services as relevant to an individual's circumstances. Compliance will be facilitated through contract language and monitored by annual contract reviews (or more frequently, if warranted by grievances or critical incidents related to individuals taken into protective custody).
- Ensure that local law enforcement agencies and county-designated staff are aware of, and provided with the location and contact information for, regional substance use disorder treatment resources available to serve individuals taken into protective custody.

NCBHO will develop policies and procedures for implementing the above requirements and incorporate these into quality improvement activities.

(27) Involuntary commitment.

NCBHO will address the involuntary commitment requirements as defined in *RCW 70.96A.140* that will become effective on April 1, 2016 by updating its policies and procedures. These same requirements will be incorporated by reference into NCBHOs' sub-contracts. An outline of the involuntary commitment process for individuals SUD related to NCBHO's responsibilities is described below.

General Provision: NCBHO will have a designated chemical dependency specialist available 24 hours a day, 7 days a week to respond to requests for commitment of an individual who presents a likelihood of serious harm or is gravely disabled as a result of chemical dependency and will perform the required activities specified in *RCW 70.96A.140.* The desired outcome of any review or intervention would be to assist the individual with a voluntary referral to a program whenever possible. NCBHO will make every effort to support the recruitment and/or training of a designated specialist who can assess consumer/enrollees for both mental health and chemical dependency involuntary commitment to make the evaluation and referral process efficient.

During business hours: A CDP at a contracted provider organization will provide the assessment and review of the information, and if determined that a petition is necessary, will discuss the information with a NCBHO Care Manager to determine an appropriate level of care. If there is

no agreement about the need for a petition for commitment, a NCBHO medical director or psychiatric consultant will review the material and make a determination.

After business hours process: The response to a request for an involuntary commitment will be performed after business hours by designated CDP providers. After reviewing the information and evaluation of the facts and the reliability and credibility of the information, the CDP may prepare a petition for commitment of the individual with the superior court, district court, or in another court permitted by court rule. The CDP will also evaluate whether an alternative to commitment at a lower level of care is appropriate. If the CDP does not believe the individual meets the criteria for commitment, the CDP will meet with a NCBHO CDP care manager during the next business day. If there is agreement by the provider CDP and the NCBHO care manager that the initial needs of such person would be better served by placement within the mental health system, the person shall be referred to either a designated mental health professional or an evaluation and treatment facility as defined in *RCW 71.05.020* or *RCW 71.34.020.* If the MH needs are emergent, the CDP will contact the mobile crisis team for assistance. If there is a determination that neither a petition nor referral to a mental health professional or an evaluation and treatment facility is necessary, the CDP will make referrals to other appropriate services or resources and inform the petitioner of the outcome.

If a petition for commitment is not filed in the case of a minor, the parent, guardian, or custodian who has custody of the minor may seek review of that decision made by the designated chemical dependency specialist in superior or district court. The parent, guardian, or custodian shall file notice with the court and provide a copy of the designated chemical dependency specialist's report. If the designated chemical dependency specialist and NCBHO Care Manager (also a CDP) finds that the initial needs of the minor would be better served by placement within the mental health system, the person shall be referred to either a designated mental health professional or an evaluation and treatment facility as defined in *RCW 71.05.020* or *RCW 71.34.020*. If there is a determination that neither a petition nor referral to a mental health professional or an evaluation and treatment facility, the CDP will make referrals to other appropriate services or resources and inform the petitioner of the outcome.

Placement Considerations: Consistent with RCW language, the commitment decision must be made with 12 hours following the request. If placement in a chemical dependency program is available and deemed appropriate, the petition shall allege that: The person is chemically dependent and presents a likelihood of serious harm or is gravely disabled by alcohol or drug addiction, or that the person has twice before in the preceding twelve months been admitted for withdrawal management, sobering services, or chemical dependency treatment pursuant to *RCW 70.96A.110* or *RCW 70.96A.120*, and is in need of a more sustained treatment program, or that the person is chemically dependent and has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed. A refusal to

undergo treatment, by itself, does not constitute evidence of lack of judgment as to the need for treatment.

Prior to the petition hearing, the NCBHO CDP or the CDP designee will arrange a medical evaluation by a licensed physician. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within five days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the licensed physician's findings in support of the allegations of the petition. A physician employed by the petitioning program or the department is eligible to be the certifying physician.

Petition Hearing: The NCBHO CDP or CDP designee must provide a copy of the petition and of the notice of the hearing, including the date fixed by the court, to the person whose commitment is sought, his or her next of kin, a parent or his or her legal guardian if he or she is a minor, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified. The court will hear all relevant testimony, including, if possible, the testimony, which may be telephonic, of at least one licensed physician who has examined the person whose commitment is sought.

Follow Up: If the placement is in an inpatient level of care, NCBHO or its designee shall:

- Contact the inpatient unit within three (3) working days of admissions.
- Provide to the inpatient unit any available information regarding the individual's treatment history at the time of admission.
- Provide all available information related to payment resources and coverage.
- Participate in treatment and discharge planning with the inpatient treatment team.
- Ensure that a contracted network BHA is designated prior to discharge for Enrollees and their families seeking community support services.

General Requirements: In the event that the NCBHO designated CDP is aware that the enrollee is a tribal member or receiving SUD services from a Tribal or Urban Indian Health Program and the enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in discharge planning and transition for the enrollee. If the enrollee chooses to be served only by the Tribal Health Service, referral to a contracted network SUD is not required. For enrollees on less restrictive alternatives (LRA) who meet medical necessity and the access to care standards, NCBHO's designated BHA shall offer covered mental health services to assist with compliance with LRA requirements.

Current agreements related to these services are included in Attachment 3. NCBHO will update these agreements as necessary.

(29) Evaluation by designated chemical dependency specialist – when required – required notifications

To meet these requirements, NCBHO will develop policies and procedures and include language in SUD provider network contracts that describes the requirements *of RCW 70.96A.142* for an evaluation by a CDP. Compliance will be facilitated through contract language and monitored by annual contract reviews (or more frequently if warranted by grievances or critical incidents related to the unavailability or other issues related to CDP access).

- When a designated chemical dependency specialist is notified by a jail that a defendant or offender who was subject to a discharge review under RCW 71.05.232 is to be released to the community, the designated chemical dependency specialist shall evaluate the person within seventy-two hours of release, if the person's treatment information indicates that he or she may need chemical dependency treatment.
- When an offender is under court-ordered treatment in the community, and supervision of the department of corrections, and the treatment provider becomes aware that the person is in violation of the terms of the court order, the treatment provider shall notify the designated chemical dependency specialist of the violation and request an evaluation for purposes of revocation of the conditional release.
- When a designated chemical dependency specialist becomes aware that an offender who is under court-ordered treatment in the community, and supervision of the department of corrections, is in violation of a treatment order or a condition of supervision that relates to public safety, or the designated chemical dependency specialist detains a person under this chapter, the designated chemical dependency specialist shall notify the person's treatment provider and the department of corrections.
- When an offender who is confined in a state correctional facility, or is under supervision of the department of corrections in the community, is subject to a petition for involuntary treatment under this chapter, the petitioner shall notify the department of corrections and the department of corrections shall provide documentation of its risk assessment or other concerns to the petitioner and the court, if the department of corrections classified the offender as a high risk or high needs offender.

Nothing in this section creates a duty on any treatment provider or designated chemical dependency specialist to provide offender supervision.

(48) Criminal justice treatment account.

To address the requirements of the Criminal Justice Treatment Account (CJTA) as specified in RCW 70.96A.350, NCBHO will work with its county partners to support local panels on the development of plans for usage of the CJTA funds. Chelan, Douglas and Grant Counties already

have effective arrangements for the use of CJTA funds with local panels. The current services provided with CJTA funds include:

- Chelan/Douglas counties are using CJTA money to expand treatment capacity and timely evaluations.
  - 50-70 additional offenders will be services with CJTA funds annually, totaling about 200 clients over the 4 year period of the funds, alleviating wait lists for evaluations and treatment.
  - Treatment services for those court ordered within Grant County to treatment are provided by Grant County PARC.

Discharge Planning for Persons under Involuntary Commitment

(124) Involuntary commitment – Individualized discharge plans.

Behavioral Healthcare Options, Inc. in Nevada, the utilization management (UM) subcontractor for NCBHO, will review all inpatient admissions and, upon authorization of care, will forward daily notification of the authorization to the NCBHO care management team. Discharge information is included on the authorization information. NCBHO will forward these notifications electronically to the designated mental health professional (DMHP) or the hospital liaison and to the BHAs serving the consumer/enrollee to increase awareness of admissions and discharges.

- NCBHO will delegate Eastern State Hospital liaison services to designated providers.
  - The care managers and quality improvement will review the liaison's monthly report of discharge planning efforts to assure coordination of care.
  - NCBHO will monitor performance through reports, tracking percentage of clients seen within three (3) days of admission, seen within seven (7) days of discharge, and seen for medication within 30 days of discharge. Targeted reviews will be completed to identify the percentage of clients discharged from psychiatric hospitalization who have a crisis plan completed/updated post discharge.
  - NCBHO will host a bi-annual hospital summit training for crisis workers, hospital liaisons, and DMHPs to learn about new legislations, changes in processes/procedures, introduce new staff, and share contacts. Presentations will be made from within the group or by guest speakers.
- Each BHA will have a hospital liaison for community hospitalizations.
  - Discharge planning efforts are documented in the EMR system (includes explanation of when a clinician was not able to complete follow-up contact) in order to analyze for trends.
  - Hospital liaisons will be required to submit discharge planning reports to NCBHO upon discharge.

  - For complex cases where there are multiple hospitalizations, the NCBHO care managers will provide intensive care management to assess the appropriateness of discharge plans and the need for services/ levels of care.
- Provide all required Children's Long-term Inpatient Program (CLIP) application materials, including community and/or family CLIP placement recommendations, and ensure they are submitted to the CLIP Administration prior to the consideration of a voluntary admission referral.
- Participate through the NCBHO children's care manager in the concurrent length-of stay management as well as decisions to transfer a child or youth to another inpatient setting (CLIP or community psychiatric hospital), in accord with the CLIP policies and procedures and the most recent CLIP working agreement.
- After the CLIP admission, provide case management, which includes a range of activities by a NCBHO care manager or BHA liaison conducted in or with a CLIP facility for the direct benefit of the admitted child or youth.

The NCBHO care manager or designated BHA representative is the primary case contact for CLIP programs and is responsible for managing individual cases from pre-admission through discharge. The NCBHO care manager or designated BHA representative must participate in treatment pre-admission and review meetings, and participate and facilitate discharge planning with the CLIP treatment team and BHA.

Court-ordered Treatment for Minors

(231) Petition for one hundred eighty-day commitment – hearing – requirements – findings by court – commitment order – release – successive commitments.

NCBHO will coordinate with the Children's Long-term Inpatient Program (CLIP) administration in accordance with requirements under RCW *71.34* and the BHO contract language. A primary goal will be to amend the current policies and procedures to be consistent with the BHO functions at the regional level, as well as with the CLIP resource management guidelines and admissions procedures. NCBHO shall work with its counties to sustain a CLIP committee comprising local child serving allied partner agencies and (where possible) youth and family representation. These committees will review request for voluntary CLIP admissions. A NCBHO children's care coordinator/care manager, will be responsible for the overall management of voluntary and involuntary CLIP applications, and serve as the primary community contact for the CLIP Administration.

The NCBHO CLIP committees, facilitated by the children's care manager, will ensure the integration of all regional assessments and CLIP referral activities, including the following activities.

- Review the needs of children and youth considered for voluntary admission to CLIP.

- Consider whether appropriate less restrictive services are available to defer hospitalization.
- Provide a written response to the applicant or family indicating the reason(s) for denial, recommendations for alternatives for services, and appeal rights.

The NCBHO CLIP committees, facilitated by the children's care manager, will ensure the integration of all regional assessments and CLIP referral activities, including the following activities.

- Create and maintain a local process to assess the needs of children and youth considered for voluntary admission to CLIP and coordinate referrals to the CLIP Administration utilizing current processes for CLIP placements, pending review by the Lead Partners.
- When a person under age 18 years is considered for a CLIP commitment for 180 days, under RCW 71.34, provide an assessment of the child or youth's needs prior to an admission to the CLIP facility and share the community and /or family recommendations for CLIP.
- Provide a designee who participates in the CLIP placement team assignment of children and youth subject to court ordered involuntary treatment. All NCBHO designated participants, including the wraparound and/or child and family team, will actively participate in the timely plan-of-care development and implementation, including discharge planning.

(234) Minor's failure to adhere to outpatient conditions – deterioration of minor's functioning – transport to inpatient facility – order of apprehension and detention – revocation of alternative treatment or conditional release – hearings.

NCBHO will assign all minors released on less restrictive alternative (LRA) treatment or conditional release to BHAs and notify the associated designated mental health professional (DMHP) of the referral. If the minor was released from inpatient care on LRA or conditional release, the minor will be screened for alternative levels of care, including WISe. If eligible and enrolled in WISe, the provider will monitor the minor's status and report any deterioration.

If the minor is not eligible for WISe or the minor/family prefers another intensive outpatient service, that outpatient provider monitors the youth's LRAs. The minor's provider monitors the progress to ensure that conditions of the court order are being met and whether there is substantial deterioration in functioning.

If the provider determines that the minor is failing to adhere to the conditions of the less restrictive order/conditional release, or determines that substantial deterioration in functioning has occurred, the provider notifies the designated crisis provider for the county/geographic area. A crisis provider/ DMHP will meet with the minor if possible, and/or review the conditions

of deterioration, and determine if an order is necessary. The assessment will determine if other services or levels or care would be useful prior to the recommendation for inpatient care. If inpatient care is the best option for the minor, the DMHP will file the order of apprehension and detention and serve it to the minor. The DMHP must also notify the minor's parent/caregiver and attorney within two days. The DMHP files a petition for revocation of the LRA in the county where the LRA was ordered. If the originating county is other than the minor's home community, a motion for good cause is typically filed, which allows the transfer of the hearing to the minor's home community.

As specified in RCW *71.34.780*, the hearing occurs within seven days. If it is determined that the minor did not adhere to the LRA/conditional release, the court either orders a modification to the LRA or orders a return to inpatient care.

Transfer between BHOs

(187) Behavioral health organizations – Transfers between organizations.

Use of Uniform Transfer Agreement: NCBHO will use the uniform transfer agreement originally developed by the RSNs and any subsequent updates to govern the transfer of clients between behavioral health organizations. NCBHO will provide a seamless transition of services consistent with the PIHIP contract requirements outlined in the PIHP draft contract, Section 11, BHO Transfer Protocol.

Transfer Process for a fully integration region: NCBHO will establish work with the key BH contacts of the fully integrated managed care plans to develop a MOU and/or policy and procedures to facilitate seamless transfers.

4

Communications and Stakeholder Plan

(151) Legislative intent and policy.

NCBHO will operate under the guiding principle that all operations and services are consumer focused, holistic and humanitarian, accessible, normalizing/non-stigmatizing, responsive and effectively managed. The Lead Planners are updating the policy and procedure that emphasizes this guiding principle. Specific strategies address the inclusion of consumers and family members on its advisory board and public forums to discuss and obtain input about service needs and priorities. NCBHO will collaborate with stakeholders to obtain information, including providing outreach and assistance with transportation. Public forums will include invitations to:

- Clients (consumers);
- Client family members and advocates;
- Culturally diverse communities including clients who have limited English proficiency;
- Social service agencies;
- Organizations representing persons with a disability;
- Tribal authorities;
- Underserved groups, and
- Service providers.

While this approach has been ongoing under the direction of CDRSN and Grant County, the transition of SUD services to NCBHO will result in increased support for the involvement of people with lived experience and their families and advocates by formally aligning SUD services with the BHO. For example, The Center for Alcohol and Drug Treatment (The Center) and Grant County have staff that are in recovery and are able to establish and participate in the development of new programs. A designated staff member at The Center conducts community outreach to identify any additional community needs. There are multiple locations within The Center for individuals to suggest changes in an anonymous format. There are patient satisfaction surveys given to each individual prior to discharge. Through this wealth of information, The Center and its advisory board will contribute greatly to the enhancement of the SUD system of care by reporting its work to NCBHO. Grant County and CDRSN hosts a monthly community resource forum that provides a venue for gathering and sharing SUD and MH information, identifying community needs and resources, and networking with other providers. At the same time, having NCBHO as the PIHP will provide a regional perspective on needs through its PIHP advisory board will contribute to region-wide planning and incorporate Grant County's needs. Typical forums cut across a variety of organizations and participants.

Both CDRSN and Grant County implement client satisfaction surveys annually, which provide direct consumer feedback.

(47) Counties may create alcoholism and other drug addiction board – generally.

NCBHO will develop an Advisory Board that covers the regional area with membership invited from Chelan, Douglas and Grant Counties, and that meets the criteria specified in Exhibit F, BHO Advisory Board. Membership will be extended to persons in recovery from SUD. The Center for Alcohol and Drug Treatment will maintain its advisory board, which addresses alcohol and drug dependence service needs, because it has an active voice in the region and contributes to planning and coordination of SUD services. The NCBHO advisory board may include committees that focus on age or topic specific areas. The County Commissioners of Chelan, Douglas and Grant Counties are meeting to discuss development of the new BHO, the Interlocal agreement and the Governing Board. Once the Interlocal agreement is finalized and the Governing Board established, the by-laws of the Advisory Committee will be developed and address the DSHS contractual requirements. CDRSN's Advisory Board is currently reviewing existing by-laws to assess the changes needed to add SUD and the partnership with Grant County.

(245) Information requirements – enrollees.

The Lead Planners are in process of developing a communications plan that will provide information to consumers/enrollees, provider and allied systems of care. CDRSN's current policies emphasize extensive collaboration with allied system partners through contractual requirements that reinforce the need for continuous communication. Grant County has existing advisory committees and stakeholders that meet continuously to identify system need and plan services. These groups cover all stakeholders including consumers/enrollees with MH and/or SUD, and their families, and will be important vehicles to share information about NCBHO, the transition of Grant County from SCRSN, and the management of SUD by NCBHO. Fortunately, these stakeholders have worked together across system boundaries.

As part of their communications plan, the Lead Planners will develop a standard set of informational materials to include:

- The role of NCBHO and how this impacts current services (minimal impact), as well as the benefits available, how to access services, and information on grievances and the Ombuds program.
- A member letter that will be mailed to all current enrollees/consumers to inform them about the NCBHO and how to access services. Informational materials on access, benefits and general information will be available at provider sites and allied system offices for distribution to current and prospective consumers/enrollees.
- An updated website that will provide information similar to the current CDRSN website, including but not limited to information for consumers/enrollees on accessing services,

benefits available, a listing of providers, filing grievances and the Ombuds program. The website will include information for providers, including NCRSN policies and procedures and the provider manual, which is also under development.

- A standard presentation and set of frequently asked questions will be available and posted on the NCBHO website.

The NCBHO staff, advisory committee members (once appointed by the Governing Board) and staff will be trained on delivering the presentation and provide presentations to stakeholders, local advisory groups, committees, and allied systems. By way of example, CDRSN had a planning committee that focuses on SUD and MH gaps in services, which will be very helpful in providing information. Its members include:

- Together for Drug Free Youth,
- Community Parent Groups,
- Law Enforcement,
- Mental Health Crisis Quality Resources,
- The Assessment Center,
- Chelan County District Court,
- Canyon View Group Home,
- Wenatchee Valley College Persons in Recovery,
- Confluence Health Clinic and Hospital,
- Wenatchee Police Department,
- National Alliance for Mentally Ill,
- The Center for Alcohol and Drug Treatment,
- Chelan/Douglas Tobacco Coalition,
- Meth Action Team,
- Chelan County Prosecutors,
- Office Juvenile Justice,
- Superior Court Judges,
- Oxford Houses,
- North Central ESD,
- North Central Liquor Control Board,
- North Central EMS Trauma Care Council,
- Office of Defense Attorneys,
- Community Choice,
- Veterans,
- MH Providers,
- DSHS,
- Community Hospitals, and
- Chelan County Jail.

Communications with this type of planning committee as well as Grant Integrated Services and its subsidiary providers will help distribute information across the region.

Provider Network Communications: The inclusion of SUD services under the management of NCBHO will have a significant impact on SUD providers. Strategy sessions for orienting and training these providers on BHO functions and managed care operations will be held between January and March 31, 2016. Provider orientation and training topics will include, but not be limited to: an introduction to NCBHO; information on managed care functions and processes, how to obtain an authorization, documentation requirements, and billing requirements; and training on grievances and appeals, fraud and abuse, reporting and monitoring, and quality improvement strategies. Provider training will be held throughout the region at multiple times to accommodate all providers, including mental health providers and any new providers to NCBHO, in addition to SUD providers.

5

Network Analysis and Development Plan

(273) Delivery Network.

1. Analysis of the Delivery Network. NCBHO covers a large rural geographic area in north central Washington. The provider network addresses all the services required by the DSHS contract, either through in region or out of network providers.

a. **Written agreements:** A standard contract template will be used that addresses all DSHS contract requirements specified in the DRAFT PIHP contract, Section 8. The Lead Planners anticipate developing similar contracts for the first year of operation to promote stability among the provider community and transition of care for consumers/enrollees.

b. **Current Network Sufficiency:** The current networks of CDRSN and Grant County, combined with out-of-region providers will be sufficient to provide adequate access to all covered services including state plans services and ASAM levels of care. Out-of-network providers will also complement the network when there is a specialized need that cannot be addressed within the network. There are currently two (2) contracted SUD providers in the region. In addition, there are out-of-region providers that assist with specialty needs such as sexual deviance. Medical personnel specialties include a child psychiatrist, a general psychiatrist and a geriatric specialist ARNP as well as prescribers for Suboxone. One of the barriers to all BH services is access to transportation within the region. Preliminary analysis completed by the Lead Planners indicates the following gaps for SUD and MH services.

- **SUD Services Gaps**
  - *MAT/OST:* As previously described in Item (19), *Comprehensive program of treatment (SUD)*, there are gaps in MAT/OST within the region. NCBHO and its capitated providers must refer consumer/enrollees to providers outside the region for these services except when health care providers are willing to prescribe Suboxone or other MAT. In Chelan-Douglas, there has been a reduction in the number of consumers/enrollees who are entering outpatient treatment and have used IV within the past 30 days. Grant County has seen an increase in IV users. The majority of these consumers/enrollees who do present for treatment with IV use are being released from jails or prisons, or directly referred from intensive inpatient programs. Tailoring MAT programs to justice involved individuals is underway.
  - *Detox and Acute Detoxification:* Chelan/Douglas County has a sub-acute detox unit. There are many times a patient does not meet the criteria for the hospital and is in

need of a higher level of care than the sub-acute detox unit. Having an acute detox unit would be of benefit. Additional sub-acute and acute detox across the region are needed.

- *Dual Licensed Facility (MH & CD)*: Chelan/Douglas County does not have a provider that has both MH and CD licensure, although the Center for Alcohol and Drug Treatment is in the process of developing expertise and applying for a dual license. Catholic Family and Child Services is also submitting an application for SUD services and has hired CDP staff. Creative programs are in place but a dually licensed facility would minimize some of the referral barriers for people with co-morbid MH and SUD conditions and facilitate integrated treatment.
- *Services in Multiple Locations:* Due to the large geographic and rural nature of the region, it would be helpful to expand service sites or have mobile teams.
- *Workforce:* The rural location provides a challenge in the recruitment of staff with training in MH and SUD service provisions. There are even greater challenges in the recruitment of bilingual Spanish and Ukrainian speaking and bicultural staff.
- *Clean and sober housing:* Housing is a significant gap and would allow more support among consumers/enrollees to reduce substance use during recovery periods.
- *Jail transition:* While the region has jail transition services in place, there is a growing demand for individuals with substance use challenges.
- *Youth engagement:* While the Center for Alcohol and Drug Treatment does provide youth outreach, engagement and education, additional services for youth across the region are needed.

- **MH Services Gaps**
  - Services in multiple locations: Access to group services in some locations is limited.
  - Jail MH Services: Grant County has identified improvements in jail MH services as a need.
  - Bilingual/Bicultural Ukrainian clinical staff: While interpreters are available, there is a need for trained clinical staff in Grant County.
  - ***For both SUD and mental health,*** the Lead Planners are assessing regional gaps and preparing a Provider Network Development Plan. This plan will target the development of specific expansion needs.

c. **Anticipated Medicaid enrollment, expected utilization, provider requirements, provider capacity, and location and physical access.** NCBHO will assess the need for providers by identifying the number of Medicaid eligible children, adolescents, adults, older adults, and special populations within Chelan, Douglas and Grant counties, and comparing it to the number of Medicaid eligible consumers receiving services from current network of providers. The overall process involves estimating client needs, the available capacity, and access to culturally competent service models and levels of care required by consumers/enrollees. NCBHO will use the projected 2016 Medicaid

enrollment figures for the development of the rates to identify potential eligible enrollees and expected utilization, as well as penetration rates from previous years. To address network sufficiency and access, NCBHO will also look at its internal reports on geographic access and timeliness of services, grievance and appeals, and other quality data, as well as information from its advisory groups, CQI committee and other stakeholder information. Cultural consideration is demonstrated by diverse staff that is also bilingual in the current alcohol and other SUD population and demographics. NCBHO will include information on its website for consumers/enrollees to access a translated copy of the Washington Medicaid Mental Health Benefits Booklet's section entitled "Your Rights as a Person Receiving Medicaid Mental Health Services" in each of the DSHS-prevalent languages. NCBHO will post and require its providers to post a multilingual notice in each of the DSHS prevalent languages, which advises consumers/enrollees that information is available in other languages and how to access this information. Spanish is the most predominant non-English language in the region. NCBHO will work with its county partners and provider network to offer training that fit the needs of its Spanish-speaking residents. Interpreters will also be available.

d. **Providers who can meet the need of pregnant women with a substance use disorder.** The Center has the capability to provide services for pregnant women across their spectrum of ASAM outpatient and residential levels of care during the first trimester when pregnancies are first discovered. Otherwise, services are provided to pregnant women through out-of- network services, or through individualized treatment offered by non-specialty providers. Grant County provides outpatient treatment and services to pregnant women. The Parent-Child Assistance Program (PCAP), works with high risk mothers who are pregnant or up to 6 months post-partum when they enter the program. It is a 3 year relationship based home visitation model. Advocates provide support so critical to women who are making fundamental changes in their lives.

e. **Referrals from corrections and drug courts:** As described in response to Item (48), *Criminal justice treatment account*, NCBHO covers services that can address the needs of individuals who have either been referred through the Department of Corrections, the drug court, or identified through activities funded by the Criminal Justice Treatment Account. In addition to the CJTA funds, the provider network routinely addresses the needs of individuals involved with the criminal justice system through other funding sources, including state and federal funds and Medicaid funds when the person is not incarcerated.

2. Current Contract Provider BHA List: The table below lists current providers.

Provider	Populations Served	Level of Care
Columbia Valley Community Health	Adult and Child MH	Outpatient Services/Psychiatric Services
Children's Home Society	Children and Youth	Outpatient Services/Psychiatric Services
Catholic Family & Child Services	Adults/Children and Youth	Outpatient Services WA PACT Jail Services Crisis/Stabilization Psychiatric Services PORCH PATH Mobile Unit
The Center for Mental Health Treatment	Adults and Youth	All ASAM Levels of Care for Adults and Outpatient Services for Youth
Grant Integrated Services/Grant County Mental Healthcare	Adults and Children	Outpatient Mental Health/ Case management Crisis Services Medication/Prescription Management Co-Occurring Peer Recovery Support Wellness/Education Employment Mental Health Residential Cityview – 16 bed Assisted Living facility
Grant Integrated Services/Prevention and Recovery Center/PARC	Adults and Children	ASAM Outpatient Levels of Care Parenting Program for Pregnant Mothers Alcohol and Drug Information School DUI Assessments
Eastern State Hospital	Adults	Inpatient
CLIP	Children	Inpatient
Sacred Heart	Adults	Inpatient

(279) Documentation of adequate capacity and services.

The Lead Planners are determining the best approach to report on network sufficiency, incorporating the SUD provider network. Current capacity to develop reports exists within as demonstrated by the 2015 mental health provider adequacy report prepared by CDRSN and included in Attachment 2.

(287) Contracts with providers.

North Central BHO County Providers by ASAM Levels of Care						
	ASAM Levels of Care					
Providers	Level 1 Outpatient Services.	Level 2 Intensive Outpatient Services	Level 3.1 Clinically Managed, Low Intensity Residential Services	Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential Services	Level 3.5 Clinically Managed, Medium Intensity Residential Services	Level 3.2 WM Clinically Managed Residential Withdrawal Mgt. (Detox Services)
The Center for Alcohol and Drug Treatment	X	X (2.1, 2.5)	X		X	X
PARC	X	X				

(50) Opiate substitution treatment – program certification by department, department duties – definition of opiate substitution treatment.

Consistent with RCW *70.96A.410*, the certification of an opiate substitution treatment (OST) program requires DSHS to consult with the county legislative authorities in the area and the city legislative authority in any city in which an applicant proposes to locate a program. The applicant must address a variety of considerations such as land use, size of the population, and availability. CDRSN and Grant County fully comply with these requirements and have worked to provide these services within their respective service areas.

As defined in the PIHP contract, OST means provision of treatment services and medication management (methadone, etc.) to individuals addicted to opiates. With the advances and more recent use of medication assisted treatment therapies (MAT), as approved by the FDA for alcohol and opioid dependence, there is a broader array of medications for implementation of MAT that can be provided in a physician's office, thereby decreasing stigma.

While neither CDRSN nor Grant County have an OST program, there are medical providers who prescribe Suboxone and refer to BHAs for treatment. The current CDRSN and Grant County SUD contract language requires outpatient providers to provide treatment to clients on medication assisted therapies prescribed by their health care providers. NCBHO county partners have each worked to increase access to MAT. However, identifying physician prescribers and addressing regulatory requirements have been challenging.

(275) Out-of-network services.

NCBHO will assure the provision of services and coordination of payment for out-of-network medically necessary services, authorized through its care management process. If the BHA serving the enrollee has a full risk contract, that provider is responsible for appropriate contracting and for payment as part of the contract. When the provider has a non-risk contract, that provider will work with the NCBHO care management team to arrange for and authorize an alternative service. The services may include out-of-network services needed in connection with specialist consultations, second opinions, interpreters, or direct services that are part of the Medicaid State Plan. The provider shall document all out-of-network services provided in the medical record as well as in their payment records. Should enrollees access out-of-state crisis services, the provider may request payment for services rendered for up to two (2) hours. The provider of that service will receive payment within sixty (60) days of the receipt of the billing. However, services that exceed two (2) hours would require prior authorization by the NCBHO care management team.

NCBHO will monitor out-of-network services arranged and paid for by providers as part of its annual contract monitoring and through review of its utilization and payment records for all contracted interpreters, specialists, and others reported to have provided services on behalf of NCBHO enrollees.

(174) Behavioral Health organizations – agreements with city and county jails.

CDRSN has a contract with Catholic Family & Child Service for the provision of jail services and training of local law enforcement and jail personnel. The services include addressing and coordinating the needs of individuals with mental illness, providing transition services to expedite, facilitate and coordinate their return to the community, and conducting intakes and arranging for local community services. The contract requires the development of an MOU and also provision of some direct mental health services to individuals who are in small jails that have no mental health staff.

For jails in Grant County, Grant Integrated Services provides mental health services through a contract with SCRSN that includes similar service delivery requirements. These services will

continue across the region under contracts will NCBHO. Please refer to Attachment 3 for copies of these agreements.

(158) Children's mental health services – children's access to care standards.

The NCBHO has the target of serving 90 youth and their families monthly by 2018 as noted in the table below.

FY 2016 WISe Targets			
START OF Q1 July 2016	START OF Q2 October 2016	START OF Q3 January 2016	START OF Q4 April 2016
0	0	20	20

FY 2017 WISe Targets			
START OF Q1 July 2017	START OF Q2 October 2017	START OF Q3 January 2017	START OF Q4 April 2017
30	30	70	70

FY 2018 WISe Targets			
START OF Q1 July 2018	START OF Q2 October 2018	START OF Q3 January 2018	START OF Q4 April 2018
70	70	90	90

Implementation planning for WISe within the Chelan and Douglas Counties is underway. WISe teams are expected to be operational as of January 2016 and operated by the Children's Home Society, which currently provides a high intensity service program. The WISe team will strive to have a monthly service capacity of 20 youth and their families, a service capacity of 40 by April 2016, and a total monthly service capacity of 50 youth and families by January 2018. The WISe target start date for Grant County youth and families is January 2017, with the target monthly capacity of serving 40 youth and their families by 2018. The Lead Planners for NCBHO are reviewing implementation plans for WISe programs and determining if earlier start up for Grant County is possible.

The CDRSN and Grant County have participated in the development of Family Youth System Partner Round Table (FYSBRT) to help foster development of the WISe program and provide information to all child-serving partners that would likely identify youth and families that would benefit from these services.

6

Staffing and Workforce Analysis and Development Plan

Personnel

The Lead Planners and the County Commissioners for Chelan, Douglas and Grant Counties are meeting to develop the Interlocal Agreement, identify resources that will be necessary for the administration of the BHO and authorize its design. It should be noted that the partners' current staffing levels cannot address all the requirements of the new BHO and the incorporation of SUD service management. Consequently, with the integration of these functions within a broader region, additional resources are necessary to carry out the BHO functions. The interim organization chart includes staffing for all key managed care functions. The level of staffing has yet to be determined. Once the Interlocal Agreement is finalized (by January 2016), the organizational design will be completed.

Staff recruitment will occur between January and April 1, 2016. Ideally, all current CDRSN staff performing the various work group functions will be hired to promote continuity.

In addition to the Governing Board, advisory boards and executive management, NCBHO will have the following committees to shape its operations:

- A Management Team that meets monthly to provide oversight of all operations – Chelan Douglas RSN has a current Management Team that will be expanded to include Grant County;
- Cross Functional Management Committee to provide oversight of key initiatives and cross functional projects – Chelan Douglas RSN has a current Cross Functional management Committee that will be expanded to include Grant County;
- A Clinical Team that meets monthly to provide oversight of clinical operations – Chelan Douglas RSN has a current Clinical Team that will be expanded to include Grant County;
- A Quality Improvement Committee, co-chaired by the quality improvement manager and the clinical/medical directors, whose members include the Ombuds and other stakeholders as required by DSHS contracts;
- A Compliance Committee that addresses fraud and abuse and other compliance matters – Chelan Douglas RSN currently has a Compliance Committee that can be expanded regionally;
- A Provider Advisory Committee to provide input on provider operations, policies and procedures, provider training needs, and network expansion.

Other ad hoc committees will occur as needed. In addition, NCBHO staff will provide linkage with regional and local community stakeholder groups. It is important to note that the NCBHO Advisory Board will review and recommend policies, plans, and budgets to the Governing Board.

Training

The Lead Planners will develop the training program for NCBHO staff. These senior managers have experience with designing training plans for the previous RSN and County staff. Components of the training will focus on orientation for all basic operations, inclusive of policies and procedures, general training on all operations of the BHOS, training on areas such as, but not limited to HIPAA, use of the IT system, sexual harassment, and cultural competence, as well as specialized training based on the roles of various positions. For example, new quality management staff will have an orientation that includes the specific QM tasks and training on the policies and procedures for QM as well.

Ongoing training will include: updates on all policies and procedures, training on evidence-based practices, cultural diversity and application of best practices/evidence-based practices with diverse cultures, and training topics related to HIPAA requirements, data management and using data to manage, and DSHS contract requirements. To prepare staff and providers on the use of ASAM criteria and DSM-5 (or ICD-10) for SUD, specific training sessions will be held between January and March 1, 2016. Follow up training on ASAM and DSM-5 (or ICD-10) will occur throughout the year. Whenever feasible, NCBHO will combine training for staff and providers related to these areas. NCBHO will also fund staff to participate in external trainings that support professional certifications and licenses, and broadens their capabilities to support NCBHO operations.

Ombuds

(175) Mental health Ombuds office.

CDRSN and Grant County already share the Ombuds services contract. NCBHO will orient the Ombuds to the SUD covered services under the BHO contracts and train them as needed on the service modalities, the network providers and SUD benefits, and how to recognize signs of SUD. The training curriculum will also include a refresher of their training on grievances and appeals to be consistent with NCBHO policies and procedures as well as federal and state requirements.

It may be necessary to expand the Ombuds contract depending on the number of grievances filed by consumers/enrollees with SUD and the resultant workload. This will be assessed during the first six months of operations. Should the Ombuds require additional resources, every effort will be made to hire a person with lived experience related to SUD.

The Ombuds will coordinate work with quality improvement staff within NCBHO and with the independent quality review teams. The Ombuds will have independent decision-making responsibilities to include all investigation activities, findings, recommendations, and reports, and provide reports (maintaining confidentiality related to consumer issues) to the QIC, the NCBHO Advisory Committee, the NCBHO Governing Board, and other stakeholders. The Ombuds staff will also have direct access to senior managers, including the CEO/Administrator, should any issues arise that the Ombuds staff believe requires that level of intervention.

7

Financial and Administrative Plan

(3) Behavioral health organizations – contracting process. Provider Reimbursements that incentivize improved performance with contractually required outcomes.

NCBHO intends to capitate most of its contracts with MH and SUD providers for the delivery of services with the exception of inpatient psychiatric services rates, which will be paid directly to facilities on a per diem basis, and residential treatment, which will be handled based on whether the program is in-region or out of region. To promote continuity for the initial period of operation beginning on April 1, 2016, contracts language will likely mirror current contract requirements modifying only those items that are new requirements outlined in the DSHS contract with NCBHO. The payment method for SUD residential treatment providers who serve out of region consumers/enrollees is under discussion with the Department of Behavioral Health and Recovery (DBHR) and the current RSNs. NCBHO will use the agreed upon payment method determined when the residential provider is out of region.

The Lead Planners and CDRSN staff are in the process of analyzing the contracts to determine the most effective strategy for each provider. NCBHO intends to adopt the current language for all providers of SUD providers with the exception of negotiating rates based on the most recent rates, and any new DSHS requirements. NCBHO wants to use this approach to promote continuity of care for consumers/enrollees and stability for provider. It will also be challenging to change these contracts significantly due to the timeframes for starting up a new BHO.

SCRNS pays incentives to Grant County MH providers for meeting certain goals such as for the appropriate use of inpatient services, meeting target goals for individuals served, submission of encounter data, and meeting person-centered documentation requirements. Grant County MH providers currently are able to earn up to 1% of the contract funding for the duration of the contract. The MH provider receives a percentage for each measurement achieved that could total 1% of the service contract if all measurements are met or a portion depending on how many measurements are achieved. NCBHO and the Governing Board will review each of the contracts and make a final determination about the use of similar incentives.

(4) Incentivizing improved outcomes, integration of BH and primary care services at the clinical level, and improved care coordination for individual with complex care needs.

The contracts for April 1, 2016 will include language to foster improved client outcomes, integration of behavioral and primary care services at the clinical level, and improved care

coordination for complex cases. All three counties already have worked to improve integration of behavioral health and primary care services as demonstrated by the description of these initiatives in Item 280, *Primary care and coordination of health care services*. Most current contracts and all new contacts will require BHAs to identify the consumer/enrollee's primary care physician (PCP) at intake. If the person does not have a PCP, the provider will be required through contract language to assist the consumer/enrollee with obtaining a PCP. For consumer/enrollees with complex health care conditions, the BH provider will document coordination with the PCP and also document the person's health status as reported during the usual course of providing services and coordinate with the PCP when health issue arise. The ideal is to move towards integrated treatment plans and coordination of complex cases through joint care management between the PCP and BH providers.

During its initial year of operations, NCBHO will begin to refine its use of reimbursement methods that will further incentivize performance related to client outcomes, integrated care and care coordination. The types of incentives include: payments for coordinating care, pay for performance (outcomes); payments for achieving accreditation, higher rates for delivering evidence based practices as demonstrated by fidelity measures, and shared savings.

NCBHO will also have a role in overseeing cases with complex health care needs through its care management process, assisting BHAs when complex health conditions requires intervention beyond what the provider can offer through care coordination. The medical and clinical leaders of NCBHO will collaborate with the Apple health plans senior staff responsible in the North Central Region. CDRSN already has MOUs for collaborative care and management of complex cases in place with all the current health plans in the region.

(5) Behavioral health organizations – access to chemical dependency and mental health professionals.

NCBHO will build on the current MOUs and contracts of CDRSN and Grant County to collaborate with managed health systems and primary care practice setting, including FQHCs, to promote access to the services of chemical dependency professionals (CDPs) and mental health professionals (MHPs). A description of current strategies to promote integration of these services follows.

Chelan and Douglas Counties: In Chelan and Douglas Counties, The Center for Alcohol and Drug Treatment (The Center) is the key link to SUD services. For MH services, there are several providers that coordinate care with the health delivery system. These include Columbia Valley Community Health, Catholic Family and Child Service, and the Children's Home Society of Washington.

Grant Integrated Services including Grant Mental Healthcare and the Prevention and Recovery Center (PARC), provide access to MH and SUD services. Robust coordination and the provision of services across managed care systems and FQHCs is active across the region. NCBHO will continue to contract with its current MH and SUD services providers to provide continuity and improve access.

CDRSN: Currently CDRSN has MOU's with all MCO's in the Chelan-Douglas Area and has several ongoing initiatives.

- The Center coordinates access to SUD services in Chelan-Douglas Counties from any point of origin.
- When individuals present with high acuity chemical dependency needs at Confluence Health, (part of the Washington Hospital and Wenatchee Valley Medical Center), The Center provides assessment, referrals, and assistance with accessing the appropriate care.
- The Emergency Department refers directly to The Center to obtain withdrawal services for its patients.
- The Center provides the SUD service referrals for PACT team individuals. This includes assessment, placement, and treatment.
- The Center currently has contractual relationships with: DOC, Federal Probation, and the Children's Administration, the Juvenile Rehabilitation Administration, Canyon View Group Home, Chemical Dependency Involuntary commitments, Interagency Agreement with Catholic Family Services and a Suboxone prescribing agreement with the FQHC Columbia Valley Community Health.

Grant County: Grant County has a number of agreements through Grant Mental Healthcare, its comprehensive provider mental health and SUD provider.

- Grant Integrated Services participated in Community Health Plan of Washington's Mental Health's Integration Project. A Master's Level Therapist was located in The Moses Lake Community Health Center (Moses Lake FQHC) to perform intakes/assessments and care coordination. While this project ended in 2013, GMH is working with Moses Lake FQHC on integrating behavioral health services in their Quincy location and adding SUD services in their Moses Lake site.
- Grant Integrated Services has co-located staff in Mattawa at the Community Medical Clinic, operated by the Grant County Public Hospital District # 5. This site offers primary care, Women, Infants and Children's (WIC a DSHS Program), Parent Support and Diabetic and Asthma registry services.
- Grant Integrated Services is working with Columbia Basin Hospital in Ephrata, a public hospital operated by Grant County Public Hospital District #3, to co-locate therapist, and case managers for MH and SUD services.

- Grant Integrated Services is a member of the Columbia Basin Autism Collaborative, which is a Center of Excellence for Applied Behavioral Analysis. Samaritan Healthcare and Grant Integrated Services have begun discussions about the potential to add Applied Behavioral Therapy as a service in the community.
- Coulee Medical Center is a critical access hospital in Grand Coulee, the northern most part of Grant County. Grant Integrated Services has met several times with their CEO and leadership team on strategies to integrate behavioral healthcare and will hopefully execute an agreement soon.
- Grant Integrated Services/PARC has contracts with the Department of Corrections and Federal Probation. PARC provides CD ITAs and coordinates with the Division of Child and Family Services and DSHS for treatment services.

(37) Payment for treatment — Financial ability of patients.

To meet the requirements as specified below in *RCW 70.96A.180* regarding the financial ability of patients, NCBHO will require its providers to determine financial eligibility at the time services are requested and when services are delivered to determine Medicaid eligibility or the availability of other insurance. The provider will be required to adopt a sliding fee scale for low income non-Medicaid individuals with incomes up to 220% of the federal poverty level who do not have private insurance, and collect funds as well as bill any private insurance consistent with the following requirements.

NCBHO will have a policy and procedure, provider manual, and contract language that ensures the following protocols:

- Contracted providers shall determine financial eligibility for patients at the time they present for services, and each time services are rendered thereafter. All persons applying for services supported by public funds are screened for financial eligibility.
- Continued financial eligibility is examined each time services are rendered and documented in patient records.
- Contracted providers shall have sliding fee schedules to determining the fees for patients who do not have publicly funded benefits.
- Persons who may be eligible for publicly funded benefits shall be either referred to assistance with application for those benefits, or shall have such assistance provided.
- If any service is available free of charge from the contractor to persons who have the ability to pay, the contractor shall ensure the county (ies) is not charged for those services.
- If a contracted agency determines that the imposition of a fee on an individual will preclude the low-income eligible patient from continuing treatment, the fee requirement may be waived.

- Each contracted provider shall supply a copy of their Agency sliding fee scale to NCBHO at the time they enter into a contract.
- Financial policies and procedures, contracts, and provider manual instructions shall be written to clearly identify Medicaid as the payer of last resort.

8

Utilization Management Plan

(24) Acceptance for approved treatment.

NCBHO will subcontract with Behavioral Healthcare Options, Inc. to provide utilization management (UM) for its routine, urgent and emergent care, integrating and e expanding the current CDRSN contract to cover Grant County and incorporating SUD services' management. Behavioral Healthcare Options is a national vendor and has expertise with MH and SUD and is the same UM vendor used by Spokane County RSN for the management of Grant County services under the current arrangement. As a result, there should be minimal changes impacting continuity of care. Behavioral Healthcare Options will provide authorizations for all treatment. NCBHO will adopt the CDRSN policies and procedures for UM, expanding these to cover SUD and ensure that the contract with Behavioral Healthcare Options is not structured in such a manner so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.

Outpatient Access Process: The access process will be the same for individuals with mental health and SUD conditions. For outpatient services, the individual or family seeking services may contact a behavioral health agency (BHA) in the NCBHO network or may contact NCBHO directly for a referral to a provider. The Behavioral Health Agency (BHA) conducts a brief screening to clarify the request, determine if the individual or family has Medicaid or other insurance coverage for services, and identify any circumstances that would require an expedited assessment (e.g., health and safety issues or current discharge from inpatient services). Service authorization requests are handled electronically. All eligible individuals are offered an intake appointment. The provider schedules an intake assessment within fourteen (14) business days of the request. If the individual's situation requires an expedited response, an intake assessment will be scheduled as soon as possible, with the intent of making an authorization decision and notifying the enrollee within three (3) working days of their request for service. This timeframe may be extended up to fourteen (14) calendar days when requested by the individual. All extension requests must be documented by the provider.

For mental health services, the intake assessment is performed by a mental health professional (MHP), or reviewed by a BHA agency MHP with broad expertise in clinical care at the BHA, and documented using a NCBHO approved format, which incorporates state access to care standards (ACS) and level of care guidelines developed by CDRSN and adopted by NCBHO following review with Grant County's providers. The intake identifies information on

functioning across multiple life domains, and consumer/enrollee and family strengths. It results in a provisional diagnosis, a determination of medical necessity, a level of care determination, and documentation of fit with ACS. The MHP will send the completed request for service authorization form to Behavioral Healthcare Options for review, approval or denial. NCBHO care managers will provide UM for reauthorization of care for MH services. When the consumer/enrollee has a co-occurring MH and SUD condition, the Behavioral Healthcare Options care manager with expertise in this area will review the reauthorization request.

A similar process will be used for SUD services where the BHA relies on a chemical dependency professional (CDP), or an individual under the supervision of a CDP, or a MHP/DMHP with required credentials to provide the assessment and determine medical necessity. The CDP will use diagnostic information from DSM-5 (or ICD-10) and ASAM criteria as specified in the DSHS contracts, and also determine if the individual meets criteria for a priority population for SUD services. NCBHO will either develop a set of written level of care guidelines for SUD services that are consistent with DSM-5 (or ICD-10) and ASAM, or adopt those in process of development by a statewide RSN and DBHR workgroup. Per existing CDRSN policies and procedures that will be adopted by NCBHO, these guidelines will be developed or reviewed in collaboration with the SUD providers and will be completed by early March 2016 in order to train all clinical staff of NCBHO, Behavioral Healthcare Options and providers by April 2016.

Requests for authorization of services are entered and reviewed in the AVATAR system, using the appropriate interfaces for Grant County's Cerner products. When Behavioral Healthcare Options processes the authorization, the request will be transmitted to the provider, reflecting the status of the authorization (approved, pended or denied). Grant County providers use the Cerner Electronic Medical Record (EMR), but there is capacity within Avatar to transmit the authorization and other information in a HIPAA compliant manner that can be received by Grant County providers. BHAs will have the ability to review all pending authorizations and related communications. They will also have the capability to view all of their denied authorizations and the reasons for those denials, which will be clearly identified within that communication screen.

Authorization decisions are based on clinical review and include current Medicaid eligibility, clinical documentation in support of the most recent mental health access to care standards and level of care criteria, ASAM criteria, and diagnostic information for SUD services. Behavioral Healthcare Options will authorize or deny outpatient services within fourteen (14) days of the date the intake evaluation was initiated. Any requests by the client or the provider to extend this timeframe an additional fourteen (14) days must be documented.

Reauthorizations/Continuing Care. NCBHO will use this same process for authorization of continuing care. Any decision to deny an enrollee request for State Plan services or to provide

them in an amount, duration, or scope that is less than requested will result in a Notice of Action (NOA) to the individual. When the intake or subsequent assessments do not support medical necessity and ACS or ASAM criteria, a NOA will be sent to the individual. Failure to make an authorization decision within required timeframes will also result in Notice of Action to the enrollee. Any denials will be made by a MHP or CDP with appropriate clinical expertise. Complex cases and inpatient treatment denials will be reviewed by the NCBHO medical director or Behavioral Healthcare Options physicians, depending on circumstances of each case. The NOA will be sent to the enrollee, BHA and NCBHO in letter form after concluding a denial for services or if services are limited.

Initial Inpatient Authorizations: For all MH and SUD inpatient authorizations, the admitting hospital must request the initial authorization following a determination by the local crisis provider. The designated mental health professional (DMHP) calls Behavioral Healthcare Options at the time of admissions to voluntary or involuntary inpatient treatment to inform Behavioral Healthcare Options of the referral. The crisis service provider must evaluate the individual's needs, determine that a less restrictive intervention is not available or appropriate, and confirm that services on an inpatient basis are medically necessary. Then, the crisis provider assists the client with securing admission to an appropriate facility and provides the facility with the justification for admission. The facility will need this information in order to obtain authorization from Behavioral Healthcare Options and must provide the information on medical necessity, diagnosis, and approval by the professional in charge of the hospital or unit. Denials for inpatient care can only be made by Behavioral Healthcare Options and only by a physician. If an individual does not meet medical necessity criteria, presents directly to a hospital and requests admission, and the hospital were to request an authorization without coordinating less restrictive options with crisis services, Behavioral Healthcare Options may deny the authorization request. Behavioral Healthcare Options handles all required notices for those denials in accordance with NCBHO policies and procedures. If there is a request for an expedited review, NCBHO will process all inpatient authorizations in accordance with the DBHR publication Community Psychiatric Inpatient Instructions. Behavioral Healthcare Options must respond to all requests for authorization within two (2) hours and make a determination within 12 hours.

Continuing Stay Inpatient Authorizations: Behavioral Healthcare Options care managers will reauthorize medically necessary inpatient care for mental health and SUD treatment and oversee the discharge planning process to assure that appropriate provider follow-up occurs. This is specifically delegated via contract language and will be monitored by NCBHO. It also follows the permitted method described in the DBHR sample BHO contract. NCBHO care managers handle transfers that are needed and consult with the provider hospital liaison regarding resources. The same protocols described above will be followed for denials, notices of action, and expedited reviews.

Initial and Continued Stay SUD Residential Treatment Placement Authorizations: Behavioral Healthcare Options will review and authorize all SUD residential treatment placements utilizing the DSM-5 (or ICD-10) and ASAM criteria following the same processes described for outpatient care and the SUD access standards under development.

Ongoing Review of Authorization Decisions: To promote inter-rater reliability for care authorization decisions, Behavioral Healthcare Options will use training and review of care management records to determine whether there is consistent application of criteria. Clinical supervisors will review a selection of care management records periodically. Training of care managers on inter-rater reliability using sample cases will occur as part of orientation and training. The NCBHO Quality Review Manager will monitor these activities through ongoing and annual review of contract performance. NCBHO will review UM reports through its Quality Improvement Committee to address under- and over-utilization of services as well as to identify service gaps. NCBHO has access to a psychiatrist with board certification in addictions treatment as a physician advisor to consult on SUD treatment issues and will hire at least one care manager with certification as a CDP during the first year of operation.

Access to Care for Non Medicaid Individuals: NCBHO will use the same intake and authorization process for Medicaid eligible and state and/or federally funded individuals. Management of the non-Medicaid funding and services will focus on the priority populations identified by DBHR listed below that are not eligible for Medicaid, do not have an income more than 220% of federal poverty level, other insurance, or cannot meet co-pays or deductibles for the services.

- Highest priority group: pregnant women who use IV drugs, pregnant women, others using IV drugs, and post-partum women (up to one year).
- Second highest priority group: Parents/legal guardians involved with child protective services; parenting adults; and youth.
- The timeliness standards for treatment include:
  - Pregnant/Intravenous Drug Users – Seen within 2 days of request for services
  - Pregnant Women – Seen within 2 days of request for services
  - Intravenous Drug Users – admitted within 14 days of request for services
  - Post-partum and Parenting Persons – admitted within 90 days of request for service.

Specific criteria to measure the severity of each substance use condition will be assessed using the diagnostic information and ASAM criteria. Those with the most severe symptoms will receive treatment as available. Once the written SUD access to care guidelines are prepared by the DBHR committee and subsequently adopted by NCBHO, these guidelines will be used to make authorization decisions. (CDRSN is participating in the DBHR access to care committee for SUD and will provide training to staff and providers once these standards are complete.) When

services are not available to non-Medicaid eligible individuals or to others meeting the priority population criteria, referrals to twelve step programs and other community resources will be made.

NCBHO will train all new mental health providers and all SUD providers on its policies and procedures between January 1 and March 31, 2016 and will outline these requirements in the provider manual under preparation.

(284) Authorization of services.

As described above, NCBHO will subcontract with Behavioral Healthcare Options, Inc. for its authorizations of routine, urgent and emergent care management/utilization management activities. Behavioral Healthcare Options currently performs UM for CDRSN and Grant County via SCRSN. The plan is to continue using Behavioral Healthcare Options for UM decisions.

While the SUD utilization management process will mirror the UM system for mental health, it will be expressly tailored to the management of SUD services by having CDPs and other licensed staff are involved in the assessment and determination of medical necessity, and that a psychiatrist board certified in addictions medicine is available to consult t on individual cases. As discussed in *Item (4), Adult Behavioral Health System – Improvement Strategy*, medical necessity will be based on diagnostic information using DSM-5 (or ICD-10) and ASAM criteria. NCBHO intends to adopt the access to care standards currently under development by DBHR and the RSNs. If these guidelines are delayed, NCBHO will work with its clinical team and SUD providers to develop level of care guidelines that will also include the input of individuals in recovery.

9

Quality Assurance Plan

(292) Quality assessment and performance improvement program.

Plan for Quality Assessment and Performance Improvement for SUD Treatment

Performance Improvement is at the core of ensuring that addiction, like other chronic treatable conditions, is treated appropriately and within acceptable standards of care and evidence-based practices. This can be challenging as substance use often goes unrecognized in many health care settings. The purpose of a Performance Improvement program within a managed care context must encompass areas related to prevention, recognition, treatment and maintenance, all within an ASAM based, trauma informed framework to fully address the continuum of needs for individuals with SUD disorders. The Continuous Quality Improvement (CQI) approach described below consists of eight (8) different dimensions, each representing a level and/or core philosophical component to care. This continuum will be considered as the NCBHO CQI team learns about the strengths and challenges of the SUD providers and systems of care within its region through: the daily interactions of care management, provider relations and quality improvement staff; data summarizing grievances and appeals, consumer and provider satisfaction surveys; credentialing activities; on-site reviews; training activities; and other stakeholder feedback. Utilizing information already known by the counties and DBHR, NCBHO will focus on enhancing the quality of SUD providers through a collaborative QI focus. While the following measures represent these areas and form the foundation of NCBHO SUD CQI program, along with DSHS required measures,[2] targeted approaches and specific priorities will be identified annually through the QI process and QI Committee, incorporating the input of consumers and other stakeholders. The approach will focus on targeting specific measures over time as NCBHO and providers collaborate on the CQI process.

- *Prevention/Education:* The goal for a managed care approach is for providers to raise the awareness of its consumers in relation to the potentially harmful effects of substance use. Measures will focus on the percentage of consumers who are given information or advised about substance use in their initial session with a provider. Prevention/education should also include the family members/significant others of consumers with SUD as they are at higher risk for such disorders, especially children. Toxicology screens may also be of use here to help determine who should move into recognition/brief intervention.

[2] DSHS required measures include SUD penetration and SUD retention.

- *Recognition/Brief Intervention:* This area looks at the effectiveness of NCBHO's providers in conducting alcohol/drug screening and then providing brief interventions intended to help enhance the enrollee's motivation to change and agree to an appropriate referral follow-up. To help ensure there is appropriate recognition of clients, NCBHO can look at the number of individuals referred into treatment who have substance abuse or dependence diagnoses on an annual basis and compare this to local and/or national averages.
- *Inpatient Withdrawal Management (Alcohol and Drug Detoxification):* This section is defined by services required for the care and/or treatment of individuals intoxicated or incapacitated by alcohol or other drugs while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Key performance indicators will focus on the percentage of clients who connect with appropriate chemical dependency service providers within 7 days post discharge. Documentation reviews will examine utilization of the stages of change and if clinical interventions are consistent with these stages.
- *Treatment:* This domain looks at the type of interventions provided to consumers in the treatment of substance use disorders. Interventions will include medications, counseling, skill building, etc., for each episode of care. It should be noted that detox and/or emergency rooms should be viewed as the potential for initiation of treatment, but unto themselves do not constitute treatment. The same is true for 12 step programs. QI measures will include the following:
  - **Established medical necessity:** A covered diagnosis based on the DSM-5 (or ICD-10) that meets ASAM criteria for SUD services.
  - **Initiation of SUD Services:** Percentage of individuals with an index diagnosis of abuse or dependence who receive any additional services within 14 days.
  - **Treatment Engagement:** Percentage of clients diagnosed with SUD disorders that receive three plan-provided services within 30 days of the initiation of care. The length of stay is enormously important as length of stay relates directly to reductions in substance use and post-treatment employment status. Engagement in treatment also is important to the reduction of risk for drug-related illnesses. Other areas that could be explored include co-occurring mental health and addictive disorders, a treatment measure on the use of laboratory tests and treatment for pregnant women.
  - **Individual Clinical Measures:** As required by contract, periodic reviews of all providers will be conducted and will address items in Section 9.2 of the PIHP contract. These will include clinical chart reviews that will examine documentation around key aspects of treatment. To this end, percentages will be established to determine how often (a) goals identified in the Individual Service Plan have been met, have been discontinued, or have continued need; (b) the use of evidence-based and other identified SUD practice guidelines; and (c) the use of discharge planning

guidelines, coordinated with ASAM levels of care; and (d) other clinical measures as identified and prioritized through the QIC.

- *Interventions for family members/significant others of SUD clients in treatment:* This domain looks at the percentage of consumers who report using SUD services while their family/significant other receives concurrent preventative interventions, including psychoeducation. This domain is important for children of parents with serious substance use disorders as these children have significantly higher rates of use in adulthood.
- *Recovery Support:* This domain reviews the percentage of patients who report receiving a specific service by the provider to promote and sustain positive treatment outcomes post discharge. This could be in conjunction with 12 step programs, peer support, and/or life style changes, and similar measures. It should be noted this domain correlates directly to the issue of medical necessity as many managed care companies cease payment when a client reports three months clean and sober. This is unfortunately a highly problematic policy, as cutting clients off from treatment after 90 days is shortsighted. Within this model, six months is viewed as a more viable timeframe, dependent upon the severity of the disorder. Toxicology screens should also be used.
- *Level of Care authorized for SUD treatment services based on ASAM PPC in comparison to treatment services provided.* This domain looks at the percentage of clients maintained in the correct level of care according to ASAM and documentation of connection with new providers within 7 days of discharge from any ASAM level of care. This domain can be connected to the ongoing process to assist eligible clients to gain access to and effectively use necessary health and related social services.
- *Trauma Informed Care:* Ensuring care is trauma informed and sensitive to clients is of enormous importance. Areas that will be measured include: (a) consumer engagement and satisfaction surveys, (b) utilization of "mystery shoppers" to assess care delivery, such as a friendly greeting to consumers, admission experience, and (3) use of peer specialists and staff training in customer service.
- *Quality Review and Remediation of Deficiencies:* Quality reviews begin with ensuring effective communication with contracted agency leadership, their boards of directors, personnel and staff, and most importantly, consumers. On a regular basis, SUD providers will be required to submit data consistent with the items above. Results will be posted allowing for provider comparison and informed decision-making on behalf of plan consumers. If deficiencies are identified, the agency will be required to submit a root-cause analysis and action plan which addresses each area specifically with a timeline for their correction. If a SUD provider requires technical assistance in conducting root-cause analysis and developing an action plan, NCBHO will provide technical assistance on such strategies. Once completed by the SUD provider, all action plans will be reviewed and approved by NCBHO and monitored throughout the year to

ensure agency implementation and progress. To supplement this, the QI team may also conduct on-site visits as well as routine visits in collaboration with DSHS or the Office of the Auditor. While in most cases, SUD treatment agencies will remediate quality concerns, in some cases, more stringent measures may need to take place. If there is a health and safety concern, NCBHO will oversee immediate action to eliminate the health and safety risk of the consumer. Within this broad context, enforcement options will include:

- Require a face-to-face meeting with SUD provider leadership, including boards of directors, and a follow-up corrective action plan.
- Freeze referrals to the agency.
- Terminate the contract.

NCBHO Quality Improvement Structure

Using these domains, NCBHO will utilize its Quality Improvement Plan (QIP) and its QIC to provide the overall structure for evaluation of the quality of SUD treatment over time. The CQI program will include regionalized oversight of CQI, under the auspices of the medical director, the clinical director and the quality improvement manager. The Lead Planners and the NCBHO Governing Board will be determining the final organization of and number of CQI staff.

Continuous Quality Improvement Committee (QIC Meetings)

The NCBHO Quality Improvement Committee (QIC), will be formed by April 2016 and include representatives from the Governing Board, Advisory Board, Ombuds, local Tribes, providers, and client and family advocates. Meetings will be facilitated by the CQI Manager and may also be co-facilitated by a QIC member selected by the QIC. The Clinical Director and/or Medical Director will also attend the meeting.

The QIC oversees the CQI Plan by reviewing all quality management and improvement activities and assuring they remain appropriately focused and cohesive, and cover all age groups and conditions served by NCBHO. After review and discussion, recommendations from the QIC are either forwarded to the Governing Board or returned by QIC to the Clinical Directors Committee for further review.

The responsibilities of the QIC include:

- Developing and approving the QI Plan;
- Reviewing and evaluating available data to prioritize needs for system improvements;
- Recommending areas for further review and/or improvement including system, program and/or policy changes;
- Identifying, developing, and reviewing quality management and improvement activities;

- Discussing standards of practice and use of effective and efficient best practice models of care;
- Identifying potential trainings and education needs; and
- Reporting on quality management and improvement activities, results, and/or recommendations to the Governing Board through the CQI Manager and QIC minutes.

NCBHO will develop the Quality Improvement Plan.

QI Review Team

NCBHO will have an independent quality review team that includes current consumers, past consumers and family members to offer an independence quality review to assess its and provider performance. Currently, CDRSN has a QRT and recently contracted with Aging & Adult Care to facilitate this inclusive team. This current team contract will likely continue under the auspices of NCBHO to promote continuity, pending review of the Lead Partners. The work of the QI Review Team(s) will focus on how well NCBHO is implementing its mission and values as a BHO. These values incorporate the requirements outlined in WAC 388-865-0282, emphasizing outcomes of care and the degree to which the services provided emphasize recovery and resiliency, promote cross communications within the service delivery systems, and facilitate community based services and integration, among others. The Review Team will also interview consumers using a standard interview protocol and work with interested consumers, service providers and others to solve identified problems. The CQI Manager will have primary responsibility for assuring the establishment, support of, and operations of the QI Review Team(s) in collaboration and provide training on confidentiality and the operations of the team.

(274) Second opinion.

As part of enrollees' rights to be actively involved in decisions about their mental health and SUD treatment, they are able to exercise the right to a second opinion. The enrollee can make a verbal request for a second opinion to their behavioral health agency (mental health and SUD providers) directly. The enrollee may also contact one of the NCBHO Ombuds for assistance in working with the provider to obtain a second opinion. The clinical staff that receives the request will let the enrollee know that they are taking steps to help the person get a second opinion and also inform the clinical director (or equivalent position) of the request. The clinical director will be responsible for arranging the second opinion or delegating this to a supervisor. The person arranging the second opinion may ask for additional information to clarify the concern and the request, which may include meeting with the enrollee. The clinical director or supervisor handling the request will be responsible for tracking the second opinion request, which includes documentation in the chart and documentation to NCBHO on the client referral form in the Avatar system (within three [3] days of the request). Grant Integrated Services will

use the Cerner system to document its grievances and submit the information to NCBHO through an electronic interface developed by AVATAR.

The BHA contractor will provide, upon request, a second opinion from a BHA within the service area. If an additional provider is not currently available within the network, the contractor must provide or pay for a second opinion provided by a BHA outside the network at no cost to the enrollee. The BHA providing the second opinion must be currently contracted with a BHO to provide mental health and SUD services to enrollees. The appointment for a second opinion must occur within thirty (30) days of the request. The enrollee may request to postpone the second opinion to a date later than thirty (30) days. The provision of a second opinion may include a review of the clinical record and, as needed, an interview with the enrollee. (Note: a request to change a mental health care provider is not considered a request for a second opinion and can be responded to in accord with guidelines for this.)

(277) Timely Access.

NCBHO is preparing contract language that will require its BHAs to meet state standards for timely access to care and services, taking into account the urgency of need for services. The BHO is in the process of updating the policies and procedures for timely access to include the following standards.

- Ensure that the network BHAs offer hours of operations for enrollees that are no less than the hours of operation offered to commercial clients or comparable to Medicaid fee for services requirements.
- Make services available twenty four (24) hours a day, seven (7) days a week, when medically necessary.
- Establish data-driven strategies to regularly monitor and ensure compliance by BHAs.
- Takes corrective action if there is failure to comply.

Under the direction of the quality management program, NCBHO will monitor compliance with these requirements, as follows:

- Monitor the percentage of intakes completed within 14 days of request for service for NCBHO as a whole and each of its providers individually to monitor for timely access to an assessment from the initial request for services.
- Monitor the percentage of clients who receive a routine service within 28 days of request for service for NCBHO as a whole and each of its providers individually to monitor for timely access to routine services.
- Monitor data monthly on crisis response times for urgent and emergent cases to assure standards are being met.

The quality improvement manager or designee reviews access times on a monthly basis. Systemic issues are viewed quarterly by the Quality Improvement Committee (QIC). This includes time from request for service to intake, and time from intake to first offered services and actually scheduled follow-up appointment. BHAs will be required to supply additional information around cases outside the standards.

(290) Sub-contractual relationships and delegation.

NCBHO understands that a subcontract does not terminate its responsibility to perform the requirements specified in DHSH contracts. NCBHO will not delegate its responsibility to contract with and manage its provider network, understanding that this does not prohibit a network provider from subcontracting with other appropriately licensed provider(s), so long as the sub-contracting provisions of the DSHS contract are met. Subcontracts will include the nature of the work, specific duties, contact information, the compensation arrangement, the monitoring plan, and language on revocation and sanctions. NCBHO will also provide DBHR with information on subcontracts once executed for the new BHO operations. For NCBHO's approach to contracting with providers, please refer to Line Item (3), *Behavioral health organizations – contracting process*.

NCBHO intends to continue the following subcontracts based on satisfactory performance:

Utilization Management: Behavioral Healthcare Options, Inc. will continue to provide utilization management (UM) functions. Behavioral Healthcare Options is the current UM subcontractor for CHDRSN and Spokane County RSN, which currently performs UM for Grant County's consumers/enrollees. Behavioral Healthcare Options has expertise with provision of UM services for SUD and will have appropriately credentialed staff for both MH and SUD services.

Delegation of Some Grievance Functions: NCBHO will delegate portions of the grievance process to its subcontracted providers. Consumers/enrollees may file a grievance at the provider level or at the BHO level. NCBHO will ensure that network providers have a process in place for reporting, tracking, and resolving customer expressions of dissatisfaction (i.e. grievances). NCBHO will monitor and report grievances documented at the provider level, as well as those documented in the Ombuds records. NCBHO will also monitor the frequency and type of enrollee grievances to ensure that systematic issues are appropriately addressed. NCBHO will conduct annual cross system surveys to assess satisfaction with service coordination and identify service gaps.

Due Diligence: Before any delegation, NCBHO evaluates the prospective subcontractor's ability to perform the activities to be delegated. NCBHO:

- Will conduct all appropriate due diligence activities including (as appropriate) the examination of the financial viability of the entity through financial and annual reports; staff professional credentials; affiliation with professional credentialing entities; policies and procedures and references.
- Has a written agreement that specifies the activities delegated to the subcontractor and provides for the revocation or imposition of sanctions should the subcontractor fail to perform.

Subcontractor Agreement to Participate in Allied Systems Coordination: All subcontractors must participate in an allied system coordination plan that includes the following systems.

- Aging and Disability Services Administration,
- Chemical Dependency and Substance Abuse Services,
- Children's Administration,
- Community Health Clinics, Federally Qualified Health Centers (FQHCs),
- Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections),
- Division of Vocational Rehabilitation,
- K-12 Education System and any Community Integration Assistance Program within the boundaries of the CDRSN.

Subcontractor Monitoring:

- Upon contracting for a sub delegated function, the CDRSN/PHIP will monitor the performance of the subcontractor through required reports, and both clinical and IS oversight, as appropriate.
- Monitors the subcontractor's performance on an annual basis and subjects it to a formal review according to schedules established by the State and in accordance with industry standards or State laws and regulations.
- Assures that corrective actions are taken to address any areas of deficiency.
- Examples of monitoring agreements for the subcontractors are included in Attachment 4.

(4) Adult BH System – Improvement Strategy.

The Lead Planners have the responsibility for updating the Quality Improvement (QI) Plan. They will incorporate all DSHS contract requirements and tailor the QI plan to address MH and SUD service improvement goals. A description of the quality structure is discussed in the response to Item 292, "Quality assessment and performance improvement program" of this document. This section of the Detailed Plan focuses on the annual Core Performance Measures and the Regional Performance Measures required under the DSHS contract.

- **Core Performance Measures:** NCBHO will collect and report on the DSHS required annual Core Performance Measures in the following areas:
  - Psychiatric hospital readmissions,
  - MH treatment penetration,
  - SUD penetration, and
  - SUD retention rates.
- **Regional Performance Measures:** NCBHO will establish regional performance measures based upon input from the Continuous Quality Improvement Committee (QIC), which includes representatives from the Governing Board, Advisory Board, Ombuds, Quality Review Team, providers, and client and family advocates, as well as allied partners. To arrive at regional performance measures, the QI staff will prepare data driven reports on service utilization, grievances and appeals, and the results from consumer and provider surveys, as well obtain direct input from stakeholders. While the approach will be data-driven, the input of local stakeholders will enable NCBHO to tailor regionally-relevant measures as well. The QIC will establish and rank performance improvement goals and determine priorities for implementation, including building baseline information and measuring improvements over time. The performance improvement areas encouraged by DSHS[3] are the areas that CDRSN and Grant County, through its provider organizations, are both familiar with and have adopted as both part of their philosophical approaches and in measuring outcomes.

[3] DSHS areas for Regional Performance Measures: access and availability, care coordination and continuity, quality of care, hope, recovery and resiliency, empowered and shared decision making, self-direction and cultural competency, health and safety, health status and functioning, integration, peer support and quality of live and outcomes, reliance on evidence based practices, provider effectiveness and satisfaction and integrated programs and systems.

10

Grievance System Plan

(296) Grievance System- general requirements.

CDRSN's policies and procedures (P&P) for the grievance system comply with all state and federal requirements, and the Chelan Douglas RSN has not had any deficiencies indicated by EQRO reports. Current policies and procedures that will be updated by the Lead Partners to address the inclusion of substance use disorder (SUD) services include:

- 8.2 Ombuds Service,
- 9.1 Grievance Systems,
- 9.1.2 Grievance System: Statutory Basis and General Requirements,
- Policy and Procedure 9.2 – CDRSN/PIHP Conflict Resolution: Appeals, Grievances and Fair Hearings,
- 9.1.3 Grievance System Notice of Action,
- 9.1.3.1 Expedited Authorization Decisions,
- 9.1.5 Grievance System: Resolution and Notification, and
- 9.1.6 Grievance System: Continuation of Benefits.

The updated P&Ps will include grievances for mental health (MH) and substance use disorder (SUD) services, referred to hereafter as behavioral health (BH) services.

"Grievance" means an expression of dissatisfaction about any matter other than an action, as "action" is defined below. The term is also used to refer to the overall system that includes grievances and appeals handled at the NCBHO/PIHP level and access to the State Fair Hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

Submission of Formal Policy: NCBHO's updated P&Ps will be submitted to DBHR 60 days prior to April 1, 2016.

(297) – Grievance system – action.

In the documentation, "Action" means: a decision that has been made by the CDRSN/PIHP, as described below in further detail:

- The denial or limited authorization of a requested service, including the type or level of service;

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State;
- The failure of the CDRSN/PIHP to act within the timeframes provided in 438.408(b).

All consumers have the right to request a fair hearing when they believe NCBHO or one of its network providers has violated a State rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a fair hearing if they disagree with a decision made by NCBHO regarding their eligibility for services or they disagree with the resolution of an appeal.

When a consumer submits a grievance to a network provider from which he/she receives services, that agency's director (or his/her designee) provides a written decision regarding the resolution of the grievance to the consumer, and to the NCBHO director (or his/her designee), within ninety (90) calendar days. The following provisions are also described in the policy:

- The timeframe may be extended up to fourteen (14) days if the consumer requests an extension or if the agency determines a need for additional information and that the extension is in the consumer's best interest.
- If the agency extends the timeframe, the consumer is provided written notice of the delay and the reason for it.
- If the Director of a network provider (or his/her designee) determines that it may not be possible to reach a decision within the 90-day timeframe, or that the consumer is not satisfied with the decision, he/she notifies the NCBHO CEO (or his/her designee) immediately.

(298) – Grievance system – service authorization.

Services authorizations include the following types and actions:

- Service Authorization, Expedited – An accelerated process for responding to service requests when a provider determines that following the standard timeframe could seriously jeopardize the Enrollee's ability to maintain, or regain maximum function or if the Enrollee presents a potential risk of harm to self or others.
- Service Authorization, Standard – The process for responding to requests for initial and/or ongoing BH services.
- Service Denial – A decision by NCBHO or its formal designee not to authorize covered BH services requested by a network provider for a Medicaid Enrollee.
- Service Reduction – A decision by NCBHO or its formal designee to decrease a previously authorized covered Medicaid BH s service described in the Level of Care Guidelines. A provider's clinical decision to decrease or change a covered service in the Individualized Service Plan is not a reduction.

- Service Suspension – A decision by NCBHO or its formal designee to temporarily stop previously authorized covered Medicaid BH s services described in the Level of Care Guidelines. A provider's clinical decision to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension
- Service Termination – A decision by NCBHO or its formal designee to stop a previously authorized covered Medicaid BH s services described in the Level of Care Guidelines. A provider's clinical decision to stop a covered service in the Individualized Service Plan is not a termination.

Based on requests from providers, NCBHO or its formal designee carry out authorization and notification processes for inpatient, and outpatient BH services, including major diagnostic and therapeutic services directly related to the treatment of BH for Enrollees. Decisions to authorize or deny services are based on the *Level of Care and Authorization Criteria* established by NCBHO. Decisions to deny services on the basis of medical necessity are approved by a licensed psychologist or a qualified physician prior to issuance of written notification regarding the decision. Apple Health, formally Healthy Options, enrollees are not referred to the enrollee's Apple Health managed care plan for BH services if the enrollee is determined to be eligible for RSN funded BH services based on medical necessity and the *Access to Care Standards.*

(299) - Grievance system – service authorization process.

The authorization process begins with a face-to-face clinical intake assessment by a MHP/CDP. If the MHP/CDP believes the enrollee meets NCBHO *Level of Care and Authorization Criteria*, a request for service authorization is faxed or sent electronically to NCBHO or its formal designee. The request includes:

- The amount, duration and scope of each service requested.
- Clinical information supporting the service(s) requested.
- A request for expedited authorization if the MHP/CDP believes it necessary.

1. Requests made to NCBHO or its formal designee is reviewed by an MHP/CDP, who authorizes them subsequent to review of the information provided and confirmation of financial eligibility. If NCBHO or its formal designee has questions or concerns regarding the authorization of services, the decision is made in consultation with the provider and/or NCBHO, as appropriate.
   - **Standard Service Authorizations**. Except when a provider requests an expedited authorization process, decisions regarding the authorization of routine outpatient BH services must occur within fourteen (14) calendar days of the date the intake evaluation was initiated, unless an extension is requested. Providers must submit an authorization request to NCBHO within three (3) business days from the date of intake.

  - Notice of service approval (i.e., Notice of Determination): Written notification is provided by NCBHO or its formal designee to the network provider and the Enrollee within the timeframe above.
  - Notice of denial (i.e., Notice of Action): Written notification is provided by BHO or its formal designee to the network provider and the enrollee, within the timeframe above.
- **Expedited Service Authorizations.** When a provider determines that an accelerated authorization process is in the best interest of the enrollee, the authorization decision is made, and notice given to the requesting provider and the enrollee, as expeditiously as the enrollee's condition requires and within three (3) working days from receipt of the service authorization request, unless an extension is requested.
  - Notice of service approval (i.e., Notice of Determination): Written notification is provided by NCBHO or its formal designee to the network provider and the Enrollee within the timeframe above.
  - Notice of denial (i.e., Notice of Action): Written notification is provided by NCBHO or its formal designee to the network provider and the Enrollee within the timeframe above.
- **Extensions**. For both Standard and Expedited service authorizations, the decision-making timeframe may be extended up to fourteen (14) additional calendar days if the enrollee or the provider requests it, or if NCBHO determines a need for additional information and how the extension is in the enrollee's best interest.
  - If the timeframe is extended, the determination must be issued and carried out as expeditiously as the enrollee's health condition requires, and no later than the date the extension expires.
  - Extension requests made by enrollees or providers are automatically granted.
  - When an extension occurs at the request of NCBHO or its formal designee or a provider, NCBHO or its formal designee provides the enrollee† written notice of the reason for the extension and of his/her right to file a grievance if he or she disagrees with the delay.
  - NCBHO or its formal designee tracks extension requests, monitoring for patterns in their use and reports such patterns to the Quality Management Oversight Committee.

2. When, on the basis of an Intake Assessment, an MHP/CDP determines that medical necessity and access criteria are not met, the assessment and other relevant documentation or medical records are submitted to NCBHO or its formal designee for review. If NCBHO or its formal designee does not reverse the recommendation of the MHP/CDP, it initiates the Notice of Action process, described below.

3. The NCBHO Children's Care Manager reviews initial intake evaluations of all enrollees under the age of 21 for medical necessity and makes Level I or Level II assignments, authorizing Level II services for children who are:
   - Involved with the Children's Administration, the Division of Developmental Disabilities, and/or the Juvenile Rehabilitation Administration/Department of Corrections in addition to BHs;
   - Diagnosed with substance abuse or addiction;
   - Receiving special education services; or
   - Have a chronic and disabling medical condition.
4. NCBHO or its formal designee maintains written records and a log of all denied requests for service.

Re-Authorization of Services

5. When a provider believes there is a need for continuation or re-authorization following the exhaustion of previously authorized services, the request to do so includes:
   - An evaluation of the effectiveness of each service modality provided during the benefit period and recommendations for changes in methods or intensity of services being provided;
   - An evaluation of the progress the enrollee made towards recovery or resiliency;
   - An identification of unmet goals in the Individual Service Plan including those identified by the enrollee; and
   - A determination of whether the enrollee has met discharge criteria.
6. NCBHO's or its formal designee's decision to re-authorize services is sent electronically or faxed to the provider, and includes the time period for which services are re-authorized.
7. A request to extend services that were previously authorized as time-limited may be treated as a new request. However, if the provider presents the request as a necessary continuation of the original authorization and the request is denied, the denial is treated as a service termination that may be appealed by an enrollee.

(300) – Grievance system – notice of action.

In the context of NCBHO funded service provision to Medicaid enrollees, actions mean: (1) the denial or limited authorization of a requested service, including the type or level of service and any service denial based on access to care; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the State; (5) the failure of NCBHO or its formal designee to act within the timeframes provided in section 42 CFR 438(b); 6) enrollee disagreement with the treatment plan.

Notices of Action

Notification of a decision to deny a service authorization request, or to authorize services in an amount, duration, or scope that is less than requested, is made via a Notice of Action form approved by NCBHO, in the enrollee's primary language. Denial decisions can only be made by a MHP/CDP who has the appropriate clinical expertise to make the decision. NCBHO or its formal designee mails this notice to enrollees. The form provides the following information:

- The date of the action.
- The action taken, and the reason(s) for it.
- An explanation of the enrollee's right to file an appeal or request a fair hearing, and how to do so, including the timelines to do so.
- Definitions of denial, reduction, suspension and termination.
- A statement that the enrollee has ninety (90) days from the postmark date on the Notice of Action to file an appeal.
- A statement that the enrollee must file an appeal within (10) days of the postmark date if the action is in regards to previously authorized services which he/she wishes to continue receiving during the appeal process.
- The circumstances under which a 3-day expedited appeal process is available, and how to request it.
- Statements regarding the enrollee's right to have services continued pending resolution of the appeal, how to request continuation or reinstatement of services during the appeal, and the circumstances under which the enrollee may be required to pay for services received during the appeal process.
- The circumstances under which the enrollee may request a fair hearing.
- A statement that the enrollee has ninety (90) days from the postmark date on the resolution of a notice of action to file fair hearing.

For all denials, a notice of action is mailed to the enrollee within the timeframes noted below. The provider from which the enrollee receives outpatient services, and, if applicable, the facility providing inpatient services are also notified within these timeframes, though not necessarily in writing.

For **termination, suspension, or reduction of previously authorized services** – At least ten (10) calendar days before the effective date of the action, except as noted below.

- A Notice of Action may be mailed not later than the date of action if:
  - NCBHO has factual information confirming the enrollee's death;
  - NCBHO has a clear written statement signed by the enrollee that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the enrollee understands that this must be the result of supplying that information;

  - NCBHO has learned that the enrollee has been admitted to an institution where he/she is ineligible for further services;
  - NCBHO has no knowledge of the enrollee's whereabouts and returned mail has no forwarding address;
  - NCBHO has knowledge that the enrollee has been accepted into another state's Medicaid program; or
  - NCBHO has knowledge that the MHP/CDP treating the enrollee has prescribed a change in the level of services.
  - If NCBHO has facts (verified through secondary resources, if possible) indicating that action should be taken because of probable fraud by the enrollee, the advance notice may be shortened to five (5) days.
- For **denial of payment** – At the time of any action affecting the payment.

For Standard and Expedited Service Authorization decisions that deny or limit services – As expeditiously as the enrollee's condition requires, and not longer than the notification timeframes established in the "Authorization of Services" section, above.

For decisions to deny a request for voluntary Medicaid inpatient services, the Notice of Action is delivered on the day the decision is made. Failure to meet the timeframes for standard or expedited service authorization requests constitutes a denial. In such instances, the notice of action must be mailed on the date the timeframe expires.
A copy of each notice of action issued is maintained at the NCBHO regional office.

(301) – General Requirements – notice of action – timeframes – termination, suspension or reduction of services.

CONTAINED IN THE PREVIOUS RESPONSE ITEM (300).

(302) Grievance system – notice of action – timeframes – denial of payment

Whenever a payment denial is processed, notifications of the action affecting non-payment is made immediately.

- Notice of service approval (i.e., notice of determination): Written notification is provided by NCBHO or its formal designee to the network provider and the enrollee within the timeframe above.
- Notice of denial (i.e., notice of action): Written notification is provided NCBHO or its formal designee to the network provider and the enrollee, within the timeframe above.

(303) Grievance system – notice of action – timeframes – denial of standard authorization.

CONTAINED IN THE PREVIOUS RESPONSE ITEM (300).

(304) Grievance system – notice of action – timeframes – denial of expedited authorization.

CONTAINED IN THE PREVIOUS RESPONSE ITEM (300).

(305) Grievance system – notice of action – timeframes – untimely authorization.

Failure to meet the timeframes for standard or expedited service authorization requests constitutes a denial. In such instances, the Notice of Action must be mailed on the date the timeframe expires.

(306) Grievance system – information to providers and subcontractors.

All consumers receive a copy of the NCBHO materials, which includes information about requesting fair hearings, when admitted to community support services. Additionally, the BH *Benefits Booklet* produced by DSHS, which also provides instructions regarding fair hearings, is made available to Medicaid enrollees at intake and upon request, and documents from the NCBHO Ombuds service are available at network provider sites and the NCBHO office. Consumers are also provided with information regarding their right to request a fair hearing, and the process for doing so under the following circumstances:

- When they file a grievance, and when a written response to that grievance is provided.
- When a Medicaid enrollee is notified of a decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.
- When a Medicaid enrollee is notified of a decision regarding his/her appeal of an action as defined herein.

All consumers receive a copy of the NCBHO materials at intake, which includes information about filing grievances. As needed, explanation is provided through qualified interpreters for non-English speaking consumers and those who are deaf or visually impaired. Additionally, Medicaid enrollees are informed that the *Benefits Booklet* produced by the Department of Social and Health Services (DSHS), which also provides instructions regarding grievances, is available upon request, and a copy is provided if an enrollee requests one.

(307) Grievance system – record keeping and reporting.

A confidential record of each grievance is maintained for six (6) years following the completion of the grievance resolution process. Such records are maintained apart from the consumer's clinical record and are not disclosed without the consumer's written permission, except as necessary to resolve the grievance or to DSHS if the consumer requests a fair hearing.

Network providers notify NCBHO upon receipt, of all grievances filed and provide information on all steps taken to resolve them.

A confidential record of each appeal is maintained for six (6) years following the completion of the appeal resolution process. At a minimum, such records include the enrollee's name, dates and times of all milestones in the appeal process, the decision appealed, the provider involved, and the disposition of the appeal. Such records are maintained apart from the enrollee's clinical record, and are not disclosed without the enrollee's written permission, except as necessary to resolve the appeal or to DSHS if the enrollee requests a fair hearing.

On-site audits of network providers, conducted by NCBHO, include checks for evidence of compliance with the provisions of this policy. When a need for corrective action is identified during such audits, network providers address compliance issues via their quality improvement processes and provide evidence of sustained improvement. NCBHO staff review audit findings for trends requiring system level intervention, and report such to the NCBHO Quality Management Oversight Committee for recommendations that are presented to the NCBHO Governing Board for action.

(308) Grievance system – appeal.

The topic of appeals – with regards to definitions – has been addressed in previous sections of this Detailed Plan. NCBHO recognizes and adopts the definitions of "Action", "Appeal" and "Grievance" as presented by 42 CFR 438.400(b).

(309) Grievance system – authority to file.

All consumers have the right to request a fair hearing when they believe NCBHO or one of its network providers has violated a State rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a fair hearing if they disagree with a decision made by NCBHO regarding their eligibility for services or they disagree with the resolution of an appeal.

Consumers may enlist family members, Ombuds service staff, advocates, friends, network provider staff or others to represent or assist them in filing a grievance.

(310) Grievance system – timing.

Appeals must be filed within ninety (90) calendar days of the postmark on the notice of action. If the enrollee wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the notice of action or the intended effective date of the action, whichever is later.

(311) Grievance system – appeal process – procedures.

Requests made to NCBHO or its formal designee is reviewed by an MHP/CDP, who authorizes them subsequent to review of the information provided and confirmation of financial eligibility.

If NCBHO or its formal designee has questions or concerns regarding the authorization of services, the decision is made in consultation with the provider and/or NCBHO, as appropriate.

- **Standard Service Authorizations**. Except when a provider requests an expedited authorization process, decisions regarding the authorization of routine outpatient BH services must occur within fourteen (14) calendar days of the date the intake evaluation was initiated, unless an extension is requested. Providers must submit an authorization request to NCBHO within five (5) business days from the date of intake.
  - Notice of service approval (i.e., notice of determination): Written notification is provided by NCBHO or its formal designee to the network provider and the enrollee within the timeframe above.
  - Notice of denial (i.e., notice of action): Written notification is provided NCBHO or its formal designee to the network provider and the enrollee, within the timeframe above.
- **Expedited Service Authorizations.** When a provider determines that an accelerated authorization process is in the best interest of the enrollee, the authorization decision is made, and notice given to the requesting provider and the enrollee, as expeditiously as the enrollee's condition requires and within three (3) working days from receipt of the service authorization request, unless an extension is requested.
  - Notice of service approval (i.e., notice of determination): Written notification is provided by NCBHO or its formal designee to the network provider and the enrollee within the timeframe above.
  - Notice of denial (i.e., notice of action): Written notification is provided by NCBHO or its formal designee to the network provider and the enrollee within the timeframe above.

Upon application for BH services, enrollees receive a copy of the NCBHO materials, which includes information relating to Enrollees' right to appeal decisions and how to do so. As needed, explanation is provided through qualified interpreters for non-English speaking enrollees and those who are deaf or visually impaired. Additionally, enrollees are informed that the *Benefits Booklet* produced by the DBHR, which also provides instructions regarding filing appeals, is available upon request, and a copy is provided if an enrollee requests one. Documents from the NCBHO Ombuds service are also available at network provider sites and the NCBHO office.

When an enrollee indicates a desire to appeal an action relating to his/her care, appeal-related processes are reviewed with the enrollee, access to the Ombuds Service is facilitated if desired, and the enrollee is reminded of his/her right to involve others.

- A staff member of a network provider may file an appeal on behalf of the enrollee if written consent is given by the enrollee, or a guardian or representative.

- As needed, enrollees are provided interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- Appeals must be filed within ninety (90) calendar days of the postmark on the notice of action. If the enrollee wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the notice of action or the intended effective date of the action, whichever is later.
- Appeals may be initiated either orally or in writing. Those initiated orally must be confirmed in writing and signed by the enrollee within seven (7) calendar days unless an expedited resolution has been requested.
- Oral inquiries seeking to appeal an action are treated as appeals and the date of the inquiry becomes the filing date of the appeal. If an oral inquiry is not confirmed in writing, it will be considered incomplete. This does not preclude another filing within ninety (90) days of the date on the notice of action.

The NCBHO CEO and his/her designee conducts a thorough review of each appeal ensuring that those making the decision on the appeal were not involved in any previous level of review or decision-making in regards to it.

- If the appeal is in regards to a denial based on lack of medical necessity, or involves clinical issues, the NCBHO CEO or his/her designee ensures that the final decision is made by a BHs Professional with the appropriate clinical expertise.
- The enrollee is provided, before and during the appeal process, the opportunity to examine his/her case file, including medical records and any other documents and records considered during the appeal process.

(312) Grievance system – appeal process – resolution and notification.

For standard resolutions of appeal, the appeal is resolved, and written notice provided by NCBHO to the enrollee, within forty-five (45) days of its receipt.

Requests for an expedited appeal resolution process are reviewed the day of receipt, and a decision as to whether an expedited process is warranted is communicated verbally by NCBHO to the enrollee no later the twenty-four (24) hours after receipt of the request.

For both standard and expedited resolution processes, the timeframe may be extended up to fourteen (14) additional calendar days if the enrollee requests it, or if NCBHO determines a need for additional information and how the extension is in the enrollee's best interest. If an extension occurs at the request of NCBHO rather than the enrollee, written notice of the reason for the delay is provided to the enrollee.

The results of the resolution process, the date it was completed and the clinical rationale for the decision, including how to obtain the utilization management clinical review or decision-making criteria.

(313) Grievance system – appeal process – format and content of resolution notice.

CONTAINED IN THE PREVIOUS RESPONSE ITEM (312)

(314) Grievance system – appeal and state fair hearing process – continuation of benefits.

When a consumer has requested and received a continuation of disputed services during the fair hearing process, and the fair hearing officer upholds a NCBHO decision to deny, limit or delay services, the consumer may be asked to pay for these services, to the extent they were provided solely for continuation of benefits during the fair hearing process.

For **termination, suspension, or reduction of previously authorized services** – At least ten (10) calendar days before the effective date of the action, except as noted below.

- A notice of action may be mailed not later than the date of action if:
  - NCBHO has factual information confirming the enrollee's death;
  - NCBHO has a clear written statement signed by the enrollee that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the enrollee understands that this must be the result of supplying that information;
  - NCBHO has learned that the enrollee has been admitted to an institution where he/she is ineligible for further services;
  - NCBHO has no knowledge of the enrollee's whereabouts and returned mail has no forwarding address;
  - NCBHO has knowledge that the enrollee has been accepted into another state's Medicaid program; or
  - NCBHO has knowledge that the MHP/CDP treating the enrollee has prescribed a change in the level of services.
- If NCBHO has facts (verified through secondary resources, if possible) indicating that action should be taken because of probable fraud by the enrollee, the advance notice may be shortened to five (5) days.

Appeals must be filed within ninety (90) calendar days of the postmark on the notice of action. If the enrollee wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the notice of action or the intended effective date of the action, whichever is later.

NCBHO continues an enrollee's benefits pending resolution of an appeal if all of the following conditions are met:

- The appeal was filed within ten (10) days of the postmark on the Notice of Action or the intended effective date of the proposed action;
- The appeal involves the termination, suspension, or reduction of a previously authorized service;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The enrollee requests extension of benefits.

If, at the enrollee's request, benefits are continued or reinstated while the appeal is pending, they must be continued until one of the following occurs:

- The enrollee withdraws the appeal.
- Ten (10) days pass after NCBHO mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a fair hearing with continuation of benefits until a hearing decision is reached.
- A fair hearing office issues a decision adverse to the enrollee.
- The time periods or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the enrollee, NCBHO may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent the services were provided solely for continuation of benefits during the appeal process.

(315) Grievance system – appeal and state fair hearing process – effectuation when services were not furnished.

When a fair hearing officer reverses a NCBHO decision to deny, limit, or delay services that were not furnished to a Medicaid enrollee while an appeal was pending, the disputed services are authorized and provided promptly, and as expeditiously as the enrollee's health condition requires.

When a fair hearing officer reverses a NCBHO decision to deny authorization of services to a Medicaid enrollee, and the enrollee received the disputed services while the appeal was pending, the services are paid for by NCBHO or the network provider from which the enrollee received them.

If NCBHO reverses a decision to deny, limit or delay BHs services that were not furnished while the appeal was pending, the disputed services are authorized promptly, and as expeditiously as the enrollee's health condition requires.

(316) Grievance system – appeal and state fair hearing process – effectuation when services were furnished.

If NCBHO reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, NCBHO must pay for those services in accordance with DSHS policy and regulations.

(317) Grievance system – expedited appeals process – general.

Expedited Resolution of Appeal. An expedited process is provided when it is determined that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning. In these cases, the appeal is resolved, and written notice provided by NCBHO to the enrollee, within three (3) working days of its receipt, unless extended as noted below.

- Requests for an expedited appeal resolution process are reviewed the day of receipt, and a decision as to whether an expedited process is warranted is communicated verbally by NCBHO to the enrollee no later the twenty-four (24) hours after receipt of the request.
- If the request for an expedited resolution process is denied, NCBHO provides written notice within two (2) calendar days. The appeal is then addressed in accord with timelines for the Standard Resolution process.
  - Denial of access to an expedited process is grounds for the filing of a grievance, if the enrollee desires to do so.

(318) Grievance system – expedited appeals process – authority to file.

Appealing an action: Upon application for BHs services, enrollees receive a copy of the NCBHO materials, which includes information relating to enrollees' right to appeal decisions and how to do so. As needed, explanation is provided through qualified interpreters for non-English speaking enrollees and those who are deaf or visually impaired. Additionally, enrollees are informed that the *Benefits Booklet* produced by the DBHR, which also provides instructions regarding filing appeals, is available upon request, and a copy is provided if an enrollee requests one. Informational documents from the NCBHO Ombuds service are also available at network provider sites and the NCBHO office.

When an enrollee indicates a desire to appeal an action relating to his/her care, appeal-related processes are reviewed with the enrollee, access to the Ombuds service is facilitated if desired, and the enrollee is reminded of his/her right to involve others. A staff member of a network provider may file an appeal on behalf of the enrollee if written consent is given by the enrollee, or a guardian or representative. As needed, enrollees are provided interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Appeals must be filed within ninety (90) calendar days of the postmark on the notice of action. If the enrollee wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the notice of action or the intended effective date of the action, whichever is later.

Appeals may be initiated either orally or in writing. Those initiated orally must be confirmed in writing and signed by the enrollee within seven (7) calendar days unless an expedited resolution has been requested.

- Oral inquiries seeking to appeal an action are treated as appeals and the date of the inquiry becomes the filing date of the appeal.
- If an oral inquiry is not confirmed in writing, it will be considered incomplete. This does not preclude another filing within ninety (90) days of the date on the notice of action.

When an appeal is filed, the enrollee is provided the following:

- Contact names and telephone numbers of the Ombuds Service, the involved network provider, and the NCBHO Regional Office.
- Information about the appeal process, including but not limited to timeframes for resolution and the enrollee's right to request a fair hearing at the state level (a) if the enrollee does not agree with NCBHO's decision regarding the appeal, (b) if NCBHO does not provide a written response within the required timeframes, or (c) if the enrollee believes there has been a violation of Washington State Department of Social and Health Services rules.

The notice of action form instructs enrollees to file their appeals directly with NCBHO. However, because enrollees may request assistance from a network provider in filing an appeal, the first knowledge of an impending appeal may be at the network provider level. Accordingly, if an enrollee indicates to a network provider that he/she wishes to appeal a notice of action, the director of the network provider (or his/her designee) notifies the NCBHO CEO:

- Within one (1) working day of receipt of this information for Standard appeals;
- Within the same day of receipt of this information for Expedited appeals.

(319) Grievance system – expedited appeals process – procedures.

The enrollee is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. When expedited resolution is requested, the enrollee is informed of the limited time available for this.

(320) Grievance system – expedited appeal process – resolution and notification.

An expedited process is provided when it is determined that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning. In these

cases, the appeal is resolved, and written notice provided by NCBHO to the enrollee, within three (3) working days of its receipt, unless extended as noted below.

Requests for an expedited appeal resolution process are reviewed the day of receipt, and a decision as to whether an expedited process is warranted is communicated verbally by NCBHO to the enrollee no later the twenty-four (24) hours after receipt of the request.

If the request for an expedited resolution process is denied, NCBHO provides written notice within two (2) calendar days. The appeal is then addressed in accord with timelines for the standard resolution process.

Denial of access to an expedited process is grounds for the filing of a grievance, if the enrollee desires to do so.

Extensions. For both standard and expedited resolution processes, the timeframe may be extended up to ninety (90) additional calendar days if the enrollee requests it, or if NCBHO determines a need for additional information and how the extension is in the enrollee's best interest. If an extension occurs at the request of NCBHO rather than the enrollee, written notice of the reason for the delay is provided to the enrollee.

At the conclusion of *Standard and Expedited* resolution processes, the NCBHO CEO/Administrator or his/her designee provides the enrollee a written notice of disposition. For expedited processes, the NCBHO CEO/Administrator or his/her designee also makes reasonable efforts to provide an oral notice of disposition prior to the written notice. The written notice includes the results of the resolution process, the date it was completed and the clinical rational for the decision, including how to obtain the utilization management clinical review or decision-making criteria

.

For appeals resolved not wholly in the enrollee's favor:

- The right to request a fair hearing, and how to do so;
- The right to request to receive benefits while the hearing is pending, and how to make the request; and
- That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds NCBHO's decision regarding the appeal.

(321) Grievance system – expedited appeal process – punitive action.

NCBHO ensures that no punitive or discriminatory action is taken against an enrollee who requests an expedited resolution process or a provider who supports an enrollee's appeal.

(322) Grievance system – state fair hearing process – notification of state procedures.

All consumers have the right to request a fair hearing when they believe NCBHO or one of its network providers has violated a state rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a fair hearing if they disagree with a decision made by NCBHO regarding their eligibility for services or they disagree with the resolution of an appeal.

All consumers receive a copy of the NCBHO materials which includes information about requesting fair hearings, when admitted to community support services. Additionally, the BH s *Benefits Booklet* produced by DSHS, which also provides instructions regarding fair hearings, is made available to Medicaid enrollees at intake and upon request, and documents from the NCBHO Ombuds service are available at network provider sites and the NCBHO office. Consumers are also provided with information regarding their right to request a fair hearing, and the process for doing so. When a Medicaid enrollee is notified of a decision regarding his/her appeal of an action. All consumers receive a copy of the NCBHO materials, which includes information about filing grievances, at intake. As needed, explanation is provided through qualified interpreters for non-English speaking consumers and those who are deaf or visually impaired. Additionally, Medicaid enrollees are informed that the *Benefits Booklet* produced by the Department of Social and Health Services (DSHS), which also provides instructions regarding grievances, is available upon request, and a copy is provided if an enrollee requests one. NCBHO's information from the Ombuds service is also available at network provider sites and the NCBHO office.

(323) Grievance system – state fair hearing – parties.

All consumers have the right to request a fair hearing when they believe NCBHO or one of its network providers has violated a state rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a fair hearing if they disagree with a decision made by NCBHO regarding their eligibility for services or they disagree with the resolution of an appeal.

(324) Grievance system – grievance – definition.

Grievance: A consumer's request that his/her expression of dissatisfaction with any aspect of care or services provided be formally heard and resolved via the NCBHO grievance process. NOTE: When a Medicaid enrollee indicates disagreement with a decision to suspend, reduce or terminate services and asks that the decision be reconsidered, the request is an appeal rather than a grievance, and is addressed via the NCBHO appeal process. The consumer is made aware that, at any time during the investigation and resolution process, he/she may interact directly with NCBHO, and is made aware of his/her rights relative to requesting a fair hearing, and the process for doing so.

(325) Grievance system – grievance process – procedures and authority to file.

Consumers may file grievances, verbally or in writing, with either the network provider from which they receive services, or directly to NCBHO. Grievances are acknowledged in writing by the agency receiving them within five (5) working days following receipt; acknowledgements are documented in the confidential grievance file.

(326) Grievance system – grievance process – disposition and notification.

When a consumer submits a grievance to a network provider from which he/she receives services, that agency's director (or his/her designee) provides a written decision regarding the resolution of the grievance to the consumer, and to the NCBHO CEO (or his/her designee), within ninety (90) calendar days.

- The timeframe may be extended up to fourteen (14) days if the consumer requests an extension or if the agency determines a need for additional information and that the extension is in the consumer's best interest.
- If the agency extends the timeframe, the consumer is provided written notice of the delay and the reason for it.
- If the director of a network provider (or his/her designee) determines that it may not be possible to reach a decision within the 90-day timeframe, or that the consumer is not satisfied with the decision, he/she notifies the NCBHO CEO (or his/her designee) immediately.

11

Tribal Communications and Coordination and Communication Plan

(169) Behavioral health organization – inclusion of tribal authorization – roles and responsibilities.

1. Inclusion of Tribal Authorities: There are no tribes located in the NCBHO region.

2. Work Plan for Implementation of the American Indian Addendum, Exhibit E to the DPR: This is not applicable because there are no tribes in the Region.

3. American Indian/Alaska Native (AI/AN) Equal Access to Behavioral Health Services: NCBHO will provide equal access to services for AI/AN presenting for services in the region.

4. Culturally Competent Services for AI/AN: NCBHO will incorporate cultural competency training on AI/AN, should any tribal members begin to use the NCBHO provider services.

5. Continuation and/or Transition of This Practice (ITA) to Assure Access to Tribal Court Orders for SUD Treatment: The NCBHO will track AI/AN individuals in SUD residential treatment services related to tribal court orders, and will develop agreements with interested tribes to assure access to SUD treatment and payment of services for Medicaid-eligible tribal members.

6. Coordination with Tribal Providers and Provision of Written Agreements: This is not applicable presently. If tribal members routinely use services in the future, NCBHO will determine tribal relationships and identify the need for written agreements.

12

Behavioral Health Data Consolidation Project Plan this

(295) Health information systems.

The Behavioral Health Data Consolidation project has identified the draft set of data elements required for collection from the BHOs. Many of the data elements have standing definitions in current data dictionaries or reporting instructions and this is indicated in the attached Tables. Reporting rules and definitions and values for new elements, will be developed with the RSN/BHO representatives between July 1 – September 11, 2015 either through the SERI workgroup or the BHDC data group.

1. Provide your plan and timeline to collect and report on the data elements contained in Table 1 (non-Provider One data elements) and Table 2 (Provider One data elements).
   RESPONSE: NCBHO will continue using the NetSmart (NTST) product Avatar to collect all required Mental Health data elements (both non-Provider One and Provider One). Avatar has the ability to collect much of the new data elements listed. Those not already within the system are being added with programmatic customization of the Avatar products currently in use, from initial data entry or EDI by an agency, EDI to the BHO, and finally ProviderOne 837 and State CIS submission.

   Grant Integrated Services for Grant County will be using Cerner Behavioral Health Data System. The Lead Partners will work with Netsmart (Avatar) and Cerner design teams to develop an electronic data transmission that involves the least amount of double entry and electronic process for transmission of authorizations, state data elements and services.

North Central BHO Milestones	
Description	**Date/Status**
Product specification requirement document	Complete
Product specification detail review by NTST programmers and Project Team	Complete
Product customization programming	October 2015
Product testing in UAT environment	November – December 2015
Product finalization and State submission testing	January 2016
Product training by agency users	February/March 2016

2. Describe your plan to assess and ensure the provider agencies in your network (or subcontractors) are able to submit client and service data that meets the BHO reporting requirements (as specified in table below).
   a. Describe any barriers your substance use disorder treatment agencies have in meeting the data collection and transmission requirements?
   RESPONSE: Currently, three CDRSN contracted agencies are using the Avatar system for mental health. The Alcohol and Drug Treatment Center for Chelan-Douglas counties will use the Avatar Data system. Grant Integrated Services for Grant County will be using Anasazi Data System and use data file imports into the Provider Management (PM) Avatar system, both of these agencies will experience larger barriers. CDRSN plans to provide all contracted agencies with the necessary training, go-live support, and on-going support post-go-live.

   b. How are you communicating the data reporting requirements?
   RESPONSE: NCBHO will be holding several trainings as part of the go-live process starting February 2016. Prior to the February 2016 trainings, there will be several cross-functional (Admin, Finance, IT/IS, Clinical) provider meetings held in January 2016 to introduce the managed care needs. The MIS policy and procedure manual will be expanded to include SUD services. It contains all modalities, the codes that are associated with those modalities and business rules around them. A non-encounter data dictionary, an authorization summary with codes and services for the authorization and other material make up this manual. This manual will be used to train new agencies coming on board. Trainings will begin as part of the go-live process starting in February 2016.
   c. Describe technical assistance or other support you are providing to substance use disorder treatment agencies?
   RESPONSE: NCBHO will be holding several meetings with providers, and trainings beginning in February 2016 to bring these agencies online. Technical support needs will be identified with each individual agency in the January 2016 meetings. Ongoing support will be provided from within our IT/IS team to the agencies.

   d. Describe the IT systems/EHRs used by the provider agencies in your network to collect and submit client and services information?
   RESPONSE: Three of CDRSN contracted agencies providing mental health services utilize the Avatar Data System as their EHR, The Center for Alcohol and Drug Treatment, the SUD provider for Chelan and Douglas Counties will use the Avatar Data System as their EHR, Grant Integrated Services for Grant County currently uses Cerner as their EHR. NCBHO will work with Netsmart and Cerner design teams to develop an agreed upon data transfer process.

3. Document your plan to collect client and services data from the substance use residential providers located throughout the state?
   RESPONSE: CDRSN plans to implement contractual arrangements with residential providers outside our region. The contractual requirements would require these out-of-region providers to submit data elements just like any other service provider, which could include direct data entry or submission of supplemental files that are accepted into our systems for inclusion with the State data sets that are generated. BHO's are collaborating to set up processes that will facilitate the data flow and information across statewide utilization.

4. Document your systems capacity to collect, store, and submit funding source information associated with a person and service, in order to meet block grant reporting requirements.
   RESPONSE: CDRSN is able to collect and store funding source information within our current system. Submission of that information may take additional programming depending on the requirements from the State. At this time, the funding source submission requirement has been dropped from submission requirements. We strongly urge that due to the high Medicaid churn, retroactive eligibility etc. that DSHS continues to determine funding when they pull the data for their use as they have done for years. Grant County's Grant Integrated Services has the ability and currently submits funding source information using Cerner to SCRSN. This includes specific program codes for specialized funding sources such as the Federal Block Grant and Co-Occurring funds.

5. Describe how will you ensure that encounters are submitted within 30 days after the close of the month of service?
   RESPONSE: The agency has 10 business days to submit their encounters from the end of the prior month into Avatar. Those encounters then proceed to the BHO system within 1 hour of that original submission. Once in the BHO system they are ready for reporting, based on our regular weekly submission schedule, those encounters are produced on an 837 for Provider One submission.

   Encounters, once produced on an 837, are flagged within our system of being sent. Returned ETRR data is also imported into the system and attached to those flagged encounters. We use quality management reports to identify encounters that have not been sent in an 837 and research and send those encounters found on the report.
   Monthly reports are run analyzing the timeliness and completeness of data submission by agencies.

   Grant Integrated Services currently submits encounters within 10 days of the date of service which allows for error reporting from SCRSN and enough time to submit corrections and still make the state-mandated deadline of within 30 days of the date of service. Grant

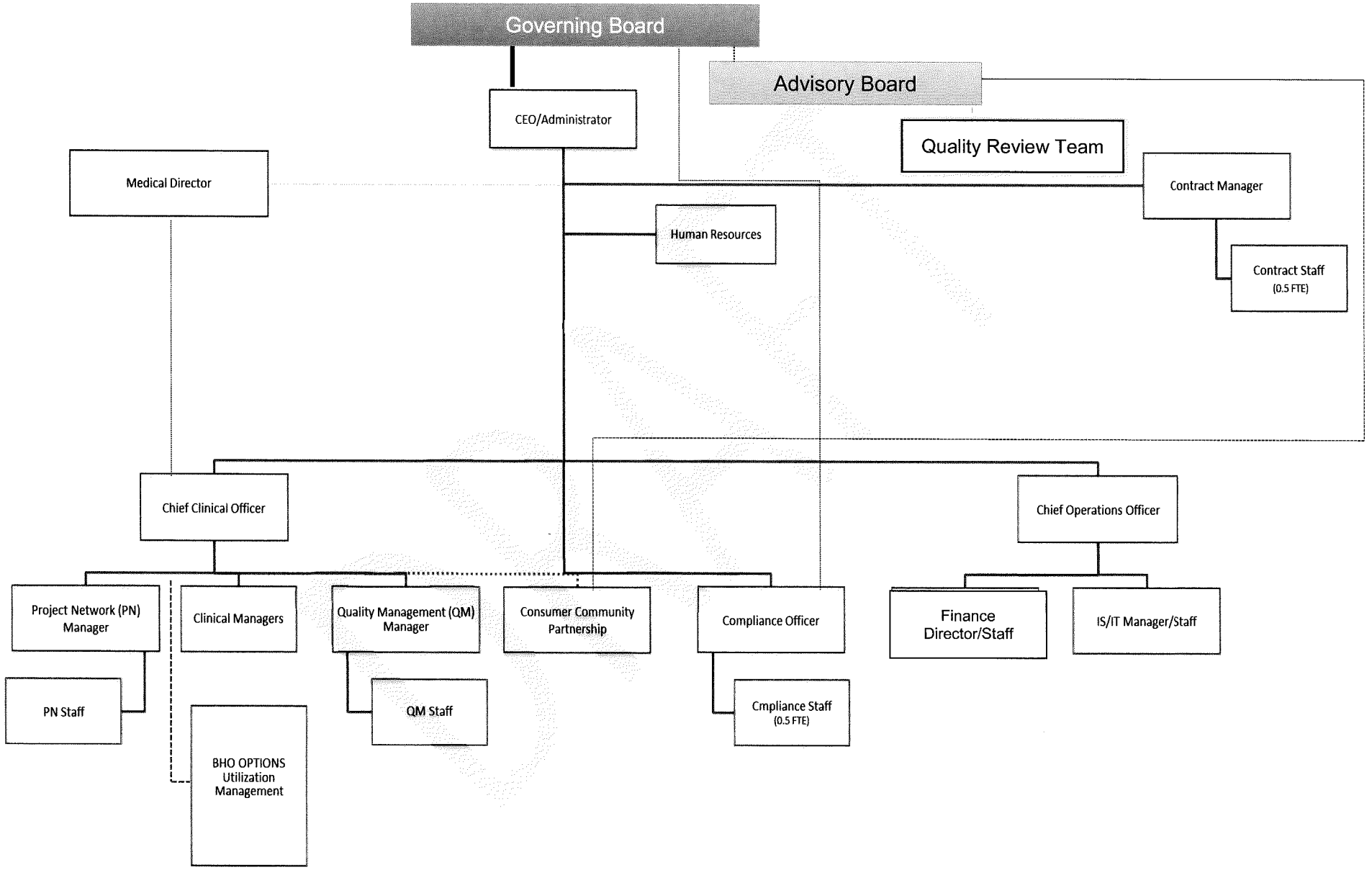
Integrated Services currently uses HIPAA Standard 837P to report encounters in order to flag the service within our Cerner product that the encounter has been submitted to SCRSN. SCRSN provides a report to the provider verifying encounter information which has been accepted for processing to Provider One.

The processes described above will be reviewed and agreed upon by the Lead Planners to address differences in the final NCBHO policies and procedures.

Attachment 1: Organizational Chart

North Central Behavioral Health Organization Chart

Draft October 26,2015



Attachment 2: 2015 Mental Health Provider Adequacy Report

Addressing Item (273), Item 3.

Sample Network Adequacy Report 1-28-14

Chelan-Douglas RSN

Provider Network Adequacy Assessment

Completed By: Craig Mott, CHC

1/28/2014

Scope

The purpose of the current assessment is to review the adequacy of the Chelan-Douglas Regional Support Network (CDRSN) provider network to comply with the State's standards for access to care, and to provide timely, adequate access to all services covered under the contract with DBHR. Service and caseload data was reviewed for the service period of 1/1/2013 to 6/30/2013. The rationale for said timeframe is to establish a baseline for the calendar months that would correspond to the months to be reviewed following the removal of Recovery Innovations from the CDRSN provider network. Additionally, data related to network capacity for the full calendar year 2013 (CY 2013) was reviewed to facilitate forecasting of expected caseloads and utilization for calendar year 2014 (CY 2014).

The current assessment was completed in accordance with requirements delineated in the CDRSN contract with DBHR, 42 CFR 438.206 and 42 CFR 438.207.

Access

Number of RFS in period under review: **273**

Number of Intake Assessments offered within 10 Business days of RFS: **273**
Number of Intake Assessments not offered within 10 business days of RFS: **0**
Percentage in compliance: **100%**

Number of intakes completed: **141**
Number of RFS with no intake assessment completed: **132**
Percentage of RFS that result in intake assessment: **51.6%**

Number of first routine service within 28 days of RFS: **132**
Number of first routine service not within 28 days of RFS: **9**
Percentage in compliance: **93.3%**

Number of consumers with no post-intake routine appointment: **74**
Percentage of consumers who received an intake but no routine appointment: **52.5%**

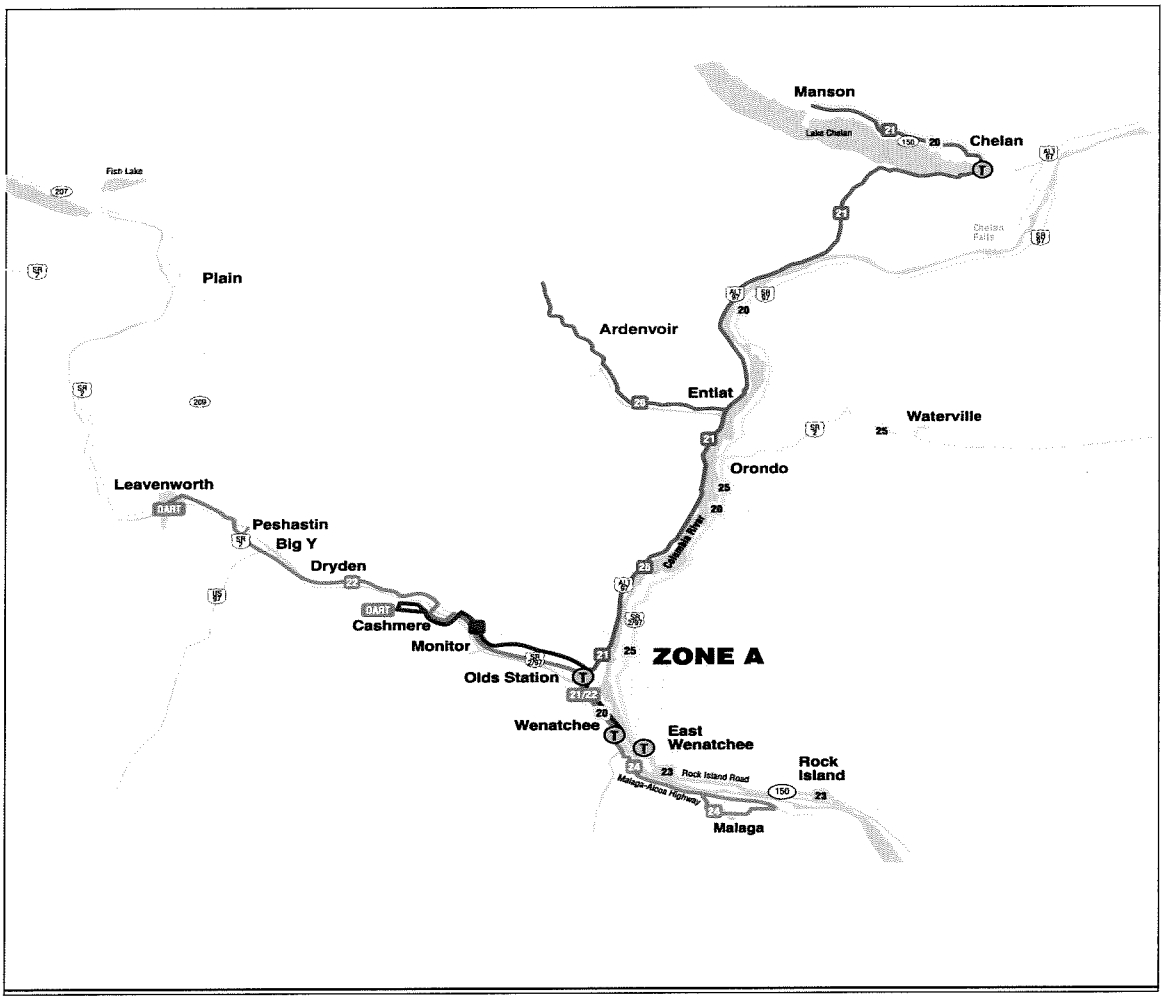
Percentage of intake services provided in the community: **0.5%**
Percentage of intake services provided in consumer's residence: **0.5%**
Percentage of intake services provided in SNF/assisted living: **1.1%**

Percentage of outpatient services provided in the community: **5.8%**
Percentage of outpatient services provided in consumer's residence: **2.8%**
Percentage of outpatient services provided in SNF/assisted living: **0.5%**

Percentage of enrollees requesting service living greater that 90-minute drive to a service location: **0 (see "Managed Care Accessibility Analysis")**

Describe any geographical barriers to access (e.g. mountain pass, river, man-made obstruction, etc.): **The Columbia River separates Chelan and Douglas Counties, but multiple crossing points exist.**

Public transportation resources available: **Link Transit provides public transportation within the major population centers of Chelan and Douglas Counties, namely Wenatchee and East Wenatchee. Link Transit also provides inter-city public transportation along the Columbia River Corridor from Malaga to the South to Chelan and Manson to the North, as well as to the West of Wenatchee along Highway 2 to Leavenworth (see service area map below).**



Service sites allow physical access to enrollees with disabilities: **All outpatient service sites are ADA accessible. ADA accessibility is reviewed annually by CDRSN**

Cultural and Linguistic Competency

Number of network clinicians that speak a language other than English: **9**

Language 1: **Spanish**
Language 1 Clinician Count: **9**

Language 2: **None**
Language 2 Clinician Count: **N/A**

Language 3: **None**
Language 3 Clinician Count: **N/A**

Number of Medicaid enrollees identified as Hispanic in the 834 Benefit Enrollment File: **10881**
Number of Hispanic Specialists employed/contracted within the provider network: **3**
Number of Medicaid enrollees identified as Native American in the 834 Benefit Enrollment File: **239**
Number of Native American Specialists employed/contracted within the provider network: **1**
Number of Medicaid enrollees identified as Asian/Pacific Islander in the 834 Benefit Enrollment File: **156**
Number of Asian/Pacific Islander Specialists employed/contracted within the provider network: **1**
Number of Medicaid enrollees identified as African American in the 834 Benefit Enrollment File: **94**
Number of African American Specialists employed/contracted within the provider network: **2**

Percentage of clinician's with cultural competency training: **100%**

Network Capacity

Number of provider by CIS provider type:

DOH Credentialed Certified Peer Counselor: **14**
Non-DOH Credentialed Peer Counselor: **0**
Below Master's Degree: **16**
MA/PHD: **37**
RN/LPN: **5**
ARNP/PA: **1**
Psychiatrist/MD: **4**
Other: **6**

Provider credentialing: **CDRSN regularly monitors subcontractor credentialing processes and assesses subcontractor provider type mix to ensure availability of services to meet member needs. For the period under review, the CDRSN provider network had an adequate number and mix of clinical staff to provide required state plan services to enrollees requesting service.**

Lowest c subcontractor clinician caseload size for full-time staff: **18**
Highest subcontractor clinician caseload size: **55**
Average subcontractor clinician caseload: **34**

Total caseload: **1,656**[1]
Total hours of service: **16,137.90**

Total annual caseload for CY 2013: **2,287**[2]
Total annual hours of service: **31,889.93**

Number of providers at capacity: **0**

Anticipated Medicaid enrollment (CY 2014): **30,188**[3]
Expected services utilization in total members (CY 2014): **3019**[4]
Expected service utilization in service hours (CY 2014): **42,084.86**[5]

Number of second opinion requests: **0**
Number of out of network referrals: **0**

Perception of Care/Satisfaction

Consumer Perception of Care:

The CDRSN utilizes Question #6 from the Consumer Outcome Self-Rating Scale as a Regional Performance Measure to evaluate consumer perception of care (see table below):

[1] Total caseload is the total number of consumers who received a routine service between 1/1/2013and 6/30/2013.
[2] Total annual caseload is the total number of consumers who received a routine service in CY 2013
[3] The anticipated Medicaid enrollment is based on forecasts presented by Washington State relative to RSN rate development. The anticipated Medicaid enrollment incudes both the traditional and newly eligible caseloads.
[4] Expected utilization assumes that the same percentage of Medicaid eligibles that received services within the period under review will be applicable to the anticipated Medicaid enrollment.
[5] Expected utilization assumes that the same average number of service hours per person will be applicable to the anticipated Medicaid enrollment.

Over the past six months: (if this is your first appointment please answer N/A.)

Answer Options	Not at all	A little	Somewhat	A lot	N/A	Rating Average	Response Count
How much were you helped by the services that you received?	10	29	89	321	481	3.61	930
					answered question		930
					skipped question		0

Consumer Satisfaction:

The CDRSN evaluates consumer satisfaction with mental health services on an ongoing basis, including with regard to several key questions related to network sufficiency (see table below):

In the past six months,

Answer Options	Never	Sometimes	Usually	Always	Rating Average	Response Count
Was the location of services convenient?	10	52	205	585	3.60	852
Were the times that services were offered good for you?	1	41	226	590	3.64	858
Were you able to get all of the services that you needed?	1	45	216	591	3.64	853
Were you given information about your rights?	7	22	94	728	3.81	851
Did you feel free to complain?	13	40	132	668	3.71	853
Did you feel respected by staff?	4	13	73	761	3.87	851
Did you feel that staff were sensitive to your cultural background (race, religion, language, etc)?	22	18	68	741	3.80	849
Did you feel as involved as you would like in making treatment goals/decisions?	10	41	158	649	3.69	858
					answered question	859
					skipped question	2

Notes/Comments

Based on a review of the data contained herein, the CDRSN network maintained adequate capacity during the period under review to serve the Medicaid population in accordance with the State's standards for access to care, and to provide timely,

adequate access to all services covered under the contract with DBHR. The CDRSN actively promotes culturally competent services, as evidenced by network provider staff training activities, as well as the availability of Mental Health Specialists to provide consultation with regard to care provided to specified ethnic populations. Consumers hold a generally positive view of the provider network, as evidenced by consumer satisfaction with services, including service location, hours of availability and perception of cultural sensitivity.

Planning

In addition to standard, ongoing network adequacy monitoring activities, CDRSN shall conduct a follow-up assessment no later than August 31, 2014 to review network adequacy for the period of January 1, 2014 to June 30, 2014. Data from monitoring activities shall be aggregated to allow for comparison to the baseline assessment described herein.

Attachment 3: Agreements with City and County Jails

Addressing Item (174).

- Chelan Douglas Regional Support Network, JAIL LIAISON SERVICES: Catholic Charities of the Diocese of Yakima d.b.a. Catholic Family & Child Service, January 1, 2014 to June 30, 2015

- Spokane County RSN contract with Grant Integrated Services for Jail Services, Attachment describing Scope of Work for Jail Services.

Chelan Douglas Regional Support Network

JAIL LIAISON SERVICES

Catholic Charities of the Diocese of Yakima d.b.a. Catholic Family & Child Service

January 1, 2014 to June 30, 2015

Chelan-Douglas Regional Support Network

Providing Public Mental Health Services
in Chelan and Douglas Counties

300 S. Columbia, Wenatchee WA 98801
509-886-6318 / FAX 509-886-6320 / Toll Free 877-563-3678

Jail Liaison Services
Catholic Family & Child Service
Contract No. 2014-0005

CONTRACT

BETWEEN

CHELAN DOUGLAS REGIONAL SUPPORT NETWORK

AND

CATHOLIC FAMILY & CHILD SERVICE

THIS CONTRACT, Is made this day and between the CHELAN DOUGLAS REGIONAL SUPPORT NETWORK (CDRSN/PIHP or the Contractor), under the managing authority of Douglas County, Washington and Chelan County, Washington (the Counties), acting cooperatively as the Chelan-Douglas Regional Support Network Governing Board (Governing Board) and Catholic Charities of the Diocese of Yakima d.b.a. Catholic Family & Child Service (alternatively herein referred to as CFCS and/or the Subcontractor) as a part of the CDRSN/PIHP provider network, and together as "parties".

THE PURPOSE OF THIS CONTRACT IS TO PROVIDE: Age, cultural (BBA 438.206) and linguistically (BBA 438.207) competent (BBA 438.210) community mental health services to people with mental disorders, mental illness and children/adolescents with serious emotional disturbance and their families. These services will be provided in accordance with the State of Washington mental health system mission statement, value statement and the guiding principles for the system which have been adapted by the CDRSN/PIHP with RCW 71.24 and WAC 388-865, 388-877 and 388-877A or their successors; administration of the involuntary treatment program as outlined in RCWs 71.05 and 71.34, WACs 388-865, 388-877 and 388-877A or successors; outpatient mental health rehabilitation services *and* community psychiatric inpatient care under a Prepaid Health Plan managed care system to eligible Medicaid recipients in accordance with the Social Security Act ("Act") waived sections: 1902(a)(1), 1902 (a)(10), and 1902(a)(23), 1902 (a)(30) and, to the extent deemed necessary by state and federal government, any other provisions of Title XIX of the Social Security Act; and applicable Federal regulations and applicable state statutes and regulations, administrative codes and policies as well as the Chelan-Douglas RSN "Application for Qualification for the Integrated Contract", CDRSN/PIHP Policy and Procedures, and other assorted application documents. These are to be the basis of all aspects of service delivery, system capacity building and implementation of this Contract. Services described will be provided to Medicaid and non-Medicaid service recipients as described in Covered Lives section of this Contract.

NOW, THEREFORE, in consideration of the promises, terms and conditions set forth below, the parties hereby agree as follows:

TERMS AND CONDITIONS

ARTICLE I
THE CONTRACT DOCUMENTS

1.01 The Contract Documents for this Contract consist of this Contract and the following Exhibits attached hereto and incorporated by this reference:

Exhibit "A" - Statement of Work
Exhibit "B" - Consideration and Payment
Exhibit "C" - Jail Services Program Guidelines
Exhibit "D" - Data Security Requirements

ARTICLE II
PERIOD OF PERFORMANCE

2.01 The term of this Contract shall be from **January 1, 2014, through June 30, 2015**. Either party may terminate this Contract, without cause, on ninety (90) days prior written notice to the other party.

ARTICLE III
COMPENSATION

3.01 The compensation to be paid by the CDRSN/PIHP to the Subcontractor and the terms for payment of such compensation are set forth at Exhibit "B."

3.02 **Payment Conditioned on Insurance**. Compensation and/or payments due to the Subcontractor under this Contract are expressly conditioned upon the Subcontractor's strict compliance with all insurance requirements under Article IV. Payment to the Subcontractor shall be suspended in the event of non-compliance. Upon receipt of evidence of Subcontractor's compliance, payments not otherwise subject to withholding or set-off will be released to the Subcontractor.

ARTICLE IV
INSURANCE

4.01 **Insurance Required**. The Subcontractor shall, at its own expense, obtain and continuously maintain the following insurance coverage with such insurer or insurers as are licensed in the State of Washington and as shall be acceptable to the CDRSN/PIHP.

a **General Commercial Liability** - $2,000,000 Minimum, Each Occurrence
$2,000,000 Minimum, Annual Aggregate

Coverage shall include personal injury, bodily injury and property damage. Coverage shall not exclude or contain sub-limits less than the minimum required for Product/Completed Operations or Contractual Liability, unless approved in writing by the CDRSN/PIHP.

b. **Business Automobile Liability** - $2,000,000 Minimum, Each Occurrence
$2,000,000 Minimum, Annual Aggregate

Coverage shall include liability for all owned, non-owned and hired motor vehicles. Coverage may be satisfied by way of endorsement to the General Commercial Liability policy.

c. **Professional Liability** - $2,000,000 Minimum, Each Occurrence
$2,000,000 Minimum, Annual Aggregate

4.02 **Occurrence Based Coverage**. All insurance policies shall provide coverage on an occurrence basis.

4.03 **Primary, Non-contributory Insurance**. All Subcontractor's insurance policies and additional named insured endorsements shall provide primary insurance coverage and be non-contributory. Any insurance,

self-insured retention, deductible, or risk retention maintained or participated in by the County shall be excess and not contributory to such insurance policies. All Subcontractors' liability insurance policies must be endorsed to show this primary coverage.

4.04 **Review of Policy Provisions**. The CDRSN/PIHP reserves the right, but not the obligation, to revise any insurance requirement, not limited to limits, coverage's and endorsements, or to reject any insurance policies which fail to meet the requirements of this Contract. Additionally, the CDRSN reserves the right, but not the obligation, to review and reject any proposed insurer providing coverage based upon the insurer's financial condition or licensing status in Washington. Any deductibles and/or self-insured retentions exceeding $50,000, stop loss provisions, and/or exclusions contained in such policies must be approved by the CDRSN/PIHP in writing. For any deductibles or self-insured retentions exceeding $25,000 or any stop-loss provisions, the shall have the right to request and review the Subcontractor's most recent annual financial reports and audited financial statements as a condition of approval.

4.05 **Waiver of Subrogation**. The parties hereby agree to a waive subrogation with respect to each insurance policy maintained under this Contract. When required by an insurer, or if a policy condition does not permit a party to enter into a pre-loss agreement to waive subrogation without an endorsement, then the parties agrees to notify the insurer and obtain such endorsement. This requirement shall not apply to any policy which includes a condition expressly prohibiting waiver of subrogation by the insured or which voids coverage should the parties enter into such a waiver of subrogation on a pre-loss basis.

4.06 **Additional Insureds**. The CDRSN/PIHP and the Counties, their departments, elected and appointed officials, employees, agents and volunteers shall be named as additional insureds on Subcontractor's insurance policies by way of endorsement and all coverage shall be primary and non-contributory.

4.07 **Certificates of Insurance**. The Subcontractor shall, for each required insurance policy, provide a Certificate of Insurance, with endorsements attached, evidencing all required coverages, limits, deductibles, self-insured retentions and endorsements and which is conditioned upon the CDRSN/PIHP receiving thirty (30) days prior written notice of reduction in coverages, cancellation or non-renewal. Each Certificate of Insurance and all insurance notices shall be provided to the Prosecuting Attorney, P.O. Box 360, Waterville, WA 98858-0360.

4.08 **No Limitation on Liability**. The insurance maintained under this Contract shall not in any manner limit or qualify the liabilities or obligations of the Subcontractor under this Contract.

4.09 **Workers' Compensation**. The Subcontractor shall maintain Workers' Compensation coverage as required under the Washington State Industrial Insurance Act, RCW Title 51, for all Subcontractor's employees, agents and volunteers eligible for such coverage under the Industrial Insurance Act.

ARTICLE V
INDEMNITY

5.01 **Indemnification by Subcontractor**. To the fullest extent permitted by law, the parties agree to indemnify, defend and hold each other and the Counties, their departments, elected and appointed officials, employees, agents and volunteers, harmless from and against any and all claims, damages, losses and expenses, including but not limited to court costs, attorney's fees and alternative dispute resolution costs, for any personal injury, for any bodily injury, sickness, disease or death and for any damage to or destruction of any property (including the loss of use resulting therefrom) which 1) are caused in whole or in part by any act or omission, negligent or otherwise, of the other party its employees, agents or volunteers or such party's sub-subcontractors and their employees, agents or volunteers; or 2) are directly or indirectly arising out of, resulting from, or in connection with performance of this Agreement; or 3) are based upon the parties' or their sub-subcontractors' use of, presence upon or proximity to the property of the other party . This indemnification obligation shall not apply in the limited circumstance where the claim, damage, loss or expense is caused by the sole negligence of the other party . This indemnification obligation of the Subcontractor shall not be limited in any way by the Washington State Industrial Insurance Act, RCW Title 51, or by application of any other workmen's compensation act, disability benefit act or other employee benefit act, and the Subcontractor hereby expressly waives any immunity afforded by such acts. The foregoing indemnification obligations of the Subcontractor are a

material inducement to County to enter into this Agreement, are reflected in the Subcontractor's compensation, and have been mutually negotiated by the parties.

Subcontractor's initials acknowledging indemnity terms: _____

5.02 **Participation by County – No Waiver**. Each party and the Counties reserve the right, but not the obligation, to participate in the defense of any claim, damages, losses or expenses and such participation shall not constitute a waiver of the indemnity obligations under this Contract.

5.03 **Survival of Indemnity Obligations**. The parties agree all indemnity obligations shall survive the completion, expiration or termination of this Contract.

5.04 **Indemnity by Subcontractors**. In the event the Subcontractor enters into subcontracts to the extent allowed under this Contract, the Subcontractor's sub-subcontractors shall indemnify the CDRSN/PIHP and the Counties on a basis equal to or exceeding Subcontractor's indemnity obligations to the CDRSN/PIHP and the Counties.

ARTICLE VI
PERFORMANCE OF CONTRACT

6.01 **Licensing and Accreditation.** The Subcontractor shall comply with all federal, state and local licensing and accreditation requirements applicable to the performance of this Contract.

6.02 **Compliance with All Laws.** The Subcontractor shall comply with all federal, state and local laws, rules, regulations and ordinances applicable to the performance of this Contract, including without limitation all those pertaining to wages and hours, confidentiality, disabilities and discrimination.

6.03 **Maintenance and Audit of Records.** The Subcontractor shall maintain books, records, documents and other materials relevant to its performance and compensation under this Contract which sufficiently and accurately reflect any and all direct and indirect costs and expenses incurred or paid in the course of performing this Contract. These records shall be subject to inspection, review and audit by the CDRSN/PIHP or its designee, the Washington State Auditor's Office, and authorized federal agencies. The Subcontractor shall retain all such books, records, documents and other materials for seven (7) years following the completion of its performance under this Contract and any extension. Full access and examination shall be granted by the Subcontractor within such seven (7) years.

6.04 **On-Site Inspections.** The CDRSN/PIHP or its designee may evaluate the performance of this Contract by the Subcontractor through on-site inspection to determine whether the Subcontractor is providing services in compliance with the standards set forth in this Contract, and in compliance with federal, state and local laws, rules, regulations and ordinances.

6.05 **Confidentiality.** All information, records, and data created and/or collected by Subcontractor during the performance of this Contract shall remain confidential and shall be disclosed only in accordance with federal, state and local laws, rules, regulations and ordinances.

6.06 **Assets Furnished or Financed.** Title to any and all property or other assets furnished through the CDRSN/PIHP shall remain the property of the CDRSN/PIHP, shall be held in the name of the Subcontractor, and shall be used exclusively by the Subcontractor for its performance of this Contract.

6.07 **Rights in Data and Work Product.** Unless otherwise agreed upon by the parties in writing, all data, reports, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes, sound reproductions, educational courses and materials and other work product which originates from the Subcontractor's performance of this Contract shall be "works for hire' and shall be the property of the CDRSN/PIHP.

6.08 **Improper Influence.** The Subcontractor agrees warrants and represents that it did not and will not employ, retain or contract with any person or entity on a contingent compensation basis for the purpose of seeking, obtaining, maintaining or extending this Contract. The Subcontractor agrees, warrants and represents that no gratuity whatsoever as been or will offered or conferred with a view towards obtaining, maintaining or extending this Contract.

6.09 **Independent Contractor**. The Subcontractor is an independent contractor. The Subcontractor is not an employee of the County or the CDRSN/PIHP. The Subcontractor shall have exclusive control over the means, manner and mode of the performance of this Contract: provided, the County reserves the right to review and reject Subcontractor's work if such work does not comply with the provisions of this Contract. The Subcontractor shall pay and hold the County harmless from any and all federal, state and local taxes due as result of the compensation paid to the Subcontractor.

ARTICLE VII
DISPUTES

7.01 **Time.** Time is of the essence of this Contract.

7.02 **Contract Representative.** The CDRSN/PIHP and the Subcontractor shall each designate the person who has the authority and responsibility for administering this Contract. Absent such designation, the representatives executing this Contract on the behalf of the parties shall be conclusively presumed to have such authority and responsibility. All notices regarding the performance or interpretation of this Contract shall be served on such person.

7.03 **Conflict**. In the event of conflict among the terms and conditions of this Contract and federal, state or local law, the inconsistency shall be resolved by giving precedence of interpretation in the following order:

A. Applicable federal case law, statutes and regulations; then
B. Applicable Washington case law, statutes and regulations; then
C. The terms and conditions of this Contract; then
D. The terms and conditions of the Statement of Work; then
E. Any other terms and conditions of this Contract attached hereto or otherwise incorporated by reference.

7.04 **Waiver Limited.** A waiver of any term or condition of this Contract must be in writing and signed by the party. Any express or implied waiver of a term or condition of this Contract shall apply only to the specific act, occurrence or omission and shall not constitute a waiver as to any other term or condition or future act, occurrence or omission.

7.05 **Compliance Review Process and Corrective Action.** In the event of Subcontractor's non-compliance with any term or condition of this Contract, the CDRSN/PIHP may provide written notice to the Subcontractor of its non-compliance. The Subcontractor shall have thirty (30) days from receipt of such written notice to implement fully corrective action and to provide adequate assurances of continuing future compliance: provided, that the Subcontractor shall have only three (3) business days to demonstrate its compliance and to provide adequate assurances if the non-compliance presents a clear and imminent danger to the health and well-being of its service recipients, a clear violation of federal or state laws, rules or regulations specifically found to be of imminent concern and requiring immediate corrective action, a breach of the time limits for performance under this Contract, or an imminent loss of federal or state funding of this Contract. In the event the Subcontractor fails to take fully corrective action and to provide adequate assurances of future full compliance, the CDRSN/PIHP may elect to immediately terminate this Contract on written notice to the Subcontractor.

7.06 **Dispute Resolution.** Disputes, other than those which relate to non-compliance requiring only a three (3) day notice pursuant to the preceding subparagraph, shall be mediated by a mediator agreeable to the parties or in the absence of such agreement, arbitrated under the rules of the American Arbitration Association. .

7.07 **Property Return on Termination.** Upon the expiration or termination of this Contract, the Subcontractor shall return to the CDRSN/PIHP any property of the CDRSN/PIHP used by the Subcontractor towards the performance of this Contract.

7.08 **Attorney's Fees**. If any legal action or other proceeding is brought for the enforcement of this Contract, or because of an alleged dispute, breach, default, or misrepresentation in connection with any of the

provisions of this Contract, each party shall pay its own attorney's fees and costs incurred in that action, arbitration or proceeding, except as may be expressly provided under the Article for Indemnity.

7.09 **Governing Law and Venue**. This Contract shall be governed exclusively by the laws of the State of Washington. The Douglas County Superior Court shall be the sole proper venue for any and all suits brought to enforce or interpret the provisions of this Contract.

ARTICLE VIII
GENERAL PROVISIONS

8.01 **Assignment.** This Contract is personal to the Subcontractor. The Subcontractor may not assign its rights or delegate its duties under this Contract, whether by assignment, subcontract or other means. Any such attempted assignment or delegation shall be void and shall constitute a material breach of this Contract.

8.02 **Entire Contract**. This Contract constitutes the entire agreement between the CDRSN/PIHP and the Subcontractor. There are no understandings or agreements between CDRSN/PIHP and the Subcontractor other than those set forth in this Contract and in the Exhibits. No other statement, representation or promise has been made to induce either party to enter into this Contract.

8.03 **Modification.** This Contract may not be amended, supplemented or otherwise modified unless expressly set forth in a written agreement signed by the parties

8.04 **Invalid Provisions**. The invalidity or unenforceability of any particular term or provision of this Contract shall not affect the validity or enforceability of any other term or provision and this Contract shall be construed in all respects as if such invalid or unenforceable term or provision was omitted.

8.05 **Loss of Funding.** In the event funding from federal, state, county or other sources is withdrawn, reduced or limited in any way, the CDRSN/PIHP may terminate this Contract under the terms included in Exhibit B.

8.06 If any of the insurance coverages required under this Agreement is written on a claims-made basis, Contractor, at Contractor's option, shall either (i) maintain said coverage for at least three (3) years following the termination of this Agreement with coverage extending back to the effective date of this Agreement; (ii) purchase an extended reporting period of not less than three (3) years following the termination of this Agreement; or (iii) acquire a full prior acts provision on any renewal or replacement policy.

SUBCONTRACTOR

DATED: _____

_____
Director
Catholic Family & Child Service
640 S. Mission Street
Wenatchee, WA 98801
FEIN:

CDRSN GOVERNING BOARD

DATED: _____

By: _____
Ron Walter, Governing Board Chair

By: _____
Dale Snyder, Governing Board Vice Chair

APPROVED AS TO FORM:

_____
Douglas County Prosecuting Attorney

APPROVED:

_____
Interim Administrator Regional Support Network

STATEMENT OF WORK

1. **STATEMENT OF WORK**
   The Subcontractor shall furnish the necessary personnel, materials and/or services and otherwise do all things necessary for or incidental to the performance of the work set forth here and as attached.

2. **GOVERNANCE STRUCTURE AND CAPACITY**
   The Subcontractor shall ensure that it is organized and governed such that it has the capacity to operate as part of an integrated mental health provider network under the CDRSN/PIHP for the Chelan-Douglas service area. (BBA 438.206)

3. **MANAGEMENT AND ADMINISTRATIVE STRUCTURE**
   The Subcontractor shall:
   - Provide services in accordance with the terms set forth by the Division of Behavioral Health and Recovery (DBHR) in Jail Liaison Expectations.
   - Ensure service recipients receive individualized and tailored care in accordance with acceptable practices.
   - Ensure prompt access is available to all eligible consumers within Chelan County Regional Justice Center and Chelan County Juvenile Justice Center without waiting lists.
   - Be licensed by the proper department/agency for services for which state or federal law requires licensure. Verification of Subcontractor license shall be on-site and a copy provided to the Contractor within fifteen (15) calendar days of the Subcontractor's receipt of the new or renewed license.
   - Comply with all applicable local, state and federal licensing standards, all applicable accrediting or certification standards, and any other standards or criteria established by the Contractor to ensure quality of services, and to supply proof of said compliance upon demand.
   - Immediately notify the Contractor when the Subcontractor may not be in compliance with licensing requirements, with this contract, or with minimum standards for community mental health programs.
   - As part of customer service, be fully responsive to the independent Ombuds service.
   - Make known to service recipients their rights (including complaint, grievance, and fair hearing procedures and the availability of Ombuds service) and their responsibilities. Service recipient rights and responsibilities shall be translated into Spanish and other DBHR required languages by a certified translator. (BBA 438.10 (c) (4))
   - Subcontractors must abide by the requirements of Section 1128A(b) of the Act prohibiting Contractors and other providers from making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to recipients.
   - Notify the CDRSN/PIHP immediately of any incident where the potential for media coverage exists. Phone notification will be made to the CDRSN/PIHP Administrator or his/her designee, by the next working day following the Subcontractor becoming aware of such an event. Notification shall include a description of the event, the actions taken and potential ramifications.
   - Be responsible to provide the Contractor with all data as described in the data dictionary for the Chelan-Douglas RSN MIS or any successor (CDRSN/PIHP MIS), incorporated herein by reference; submit the CDRSN/PIHP MIS Data Dictionary defined transactions, within 7 days of the close of each calendar month. Submit data corrections related to encounters and/or Data Dictionary defined transactions by the 30th day of the calendar month following the month of the event.
   - Reports submitted by the Subcontractor shall be balanced against the RSN reports before submission according to the MIS policy in order to balance provider and PIHP CDRSN/PIHP data. Reports submitted to the RSN shall be considered final the last day of the month submitted.
   - Subcontractor shall grant designated PIHP CDRSN/PIHP staff 'view' privileges to publicly funded mental health consumers (TXIX, State, and County funded) data in subcontractors information system in order to allow the PIHP CDRSN/PIHP staff access to consumer's information.

4. **COVERED LIVES/SCOPE OF SERVICES**
Services include but are not limited to services described in WAC 388-877A and the community mental health outpatient rehabilitation services detailed in the Medicaid State Plan. While these service definitions are attached, they do not limit or preclude the Subcontractor from providing psychosocial rehabilitation services or other more innovative services and supports that address the individual needs of the service recipient. Subcontractor is responsible for sufficient staff within the jail to perform necessary interventions, direct service and case management to all eligible service recipients.

5. **DBHR AND CDRSN/PIHP PERFORMANCE INDICATORS**
Upon request, the Subcontractor shall promptly report to the Contractor specific data for the development and implementation of the performance indicators described in the Contractor/DBHR Contract in effect during the course of this Contract.

CONSIDERATION AND PAYMENT

1. PREMIUM PAYMENTS

1.1 Compensation shall be at a rate of **$3,685** per month.

1.2 Subcontractor shall ensure that administration, as a percentage of total program expenditures, does not cause the cumulative CDRSN/PIHP Provider Network administration average to exceed twenty (20) percent. As this is a cumulative figure which is inclusive of RSN administrative costs, Subcontractor administrative costs must never exceed 15% of revenue. This shall be monitored by the Subcontractor submitting a Cost Allocation Plan that crosswalks provider accounting methodology to the DSHS R&E reports and BARS guidelines defining direct, indirect and administrative costs to the Contractor within ten (10) business days of the close of the reporting period..

1.3 Payments shall be made to the Subcontractor by the 20th of the month.

1.4 In the event of a reduction in funding from DBHR/DSHS, payments to Subcontractor will be adjusted to accommodate monthly CDRSN/PIHP revenues.

2. REPORTS

2.1 Monthly reports are due from the Subcontractor by the 10th day of the close of each calendar month. Monthly reports shall consist of service reports.

2.2 Quarterly reports shall be submitted as deemed necessary by the CDRSN/PIHP.

2.3 Additional information/reports shall be submitted on an as needed basis by the request of CMS, DSHS and/or the CDRSN/PIHP within the timeframes identified by DSHS.

3. PERFORMANCE MEASURES

3.1 Subcontractor shall develop systems to measure and subsequently monitor and report to the CDRSN/PIHP the following performance outcomes utilizing measures mutually agreed to by Subcontractor and CDRSN/PIHP:

3.1.1 Reduce involvement with criminal justice systems, including jails and prisons; and

3.1.2 Reduce avoidable costs to jails.

4. PAYMENT SUSPENSION

4.1 CDRSN/PIHP may suspend payment, in whole or in part, upon initiating an investigation of a credible allegation of fraud.

5. LOSS OF FUNDING

5.1 In the event of a notification of loss of funding or termination of DSHS contract from DSHS, Subcontractor shall be notified by email or personally delivered letter the next business day.

5.2 Subcontractor shall be paid from any available Risk Reserves/State Advance for thirty (30) days of services as per this contract after such written notification is provided to Subcontractor.

JAIL SERVICES PROGRAM GUIDELINES

Intent

Jail Services funding is provided by the Washington Legislature to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health services upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re-instated Medicaid benefits.

Primary responsibility for direct mental health services and medications for individuals while they are in jail is the responsibility of the county or local jail. Services provided with this funding are intended to facilitate safe transition into community services. To that end, the funding provided through this exhibit shall supplement, and not supplant, local or other funding or in-kind resources being used for these purposes that were in effect in April 2005. This restriction does not apply to services previously provided by RSN savings which can no longer be used to provide Non-Medicaid services.

Reports

Reporting information will be captured in the database and reports will be submitted monthly. Additional reporting will be developed if and when a need arises.

Purpose

This Contract exhibit is in accordance with ESSB-6090, Sec. 204 Subsection 1(h): Department of Social and Health Services—Mental Health Program.

Scope of Work

At a minimum, the Contractor must:

1) Coordinate with local law enforcement and jail personnel including development of Memorandum of Understandings with local county and city jails in the contractors' service area which detail a referral process for individuals with mental illness who are incarcerated and need mental health services.
2) Identify and provide transition services to individuals with mental illness to expedite, facilitate, and coordinate their return to the community.
3) Give high priority to the completion of the report to the courts.
4) Identify and accept referrals for intake of individuals who are not enrolled in community mental health services but who meet priority populations as defined in 71.24. The Contractor shall conduct mental health intake assessments for these individuals and provide transition services prior to their release from jail. Intake assessments shall be completed using the Avatar Electronic Assessment.
5) Develop a Memorandum of Understanding with local community service offices toward the facilitation of expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. The Contractor shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

As funds and time allow, The Contractor may provide the following:

1) Development of individual alternative service plans (alternative to the jail) for submission to the courts – if receptive.
2) Pre-release transition planning (e.g. assessments, mental health services, co-occurring services, and housing).
3) Intensive post-release outreach to ensure individuals follow up with CSO and appointments for mental health and other services (e.g. substance abuse.)
4) Inter-local agreements with juvenile detentions facilities.
5) Training to local law enforcement and jail services personnel.
6) Provision of some direct mental health services to individuals who are in small jails which have no mental health staff.

Data Security Requirements

1. Data Transport. When transporting Confidential Information electronically, including via email, the data will be protected by:

a. Transporting the data within the (State Governmental Network) SGN or contractor's internal network, or;

b. Encrypting any data that will be in transit outside the SGN or contractor's internal network. This includes transit over the public Internet.

2. Protection of Data. The Subcontractor agrees to store data on one or more of the following media and protect the data as described:

a. **Hard disk drives.** Data stored on local workstation hard disks. Access to the data will be restricted to authorized users by requiring logon to the local workstation using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Complex passwords shall at minimum require at least 8 character and include a mix of upper- and lower- case letters, numbers and special characters.

b. **Network server disks.** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the data will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Complex passwords shall at minimum require at least 8 character and include a mix of upper- and lower- case letters, numbers and special characters. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

For confidential data stored on these disks, deleting unneeded data is sufficient as long as the disks remain in a secured area and otherwise meets the requirements listed in the above paragraph. Destruction of the data as outlined in Section 4. Data Disposition may be deferred until the disks are retired, replaced, or otherwise taken out of the secure environment.

c. **Optical discs (CDs or DVDs) in local workstation optical disc drives.** Data created or maintained under this agreement on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a secure area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access Data created or maintained under this agreement on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

d. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers.** Data created or maintained under this agreement on optical discs which will be attached to network servers and which will not be transported out of a secure area. Access to data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

e. **Paper documents.** Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

f. **Access via remote terminal/workstation over the State Governmental Network (SGN).** Data accessed and used interactively over the SGN. Access to the data will be controlled by DSHS staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Subcontractor will notify DSHS staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor, and whenever a user's duties change such that the user no longer requires access to perform work for this contract.

g. **Access via remote terminal/workstation over the Internet through Secure Access Washington.** Data accessed and used interactively over the SGN. Access to the data will be controlled by DSHS staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Subcontractor will notify DSHS staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor and whenever a user's duties change such that the user no longer requires access to perform work for this contract.

h. **Data storage on portable devices or media.**

(1) Data created or maintained under this agreement shall not be stored by the Subcontractor on portable devices or media unless specifically authorized within the Special Terms and Conditions of the contract. If so authorized, the data shall be given the following protections:

(a) Encrypt the data with a key length of at least 128 bits

(b) Control access to devices with a unique user ID and password or stronger authentication method such as a physical token or biometrics.

(c) Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity is 20 minutes.

Physically protect the portable device(s) and/or media by

(d) Keeping them in locked storage when not in use

(e) Using check-in/check-out procedures when they are shared, and

(f) Taking frequent inventories

(2) When being transported outside of a secure area, portable devices and media with confidential data must be under the physical control of contractor staff with authorization to access the data.

(3) Portable devices include, but are not limited to; handhelds/PDAs, Ultramobile PCs, flash memory devices (e.g. USB flash drives, personal media players), portable hard disks, and laptop/notebook computers if those computers may be transported outside of a secure area.

(4) Portable media includes, but is not limited to; optical media (e.g. CDs, DVDs), magnetic media (e.g. floppy disks, tape, Zip or Jaz disks), or flash media (e.g. CompactFlash, SD, MMC).

3. Data Segregation.

a. Data created or maintained under this agreement must be segregated or otherwise distinguishable from data not covered under this agreement.

b. Data created or maintained under this agreement will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no data not covered under this agreement. Or,

c. Data created or maintained under this agreement will be stored in a logical container on electronic media, such as a partition or folder dedicated to such data. Or,

d. Data created or maintained under this agreement will be stored in a database which will contain no data not covered by this agreement. Or,

e. Data created or maintained under this agreement will be stored within a database and will be distinguishable from other data by the value of a specific field or fields within database records. Or,

f. When stored as physical paper documents, Data created or maintained under this agreement will be physically segregated from data not covered under this agreement in a drawer, folder, or other container.

g. When it is not feasible or practical to segregate Data created or maintained under this agreement from data not covered under this agreement, then both the Data created or maintained under this agreement and the data not covered under this agreement with which it is commingled must be protected as described in this exhibit.

4. Data Disposition. When the contracted work has been completed or when no longer needed, data shall be returned to CDRSN/PIHP or destroyed. Media on which data may be stored and associated acceptable methods of destruction are as follows:

Data stored on:	**Will be destroyed by:**
Server or workstation hard disks, or Removable media (e.g. floppies, USB flash drives, portable hard disks, Zip or similar disks)	Using a "wipe" utility which will overwrite the data at least three (3) times using either random or single character data, or Degaussing sufficiently to ensure that the data cannot be reconstructed, or Physically destroying the disk
Paper documents with sensitive or confidential data	Recycling through a contracted firm provided the contract with the recycler assures that the confidentiality of data will be protected.
Paper documents containing confidential information requiring special handling (e.g. protected health information)	On-site shredding, pulping, or incineration
Optical discs (e.g. CDs or DVDs)	Incineration, shredding, or completely defacing the readable surface with a course abrasive
Magnetic tape	Degaussing, incinerating or crosscut shredding

5. Notification of Compromise or Potential Compromise. The compromise or potential compromise of DSHS shared data must be reported to the DSHS Contact designated on the contract within one (1) business day of discovery.

6. Data shared with Sub-contractors. If data created or maintained under this agreement is to be shared with a sub-contractor, the contract with the sub-contractor must include all of the data security provisions within this contract and within any amendments, attachments, or exhibits within this contract. If the contractor cannot protect the data as articulated within this contract, then the contract with the sub-contractor must be submitted to the DSHS Contact specified for this contract for review and approval.

14.2.2. If the Contractor chooses to enter into a Subcontract with a RAIO, the Contract must include one of the following:

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

14.2.2.2. 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.

14.2.3. Any Subcontracts with Tribes and RAIOs must be consistent with the laws and regulations that are applicable to the Tribe or RAIO. The Contractor must work with each Tribe to identify those areas that place legal requirements on the Tribe that are not applicable and refrain from passing these requirements on to Tribes.

14.2.4. The DBHR Tribal Liaison may be available for technical assistance in identifying what legal requirements the Contactor can be relieved of in Tribal or RAIO Subcontracts.

14.2.5. The Contractor shall have a policy and procedure that requires efforts to recruit and maintain Ethnic Minority Mental Health Specialists – Native American from each Tribe or RAIO listed in section 14.1.1 for use in specialists consults whenever possible.

15. SPECIAL PROJECTS

15.1. **Jail Coordination Services** – Are to be provided within the identified resources in Exhibit C.

15.1.1. The Contractor shall coordinate with local law enforcement and jail personnel. This shall include the development or maintenance of Memoranda of Understanding with local county and city jails in the Contractors' Service Area.

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.

15.1.1.1. The Contractor shall identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.

15.1.1.2. The Contractor shall accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. The Contractor shall conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.

15.1.1.3. The Contractor shall develop and execute a Memorandum of Understanding with local community service offices (CSO) for expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. The Contractor shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

15.1.1.4. Pre-release services shall include:

- 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.
- Mental health intake assessments for persons identified during the mental health screening as a member of the priority populations as defined in Chapter 71.24 RCW.
- Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.
- Other prudent pre-release (including pre-trial) case management and transition planning.

15.1.1.5. Provision of direct mental health services to individuals who are in jails that have no mental health staff.

15.1.1.6. 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 client in the community.

15.1.2. If the Contractor has provided the jail services above the Contractor may use the Jail Coordination Services funds provided to facilitate any of the following activities if there are sufficient resources:

15.1.2.1. Daily cross-reference between new bookings and the RSN database to identify newly booked, persons known to the RSN.

15.1.2.2. Development of individual alternative service plans (alternative to the jail) for submission to the courts.

15.1.2.3. Inter-local Agreements with juvenile detentions facilities.

15.1.2.4. Provision of up to a seven (7) day supply of medications prescribed for the treatment of mental health symptoms following the release from jail.

15.1.2.5. Training to local law enforcement and jail services personnel.

15.2. Expanded Community Services (ECS) (These terms are only in the following RSN's – Clark, King, North Sound, Peninsula, Pierce, Thurston, Timberlands) The ECS funding provided in Exhibit C 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.

15.2.1. The Contractor shall provide or maintain community residential and support services for Consumers with treatment needs that constitute substantial barriers to community placement. The Consumer must no longer need an inpatient Level of Care and be determined clinically ready for discharge.

15.2.2. The Contractor shall screen all new referrals for ECS using the state developed ECS screening form. Consumers are determined to be eligible for services under ECS by the Contractor. Additional Consumers may be identified during this contract period to participate in ECS if there is capacity.

Attachment 4: Subcontracts and Delegation

Addressing Item (290).

- Behavioral Health Options Contracts and Amendments

- CONTRACT Between AGING AND ADULT CARE OF WASHINGTON (AACW) and CHELAN-DOUGLAS REGIONAL SUPPORT NETWORK (CDRSN) for Ombuds Services and Addendum on Quality Review Team

- Sample Monitoring of Delegated Functions

CHELAN-DOUGLAS RSN/PIHP POLICY AND PROCEDURE MANUAL		Chapter:	2.27
Title:	DELEGATION	Page:	1 of 1
		Date Effective:	January 24, 2007
Subject:	DELEGATION AGREEMENTS	Date Revised: January 3, 2011	
		Authorizing Signature:	

AUTHORITY: BBA 438.230 (B)

PURPOSE: To ensure the compliance of the CDRSN Provider Network regarding the overseeing and accountability for any functions and responsibilities that are delegated to any subcontractor.

POLICY: The CDRSN/PIHP;

1) Before any delegation, evaluates the prospective subcontractor's ability to perform the activities to be delegated.
2) Has a written agreement that specifies the activities delegated to the subcontractor and provides for the revocation or imposition of sanctions should the subcontractor fail to perform.
3) Monitors the subcontractor's performance on an annual basis and subjects it to a formal review according to schedules established by the State and in accordance with industry standards or State laws and regulations.
4) Assures that corrective actions are taken to address any areas of deficiency.

PROCEDURE:

1) Before contracting for a sub delegated function the CDRSN/PHIP will conduct all appropriate due diligence activities including (as appropriate) the examination of the financial viability of the entity through financial and annual reports; staff professional credentials; affiliation with professional credentialing entities; policies and procedures and references.
2) Upon contracting for a sub delegated function, the CDRSN/PHIP will monitor the performance of the subcontractor through required reports, and both clinical and IS oversight, as appropriate.

Chelan-Douglas
Regional Support Network
For
Mental Health

300 S. Columbia, Wenatchee WA 98801
509-886-6318 / FAX 509-886-6320 / Toll Free 877-563-3678

SUPPLEMENT TO THE CONTRACT BETWEEN

CHELAN-DOUGLAS REGIONAL SUPPORT NETWORK
and
AGING AND ADULT CARE OF CENTRAL WASHINGTON

This Agreement Is made this day and between the Chelan-Douglas Regional Support Network (CDRSN/PIHP or the Contractor), under the managing authority of the CDRSN/PIHP Governing Board and Aging and Adult Care of Central Washington (the Subcontractor), and together as "parties".

The purpose of this Agreement is to supplement the existing contract between the parties to reflect additional services to be provided by the Subcontractor.

NOW, THEREFORE, in consideration of the promises, terms and conditions set forth below, the parties hereby agree as follows:

1. Supplemental Services.

   Subcontractor shall develop and maintain an independent Quality Review Team (QRT). The QRT shall include current consumers of the mental health system, past consumers or family members and be responsible for the following tasks:

   (1) Fairly and independently review the performance of the CDRSN/PIHP and service providers to evaluate systemic customer issues as measured by objective indicators of consumer outcomes in rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, including:
      a. Quality of care;
      b. The degree to which services are consumer-focused/ directed and are age and culturally competent;
      c. The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and
      d. The adequacy of the CDRSN/PIHP cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.

   (2) Work with the CDRSN/PIHP to ensure QRT staff have the authority to enter and monitor any CDRSN/PIHP contracted agency, as well as state and community hospitals, freestanding evaluation and treatment facilities, and community support service providers

   (3) Meet with interested consumers and family members, allied service providers, including state or community psychiatric hospitals, regional support network contracted service providers, and persons that represent the age and ethnic diversity of the CDRSN/PIHP to:
      a. Determine if services are accessible and address the needs of consumers based on sampled individual recipient's perception of services using a standard interview protocol provided by the CDRSN/PIHP. 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
      b. Work with interested consumers, service providers, and the CDRSN/PIHP to resolve identified problems.

(4) Provide reports and formalized recommendations at least biennially to the CDRSN Administrator and Advisory Board. Reports and recommendations shall synthesize the findings stemming from the activities completed by the QRT, and be in a form approved by the CDRSN/PIHP.

(5) Ensure QRT staff receive training regarding and adhere to confidentiality standards.

2. Reimbursement for Supplemental Services.

In consideration for the work to be provided by the Subcontractor in accordance with this supplemental agreement, AACCW shall be compensated at the set rate of $2,000.00 per month.

All other terms and conditions of the existing contract remain in full force and effect.

SUBCONTRACTOR

DATED:_____

_____
Bruce Buckles
Aging and Adult Care of Central Washington
50 Simon Street SE
East Wenatchee, WA 98802

CDRSN GOVERNING BOARD

DATED: _____

_____
Dale Snyder, CDRSN Governing Board Chair

DATED: _____

_____
Doug England, CDRSN Governing Board Vice Chair

APPROVED AS TO FORM:

_____
Douglas County Prosecuting Attorney

_____
Interim Administrator Regional Support Network

Chelan-Douglas
Regional Support Network

300 S Columbia, 3rd Floor, Wenatchee, WA 98801
(509) 886-6318 / FAX (509) 886-6320

Monday, April 21, 2014

Behavioral Healthcare Options, Inc.
2716 North Tenaya Way, Suite 563
Las Vegas, Nevada 89128

Dear Garyn Ramos,

The Chelan-Douglas Regional Support Network (CDRSN) is required by contract with the Division of Behavioral Health and Recovery (DBHR) of the Department of Social and Health Services (DSHS) to ensure that the CDRSN and its contractors and subcontractors are in compliance with the requirements mandated in the DBHR contract.

The CDRSN conducted its annual contract audit for Behavioral Health Options, Inc. on April 3rd and April 4th, 2014. The audit included the following items:

Section 1 – Operating and Systems

- Necessary Licenses and Certification by Law
- Certification of Liability Insurance
- Criminal Background checks
- DOH, OIG, LEIE, EPLS checks
- Employed staff credential in personnel files
- Staff Trainings and Development Plans
- Regular Supervision
- Second Opinion
- Caseloads
- Track Calls
- Inter-Rater Reliability Trainings and Determinations
- UM Plan for Outpatient and Inpatient Authorization Process by MHP
- Standard and Expedited Authorization Decision
- Authorization Extension Request
- Notice of Action Procedure
- Notice of Action Tracking Mechanism
- Utilization Review Accreditation Commission (URAC)
- Organization Chart

REVIEW RESULTS:

The CDRSN reviewed all of the subsections under **Section 1- Operating and Systems** and found Behavioral Healthcare Options, Inc. in compliance with all subsections. Policy and Procedures and backup documentation were reviewed.

Section 2- Compliance

- Fraud and Abuse Policy
- Fraud and Abuse Training
- Fraud and Abuse Log
- Compliance Program/Compliance Plan
- Regular Compliance Risk Assessments
- Corporate Compliance Office
- Corporate Compliance Committee
- Internal Compliance Monitoring/Auditing Activities
- Business Associate Agreements

REVIEW RESULTS:

The CDRSN reviewed all of the subsections under **Section 2- Compliance** and found Behavioral Healthcare Options, Inc. in compliance with all subsections. Policy and Procedures and backup documentation were reviewed.

Section 3- Information Systems/Security/Privacy

- Risk Analysis
- Risk Management Plan Implemented
- HIPAA Trainings
- Publication of Disciplinary Guidelines for HIPAA Violation
- Disclose PHI
- Monitor EPHI Access
- Assessing Breach Incidents
- Breach Notification Policy and Procedure
- Building Security Policy or Plan
- Backup and Recovery Procedure
- Password Protection and Auto timeout for unattended Desktops
- Disposal of Electronic and Physical PHI data
- Business Plan and Disaster Recovery Plan

REVIEW RESULTS:

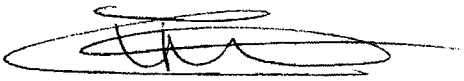
The CDRSN reviewed all the subsections under **Section 3- Information Systems/Security/Privacy** and found Behavioral Healthcare Options, Inc. in compliance with all subsections. Policy and Procedures and backup documentation were reviewed.

CORRECTIVE ACTION
The CDRSN did not find any deficiencies requiring corrective action as all subsections were in compliance.

However, CDRSN requests a back plan for future network connectivity issues with Avatar. CDRSN acknowledges that Behavioral Healthcare Options, Inc. is in the midst of setting up a backup PC in the Spokane location that will successfully connect to Avatar.

The Chelan-Douglas Regional Support Network (CDRSN) would like thank Behavioral Healthcare Options, Inc. for all their assistance in making this annual contract audit successful, and looks forward to continued successful outcomes throughout the years to come. Attached please also find the Contract Audit Tool with scoring and comments.

Best regards,



Rosa Guerrero, CDRSN IS Administrator

Cc: Contract File
Michelle Agnew
Tamara Cardwell-Burns, CDRSN Interim Administrator
Sandy Mitchell, TRSN
Sherri Maywald, GHRSN

Chelan-Douglas
Regional Support Network

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Best regards,

Rosa Guerrero, CDRSN IS Administrator

Cc: Contract File
Michelle Agnew
Tamara Cardwell-Burns, CDRSN Interim Administrator
Sandy Mitchell, TRSN
Sherri Maywald, GHRSN

BHO MONITOR[illegible]G TOOL

AUDIT DATE: April 3, 2014- April 4, 2014

Scoring Guidelines: 0 = Not Met; 1 = Partially Met; 2 = Met

	AUDIT SCOPE	P&P	STATUS	DOCUMENTATION	SCORE	COMMENTS
1.	OPERATING AND SYSTEMS					
1	Does Subcontractor hold all necessary license & certifications required by law? Including Certification of Liability Insurance		Complete	Copy of Licenses, liability insurance	2 = Met	Behavioral Healthcare Options, Inc. provided a copy of URAC certified 8/1/2013-8/1/2016 which was reviewed including a copy of Certification of Liability Insurance 5/1/2013-5/1/2014, both found in compliance.
2	Does the subcontractor have after hours coverage?	UM-WA-19	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. provided the after hours coverage which included Dr. on call. This was found in compliance.
3	Does the subcontractor conduct Criminal Backgroud checks through the Nevada Department of Public Safety and Washington State Patrol for all employees with unsupervised access to vulnerable populations?	UHG P&P	Complete	Copy of P&P and review paper backgroud checks	2 = Met	Behavioral Healthcare Options, Inc. provided documentation to show criminal background checks are performed for employees and found in compliance.
4	Does subcontractor conduct checks for employed staff through DOH? Does the subcontractor perform monthly excludsion checks using both the LEIE and EPLS exclusion databasees? Is a databased used to query the LEIE and EPLS files? If so, how is comparison done? (queries)	UHG P&P	Complete	Copy of P&P, DOH, LEIE and EPLS, Sample reviewed on site	2 = Met	Behavioral Healthcare Options, Inc. provided documentation of DOH, OIG, LEIE and EPLS checks were performed on employed staff and found in compliance.
5	Does subcontractor have employed staff credentials in personnel files?		Complete	Copy of staff roster & Staff Linceses	2 = Met	Behavioral Healthcare Options, Inc. provided documentation for employed staff and their credentials were are up to date and found in compliance.
6	Does subcontractor conduct Staff Trainings? How are Development Plans conducted?		Complete	Copy of training rosters, Development Plans	2 = Met	Behavioral Healthcare Options, Inc. provided documentaiton of Staff Trainings which are done quarterly by Garyn Ramos and Michelle Agnew.
7	Does subcontractor conduct regular supervision?	UHG P&P	Complete	Copy of P&P, supervision logs	2 = Met	Behavioral Healthcare Options, Inc. conducts regular supervison once a month, supervision documentation and logs were prvoided and reveiwed and found in compliance.
8	Does subcontractor provide Second Opinions? If so, how is it tracked?	UM-WA 008	Complete	Copy of P&P, 2nd Opinion tracking mechanisim	2 = Met	Behavioral Healthcare Options, Inc. does not have a formal second opinion process as BHO does not authorize second opinions for outpatient and for the inpatient process the second opinion is an appeal and not a second opinion, which are tracked in their Facets database. This was found in compliance.
9	Does subcontractor track caseloads?		Complete	Copy of Caseloads	2 = Met	Behavioral Healthcare Options, Inc. provided documentation for caseloads which were reviewed and found in compliance.
10	Does subcontractor track calls?	UM-WA-025 UM-WA-026	Complete	Copy of P&P, call monitoring logs	2 = Met	Behavioral Healthcare Options, Inc. tracks calls through EXP Macess and provided documentation on tracking calls which were reviewed and found in compliance.
11	Does subcontractor conduct Inter-Rater Reliability (IRR) Trainings and Determination? How is goal rate defined?	UHG &P	Complete	Copy of P&P, IRR Assessment Log and IRR Audit	2 = Met	Behavioral Healthcare Options, Inc. provided documentation for Inter-Rater Reliablity Trainings and Determination and were found in compliance, goal rate defined by their Learning Source online program. 6 employees passed with a 100% and 1 with a 90% percent, all employees passed.
12	Does subcontractor have a Utilization Management Plan for Outpatient and Inpatient Authorization process by MHP?	# 023, 024	Complete	Copy of P&P, Quality Improvement and Program Description	2 = Met	Behavioral Healthcare Options, Inc. provided Outpatient and Inpatient process by MHP documentation which was reviewed and found in compliance. Robert Brandon and Chery Musson are Child Specialist and supervise Evelyn Galasso.
13	Does subcontractor have a Authorization Decision (Standard & Expedited) policy?	UM-WA 008	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. Provided documentation for Standard and Expidited Authorization Decision which was reviewed and found in compliance.

14	Does Subcontrac ave a Request for Authorization Extension policy?	UM-WA 014	Complete	Copy of P&P	Met	Behavioral Healthcare Options, Inc. Provided documentation for an Authorizat Extension Request which was reviewed and found in compliance.
15	Does subcontractor have a Notice of Action, Notice for Denials and Appeals procedure?	UM-WA 002 UM-WA 003 UM-WA 008	Complete	Copy of p&P	2 = Met	Behavioral Healthcare Options, Inc. provided NOA process which were reviewed and found in compliance.
16	Does subcontractor have a tracking mechanism for Notice of Actions and Notice of Denials?		Complete	NOA & NOD log	2 = Met	Behavioral Healthcare Options, Inc. provided copy of NOA tracking log and found in compiance.
17	Is subcontractor a accredited Utilization Review Accreditation Commision (URAC) ?		Complete	Copy of URAC certificate	2 = Met	Behavioral Healthcare Options, Inc. provided copy of URAC certified for 8/1/2013-8/1/2016 found in compliance.
18	Does subcontractor have an Organization Chart?		Complete	Copy of Organization Chart	2 = Met	Behavioral Healthcare Options, Inc. provided copy of organization chart and found in compliance.
	AUDIT SCOPE	**P&P**	**STATUS**	**DOCUMENTATION**	**SCORE**	**COMMENTS**
2.	**COMPLIANCE**					
1	Does subcontractor have a Fraud and Abuse Policy?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. provided documentation of Fraud and Abuse compliance policy. This was reviewed in found in compliance.
2	Does subcontractor conduct Fraud and Abuse Training?	Compliance Plan Handbook	Complete	Fraud & Abuse Training Roster	2 = Met	Behavioral Healthcare Options, Inc. provided copy of Compliance Plan Handbook, trainings are done via LearnSource which sends email notificaion to staff informing them of trainings, copy of fraud and abuse training "my course and history" including email notification were reviewed and found in compliance.
3	Does subcontractor have a Fraud and Abuse Log?	Compliance Plan Handbook	Complete	Fraud & Abuse Log	2 = Met	Behavioral Healthcare Options, Inc. tracks Fraud and Abuse thru their HelpCenter Log and also Tripwire to alert of possible non-compliance. Documentation reviewed and found in compliance.
4	Does subcontractor have a Compliance Program/Compliance Plan?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. Compliance Plan Handbook was reviewed and found in compliance.
5	Does subcontractor conduct regular Compliance Risk Assessments?	Compliance Plan Handbook	Complete	Risk Assessment	2 = Met	Behavioral Healthcare Options, Inc. has a risk assessment system that determines where company is at risk and prioritizes (ranks) the risks.
6	Does subcontractor have a Corporate Compliance Officer?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. compliance officer Keith Hawkins at Office (702) 242-7181 Fax (702)242-5439
7	Does subcontractor have a Corporate Compliance Committee?	Compliance Plan Handbook	Complete	Copy of P&P, Compliance Committee Minutes	2 = Met	Behavioral Healthcare Options, Inc. Corporate Committee is formed by Compliance Officerand Deputy General Counsel. GPCC minutes were reviewed.
8	What internal compliance monitoring/auditing activities are being completed? How are they monitored?	Compliance Plan Handbook	Complete	Copy of P&P, Monitoring/Auditing Verification	2 = Met	Behavioral Healthcare Options, Inc. uses Tripwire for internal compliance monitoring/auditing activities and are reported to the complinace officer.
9	Does subcontractor have Business Associate Agreements?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. does have Business Associate Agreements that comply with the HITECH Act requirements.
	AUDIT SCOPE	**P&P**	**STATUS**	**DOCUMENTATION**	**SCORE**	**COMMENTS**
3.	**INFORMATION SYSTEMS/SECURITY/PRIVACY**					
1	Has a Risk Analysis been completed? Has a Risk Management Plan Implemented?	Annual Security Risk Analysis	Complete	Review paper Analysis and Risk Plan	2 = Met	Behavioral Healthcare Options, Inc. completed it's annual Risk Analysis in 12/2103 which includes action plan to mitigate risks and compliance issues.

2	Does subcontrac ave HIPAA Privacy and Security Policies in place?	UHG P&P	Complete	Copy of P&P	Met	Behavioral Healthcare Options, Inc. stores P&P in "SPARK" system and in Infor n System Security Policy.
3	Does subcontractor conduct HIPAA Trainings?		Complete	HIPAA Training rosters	2 = Met	Behavioral Healthcare Options, Inc. conducts HIPAA trainings via LearnSource. Reviewed documenentation and found in compliance.
4	Does subcontract have policy that publicizes disciplinary guidelines for HIPAA Violation?	UHC Privacy Policy P20	Complete	HIPAA Violation Log	2 = Met	Behavioral Healthcare Options, Inc. publicizes diciplinary actions through P&P
5	Does subcontractor disclose PHI to others?	UHC Privacy Policy P9	Complete	Copy of P&P, review PHI Disclosure Logs	2 = Met	Behavioral Healthcare Options, Inc. has policy which addresses Disclosure of PHI to third parties with BAAs.
6	Does subcontractor have a Security Awareness Program?		Complete	Copy of P&P, Security Awareness Program Definition and Evidence of Security Reminders	2 = Met	Behavioral Healthcare Options, Inc. uses "Safe with Me" program to send automatic security reminders.
7	How does subcontractor monitor EPHI access? If data maintained on own servers, how do you monitor access and incedents including unauthorized alteration or deletion?		Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. maintains a core product systems that provides PHI audit trails on any user that access PHI. Quarterly audits of PHI access are also performed. Tripwire is also used to monitor changes to the system resources to provide audit trail on any unauthorized alteration or deletions.
8	Does Subcontract have process for assessing for Breach Incidents (breach risk assessment)?	IS Security Policy & UGH P&P	Complete	Copy of P&P, Breach Incident Report Form	2 = Met	Behavioral Healthcare Options, Inc. uses the UHG help desk for assessing Breach Incidents which are directed to Compliance Officer.
9	Does subcontractor have a Breach Notification P&P?	IS Security Policy & UGH P&P	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. includes Breach Notification process in the IS Security Policy.
10	Does subcontractor have Building Security policies or plan?	UHG P&P	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. has controlled access to building by key cards and security guards monitor entrances for guests. All guest are required to be escorted into UHG facilities and required to sign in.
11	Does subcontractor have a Backup and Recovery Procedure?	IS Disaster Recovery Plan	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. does have Backup and Recovery Procedure which was reviewed and found compliant.
12	Does subcontractor have a password protection policy? Is so, what is your password complexity and how is it enforced? Auto timeout on unattented desktops?	IS System Security Policy	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. provided IS System Securtiy Policy which includes Password Protection, Password Complexity and Auto Timeout on inactive PCs. Password complexity is 8 characters (upper, lower, symbol, number). Timeout on unattended PCs is 15 minutes.
13	How does subcontractor dispose of electronic and physical (e.g. paper PHI)?	IS System Security Policy	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. shreds all paper documentation that includes PHI by placing paper documentation in lock containers that are shredded on site by a contracted vendor. All EPHI information must be stored on a secured, access-controlled system within UHG Data Centers. No EPHI will be stored on local machines except on portable devices that are encrypted.
14	Does subcontractor have a Business Plan & Disaster Recovery Plan? How often is plan tested? What method is used?	Business Continuity Plan and	Complete	Copy of P&P, review copy of actual testing documentation	2 = Met	Behavioral Healthcare Options, Inc. does have a business plan and disaster recovery plan and tested annually. Different scenarios are used to evaluate and test disasters.

15	In the event mec al, ISP, phones, etc. failed, how does subcontracto proceed with contracted required processes?		In Progress	Copy of P&P	Partially N	Per Robert Brandon, in the event that there are ISP issues, they were transferr the Spokane location. 4/11/2014- BHO reported that PCs used for Avatar were not able to connect. The Spokane location did not have a PC setup for Avatar therefore Outpatient Authorizations were not being reviewed as scheduled. On 4/15/2014, CDRSN recieved email confirmation that PC's were successfully connecting to Avatar. 4/15/2014- Robert Brandon emailed that a PC was being setup in the Spokane location in the event future network connection issues arised but were not successful loading Avatar and Connectra. Behavioral Healthcare Options, Inc. will need to provide and implement procedure for future incedents as experienced on 4/11/2014 with Avatar.

COMMENTS: Please see section 3 question 15 and submit procedure for PC backup for Avatar Access for future unsuccessful connectivity to Avatar.

Date:	4/21/2014
RSN Reviewing Staff:	Rosa Guerrero, CDRSN IS Administrator
BHO Staff Participating:	Robert Brandon, LMHC, LMFT

BHO MONITO IG TOOL

AUDIT DATE: April 3, 2014- April 4, 2014

Scoring Guidelines: **0** = Not Met; **1** = Partially Met; **2** = Met

	AUDIT SCOPE	P&P	STATUS	DOCUMENTATION	SCORE	COMMENTS
OPERATING AND SYSTEMS						
1	Does Subcontractor hold all necessary license & certifications required by law? Including Certification of Liability Insurance			Copy of Licenses, liability insurance		
2	Does the subcontractor have after hours coverage?			Copy of P&P		
3	Does the subcontractor conduct Criminal Backgroud checks through the Nevada Department of Public Safety and Washington State Patrol for all employees with unsupervised access to vulnerable populations?			Copy of P&P and review paper backgroud checks		
4	Does subcontractor conduct checks for employed staff through DOH? Does the subcontractor perform monthly excludsion checks using both the LEIE and EPLS exclusion databasees? Is a databased used to query the LEIE and EPLS files? If so, how is comparison done? (queries)			Copy of P&P, DOH, LEIE and EPLS, Sample reviewed on site		
5	Does subcontractor have employed staff credentials in personnel files?			Copy of staff roster & Staff Linceses		
6	Does subcontractor conduct Staff Trainings? How are Development Plans conducted?			Copy of training rosters, Development Plans		
7	Does subcontractor conduct regular supervision?			Copy of P&P, supervision logs		
8	Does subcontractor provide Second Opinions? If so, how is it tracked?			Copy of P&P, 2nd Opinion tracking mechanisim		
9	Does subcontractor track caseloads?			Copy of Caseloads		
10	Does subcontractor track calls?			Copy of P&P, call monitoring logs		
11	Does subcontractor conduct Inter-Rater Reliability (IRR) Trainings and Determination? How is goal rate defined?			Copy of P&P, IRR Assessment Log and IRR Audit		
12	Does subcontractor have a Uitlization Management Plan for Outpatient and Inpatient Authorization process by MHP?			Copy of P&P, Quality Improvement and Program Description		

13	Does subcontra ave a Authorization Decision (Standard & Expedited) policy?			Copy of P&P		
14	Does Subcontractor have a Request for Authorization Extension policy?			Copy of P&P		
15	Does subcontractor have a Notice of Action, Notice for Denials and Appeals procedure?			Copy of p&P		
16	Does subcontractor have a tracking mechanism for Notice of Actions and Notice of Denials?			Copy of P&P, NOA & NOD log		
17	Is subcontractor a accredited Utilization Review Accreditation Commision (URAC) ?			Copy of URAC certificate		
18	Does subcontractor have an Organization Chart?			Copy of Organization Chart		
	AUDIT SCOPE	**P&P**	**STATUS**	**DOCUMENTATION**	**SCORE**	**COMMENTS**
COMPLIANCE						
1	Does subcontractor have a Fraud and Abuse Policy?			Copy of P&P		
2	Does subcontractor conduct Fraud and Abuse Training?			Copy of P&P, Fraud & Abuse Training Roster		
3	Does subcontractor have a Fraud and Abuse Log?			Copy of P&P, Fraud & Abuse Log		
4	Does subcontractor have a Compliance Program/Compliance Plan?			Copy of P&P		
5	Does subcontractor conduct regular Compliance Risk Assessments?			Copy of P&P, Risk Assessment		
6	Does subcontractor have a Corporate Compliance Officer?			Copy of P&P		
7	Does subcontractor have a Corporate Compliance Committee?			Copy of P&P, Compliance Committee Minutes		
8	What internal compliance monitoring/auditing activities are being completed? How are they monitored?			Copy of P&P, Monitoring/Auditing Verification		

9	Does subcontra ave Business Associate Agreements?			Copy of P&P		
	AUDIT SCOPE	**P&P**	**STATUS**	**DOCUMENTATION**	**SCORE**	**COMMENTS**
INFORMATION SYSTEMS/SECURITY/PRIVACY						
1	Has a Risk Analysis been completed? Has a Risk Management Plan Implemented?			Copy of P&P, review paper Analysis and Risk Plan		
2	Does subcontractor have HIPAA Privacy and Security Policies in place?			Copy of P&P		
3	Does subcontractor conduct HIPAA Trainings?			Copy of P&P, HIPAA Training rosters		
4	Does subcontract have policy that publicizes disciplinary guidelines for HIPAA Violation?			Copy of P&P, HIPAA Violation Log		
5	Does subcontractor disclose PHI to others?			Copy of P&P, review PHI Disclosure Logs		
6	Does subcontractor have a Security Awareness Program?			Copy of P&P, Security Awareness Program Definition and Evidence of Security Reminders		
7	How does subcontractor monitor EPHI access? If data maintained on own servers, how do you monitor access and incedents including unauthorized alteration or deletion?			Copy of P&P		
8	Does Subcontract have process for assessing for Breach Incidents (breach risk assessment)?			Copy of P&P, Breach Incident Report Form		
9	Does subcontractor have a Breach Notification P&P?			Copy of P&P		
10	Does subcontractor have Building Security policies or plan?			Copy of P&P		
11	Does subcontractor have a Backup and Recovery Procedure?			Copy of P&P		

12	Does subcontra ave a password protection policy? Is so, what is your password complexity and how is it enforced? Auto timeout on unattented desktops?			Copy of P&P		
13	How does subcontractor dispose of electronic and physical (e.g. paper PHI)?			Copy of P&P		
14	Does subcontractor have a Business Plan & Disaster Recovery Plan? How often is plan tested? What method is used?			Copy of P&P, review copy of actual testing documentation		
15	In the event mechanical, ISP, phones, etc. failed, how does subcontractor proceed with contracted required processes?			Copy of P&P		

Date:	
RSN Reviewing Staff:	
BHO Staff Participating:	

BHO Monitoring Tool
2012-2013

Scoring Guidelines: **0** = Not Met; **1** = Partially Met; **3** = Met.

General Requirements: Must demonstrate the following as the item applies to the delegated function.

Audit Scope	Score	Comments
Operations and Systems		
After Hours Coverage		
Authorization by MHP (Verified)		
Inter-Rater Reliability Training & Determination		
Staff Credentials and Personnel Files		
Staff Training Curriculum and Logs		
Supervision Logs		
ACD Times and Reports		
Call Monitoring Logs (side-by-side and silent)		
Second Opinion Tracking		
Compliance		
HIPAA Privacy & Security Policies		
HIPAA Training		
HIPAA Violation Log		
HIPAA Disclosure Log		
Security Awareness Program		
Building Security		
Insurance Coverage		
Employee Handbook		
Excluded Provider/Debarment Policies		
Employee Background Check Policy		

Fraud & Abuse Policy		
Fraud & Abuse Training		
Fraud & Abuse Log		
Compliance Program/Compliance Plan		
Corporate Compliance Officer		
Corporate Compliance Committee		
Business Associate Agreements		
Breach Assessment Procedure		
Breach Notification Policy and Procedure		
Information Systems		
HIPAA Physical, Technical and Administrative Safeguards		
Network Security		
Backup and Recovery		
Password Protection		
Business Plan & Disaster Recovery		
Policies/Procedures/Contract Requirements		
URAC Accreditation		
Organizational Chart		
Staff Roster (including Credentials)		
Utilization Management Plan		
Authorization Decisions (Standard and Expedited) P & P's		
Requests for Authorizations Extensions P & P's		
Denials (NOA & NOD) P & P's		
Tracking of Denials (NOD & NOA) P & P's		

RSN Reviewing Staff: _____ Date: _____

BHC Staff Participating: _____

BHO MONITO G TOOL

AUDIT DATE: April 3, 2014- April 4, 2014

Scoring Guidelines: **0** = Not Met; **1** = Partially Met; **2** = Met

	AUDIT SCOPE	P&P	STATUS	DOCUMENTATION	SCORE	COMMENTS
1.	**OPERATING AND SYSTEMS**					
1	Does Subcontractor hold all necessary license & certifications required by law? Including Certification of Liability Insurance		Complete	Copy of Licenses, liability insurance	2 = Met	Behavioral Healthcare Options, Inc. provided a copy of URAC certified 8/1/2013-8/1/2016 which was reviewed including a copy of Certification of Liability Insurance 5/1/2013-5/1/2014, both found in compliance.
2	Does the subcontractor have after hours coverage?	UM-WA-19	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. provided the after hours coverage which included Dr. on call. This was found in compliance.
3	Does the subcontractor conduct Criminal Backgroud checks through the Nevada Department of Public Safety and Washington State Patrol for all employees with unsupervised access to vulnerable populations?	UHG P&P	Complete	Copy of P&P and review paper backgroud checks	2 = Met	Behavioral Healthcare Options, Inc. provided documentation to show criminal background checks are performed for employees and found in compliance.
4	Does subcontractor conduct checks for employed staff through DOH? Does the subcontractor perform monthly excludsion checks using both the LEIE and EPLS exclusion databasees? Is a databased used to query the LEIE and EPLS files? If so, how is comparison done? (queries)	UHG P&P	Complete	Copy of P&P, DOH, LEIE and EPLS, Sample reviewed on site	2 = Met	Behavioral Healthcare Options, Inc. provided documentation of DOH, OIG, LEIE and EPLS checks were performed on employed staff and found in compliance.
5	Does subcontractor have employed staff credentials in personnel files?		Complete	Copy of staff roster & Staff Linceses	2 = Met	Behavioral Healthcare Options, Inc. provided documentation for employed staff and their credentials were are up to date and found in compliance.
6	Does subcontractor conduct Staff Trainings? How are Development Plans conducted?		Complete	Copy of training rosters, Development Plans	2 = Met	Behavioral Healthcare Options, Inc. provided documentaiton of Staff Trainings which are done quarterly by Garyn Ramos and Michelle Agnew.
7	Does subcontractor conduct regular supervision?	UHG P&P	Complete	Copy of P&P, supervision logs	2 = Met	Behavioral Healthcare Options, Inc. conducts regular supervison once a month, supervision documentation and logs were prvoided and reveiwed and found in compliance.
8	Does subcontractor provide Second Opinions? If so, how is it tracked?	UM-WA 008	Complete	Copy of P&P, 2nd Opinion tracking mechanisim	2 = Met	Behavioral Healthcare Options, Inc. does not have a formal second opinion process as BHO does not authorize second opinions for outpatient and for the inpatient process the second opinion is an appeal and not a second opinion, which are tracked in their Facets database. This was found in compliance.
9	Does subcontractor track caseloads?		Complete	Copy of Caseloads	2 = Met	Behavioral Healthcare Options, Inc. provided documentation for caseloads which were reviewed and found in compliance.
10	Does subcontractor track calls?	UM-WA-025 UM-WA-026	Complete	Copy of P&P, call monitoring logs	2 = Met	Behavioral Healthcare Options, Inc. tracks calls through EXP Macess and provided documentation on tracking calls which were reviewed and found in compliance.
11	Does subcontractor conduct Inter-Rater Reliability (IRR) Trainings and Determination? How is goal rate defined?	UHG &P	Complete	Copy of P&P, IRR Assessment Log and IRR Audit	2 = Met	Behavioral Healthcare Options, Inc. provided documentation for Inter-Rater Reliablity Trainings and Determination and were found in compliance, goal rate defined by their Learning Source online program. 6 employees passed with a 100% and 1 with a 90% percent, all employees passed.
12	Does subcontractor have a Utilization Management Plan for Outpatient and Inpatient Authorization process by MHP?	# 023, 024	Complete	Copy of P&P, Quality Improvement and Program Description	2 = Met	Behavioral Healthcare Options, Inc. provided Outpatient and Inpatient process by MHP documentation which was reviewed and found in compliance. Robert Brandon and Chery Musson are Child Specialist and supervise Evelyn Galasso.
13	Does subcontractor have a Authorization Decision (Standard & Expedited) policy?	UM-WA 008	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. Provided documentation for Standard and Expidited Authorization Decision which was reviewed and found in compliance.
14	Does Subcontractor have a Request for Authorization Extension policy?	UM-WA 014	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. Provided documentation for an Authorization Extension Request which was reviewed and found in compliance.

15	Does subcontra ave a Notice of Action, Notice for Denials and Appeals procedure?	UM-WA 002 UM-WA 003 UM-WA 008	Complete	Copy of p&P	= Met	Behavioral Healthcare Options, Inc. provided NOA process which were revie nd found in compliance.
16	Does subcontractor have a tracking mechanism for Notice of Actions and Notice of Denials?		Complete	NOA & NOD log	2 = Met	Behavioral Healthcare Options, Inc. provided copy of NOA tracking log and found in compiance.
17	Is subcontractor a accredited Utilization Review Accreditation Commision (URAC) ?		Complete	Copy of URAC certificate	2 = Met	Behavioral Healthcare Options, Inc. provided copy of URAC certified for 8/1/2013-8/1/2016 found in compliance.
18	Does subcontractor have an Organization Chart?		Complete	Copy of Organization Chart	2 = Met	Behavioral Healthcare Options, Inc. provided copy of organization chart and found in compliance.
	AUDIT SCOPE	**P&P**	**STATUS**	**DOCUMENTATION**	**SCORE**	**COMMENTS**
2.	**COMPLIANCE**					
1	Does subcontractor have a Fraud and Abuse Policy?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. provided documentation of Fraud and Abuse compliance policy. This was reviewed in found in compliance.
2	Does subcontractor conduct Fraud and Abuse Training?	Compliance Plan Handbook	Complete	Fraud & Abuse Training Roster	2 = Met	Behavioral Healthcare Options, Inc. provided copy of Compliance Plan Handbook, trainings are done via LearnSource which sends email notificaion to staff informing them of trainings, copy of fraud and abuse training "my course and history" including email notification were reviewed and found in compliance.
3	Does subcontractor have a Fraud and Abuse Log?	Compliance Plan Handbook	Complete	Fraud & Abuse Log	2 = Met	Behavioral Healthcare Options, Inc. tracks Fraud and Abuse thru their HelpCenter Log and also Tripwire to alert of possible non-compliance. Documentation reviewed and found in compliance.
4	Does subcontractor have a Compliance Program/Compliance Plan?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. Compliance Plan Handbook was reviewed and found in compliance.
5	Does subcontractor conduct regular Compliance Risk Assessments?	Compliance Plan Handbook	Complete	Risk Assessment	2 = Met	Behavioral Healthcare Options, Inc. has a risk assessment system that determines where company is at risk and prioritizes (ranks) the risks.
6	Does subcontractor have a Corporate Compliance Officer?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. compliance officer Keith Hawkins at Office (702) 242-7181 Fax (702)242-5439
7	Does subcontractor have a Corporate Compliance Committee?	Compliance Plan Handbook	Complete	Copy of P&P, Compliance Committee Minutes	2 = Met	Behavioral Healthcare Options, Inc. Corporate Committee is formed by Compliance Officerand Deputy General Counsel. GPCC minutes were reviewed.
8	What internal compliance monitoring/auditing activities are being completed? How are they monitored?	Compliance Plan Handbook	Complete	Copy of P&P, Monitoring/Auditing Verification	2 = Met	Behavioral Healthcare Options, Inc. uses Tripwire for internal compliance monitoring/auditing activities and are reported to the complinace officer.
9	Does subcontractor have Business Associate Agreements?	Compliance Plan Handbook	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. does have Business Associate Agreements that comply with the HITECH Act requirements.
	AUDIT SCOPE	**P&P**	**STATUS**	**DOCUMENTATION**	**SCORE**	**COMMENTS**
3.	**INFORMATION SYSTEMS/SECURITY/PRIVACY**					
1	Has a Risk Analysis been completed? Has a Risk Management Plan Implemented?	Annual Security Risk Analysis	Complete	Review paper Analysis and Risk Plan	2 = Met	Behavioral Healthcare Options, Inc. completed it's annual Risk Analysis in 12/2103 which includes action plan to mitigate risks and compliance issues.

2	Does subcontra ave HIPAA Privacy and Security Policies in place?	UHG P&P	Complete	Copy of P&P	= Met	Behavioral Healthcare Options, Inc. stores P&P in "SPARK" system and in Inf ion System Security Policy.
3	Does subcontractor conduct HIPAA Trainings?		Complete	HIPAA Training rosters	2 = Met	Behavioral Healthcare Options, Inc. conducts HIPAA trainings via LearnSource. Reviewed documenentation and found in compliance.
4	Does subcontract have policy that publicizes disciplinary guidelines for HIPAA Violation?	UHC Privacy Policy P20	Complete	HIPAA Violation Log	2 = Met	Behavioral Healthcare Options, Inc. publicizes diciplinary actions through P&P
5	Does subcontractor disclose PHI to others?	UHC Privacy Policy P9	Complete	Copy of P&P, review PHI Disclosure Logs	2 = Met	Behavioral Healthcare Options, Inc. has policy which addresses Disclosure of PHI to third parties with BAAs.
6	Does subcontractor have a Security Awareness Program?		Complete	Copy of P&P, Security Awareness Program Definition and Evidence of Security Reminders	2 = Met	Behavioral Healthcare Options, Inc. uses "Safe with Me" program to send automatic security reminders.
7	How does subcontractor monitor EPHI access? If data maintained on own servers, how do you monitor access and incedents including unauthorized alteration or deletion?		Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. maintains a core product systems that provides PHI audit trails on any user that access PHI. Quarterly audits of PHI access are also performed. Tripwire is also used to monitor changes to the system resources to provide audit trail on any unauthorized alteration or deletions.
8	Does Subcontract have process for assessing for Breach Incidents (breach risk assessment)?	IS Security Policy & UGH P&P	Complete	Copy of P&P, Breach Incident Report Form	2 = Met	Behavioral Healthcare Options, Inc. uses the UHG help desk for assessing Breach Incidents which are directed to Compliance Officer.
9	Does subcontractor have a Breach Notification P&P?	IS Security Policy & UGH P&P	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. includes Breach Notification process in the IS Security Policy.
10	Does subcontractor have Building Security policies or plan?	UHG P&P	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. has controlled access to building by key cards and security guards monitor entrances for guests. All guest are required to be escorted into UHG facilities and required to sign in.
11	Does subcontractor have a Backup and Recovery Procedure?	IS Disaster Recovery Plan	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. does have Backup and Recovery Procedure which was reviewed and found compliant.
12	Does subcontractor have a password protection policy? Is so, what is your password complexity and how is it enforced? Auto timeout on unattented desktops?	IS System Security Policy	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. provided IS System Securtiy Policy which includes Password Protection, Password Complexity and Auto Timeout on inactive PCs. Password complexity is 8 characters (upper, lower, symbol, number). Timeout on unattended PCs is 15 minutes.
13	How does subcontractor dispose of electronic and physical (e.g. paper PHI)?	IS System Security Policy	Complete	Copy of P&P	2 = Met	Behavioral Healthcare Options, Inc. shreds all paper documentation that includes PHI by placing paper documentation in lock containers that are shredded on site by a contracted vendor. All EPHI information must be stored on a secured, access-controlled system within UHG Data Centers. No EPHI will be stored on local machines except on portable devices that are encrypted.
14	Does subcontractor have a Business Plan & Disaster Recovery Plan? How often is plan tested? What method is used?	Business Continuity Plan and	Complete	Copy of P&P, review copy of actual testing documentation	2 = Met	Behavioral Healthcare Options, Inc. does have a business plan and disaster recovery plan and tested annually. Different scenarios are used to evaluate and test disasters.

15	In the event me cal, ISP, phones, etc. failed, how does subcontractor proceed with contracted required processes?		In Progress	Copy of P&P	= Partially M	Per Robert Brandon, in the event that there are ISP issues, they were transfe o the Spokane location. 4/11/2014- BHO reported that PCs used for Avatar were not able to connect. The Spokane location did not have a PC setup for Avatar therefore Outpatient Authorizations were not being reviewed as scheduled. On 4/15/2014, CDRSN recieved email confirmation that PC's were successfully connecting to Avatar. 4/15/2014- Robert Brandon emailed that a PC was being setup in the Spokane location in the event future network connection issues arised but were not successful loading Avatar and Connectra. Behavioral Healthcare Options, Inc. will need to provide and implement procedure for future incedents as experienced on 4/11/2014 with Avatar.

COMMENTS: Please see section 3 question 15 and submit procedure for PC backup for Avatar Access for future unsuccessful connectivity to Avatar.

Date:	4/21/2014
RSN Reviewing Staff:	Rosa Guerrero, CDRSN IS Administrator
BHO Staff Participating:	Robert Brandon, LMHC, LMFT

BEHAVIORAL HEALTHCARE OPTIONS, INC.

a subsidiary of Sierra Health Services, Inc.

UTILIZATION MANAGEMENT SERVICES AGREEMENT
AMENDMENT ONE

THIS FIRST Amendment dated September 14, 2007 shall amend the September 1, 2005 Agreement between "), Behavioral Healthcare Options, Inc. (hereinafter called the "Company" or "Delegate") and Chelan Douglas Regional Support Network (hereinafter called "CDRSN"), as detailed below. All other terms and conditions of this Agreement shall be in full force and effect as if fully set forth herein.

SERVICES PROVIDED AND FEES

A. ADDITIONAL FEES:

1. In consideration of the Company providing comprehensive utilization management services to all CDRSN consumers that meet the guidelines set forth in the Community Psychiatric Inpatient procedures implemented by the State of Washington Mental Health Division August 2007, CDRSN agrees to pay the Company an additional $ **.03** Per Member per Month, as of the date of DSHS monthly postings. The effective date for this increase will be September 1, 2007.

The individuals signing below for their respective organizations (the parties) have been authorized by those organizations to enter into and be bound by this Agreement on behalf of the organization.

BEHAVIORAL HEALTHCARE OPTIONS, INC.

By: _____

Name: Garyn E. Ramos

Vice President & COO
Title

2716 N. Tenaya Way
Las Vegas, NV 89128

CHELAN DOUGLAS RSN

By: _____

Name: James Colvin

CDRSN Administrator
Title

636 Valley Mall Parkway, Suite 200
E. Wenatchee, WA 98802

UTILIZATION MANAGEMENT SERVICES AGREEMENT

ATTACHMENT NO. 1

SERVICES PROVIDED AND FEES

A. FEES:

In consideration of the Company providing the management services described herein, the CDRSN agrees to pay the Company $ .30 Per Member Per Month.

B. SPECIAL SERVICES:

Exclusive of the state of Washington's mental health inpatient facilities and Child long-term Inpatient Program facilities, the Company agrees to provide management services for all behavioral health care benefits for which CDRSN's Members are eligible. Such utilization and case management services shall include the following services:

1. Prior authorization of inpatient, residential and outpatient treatment for mental health as required in the benefit plan on a 24-hours a day, 7 days a week basis;

2. Prior authorization of major diagnostic and therapeutic services that are directly related to the treatment of mental health disorders.

3. Recommendations concerning the medical necessity of all services described in this paragraph, to include a review process.

4. Recommendations concerning the most appropriate level of care at which the requested mental health services could be provided.

5. Concurrent review of all prior authorized inpatient and residential mental health courses of treatment;

6. Notification for denials and appeals .

7. Upon reasonable request, review of non-authorized mental health courses of treatment to include the involvement of the Company's Medical Director and Peer Review staff;

8. Coordination and recommendations concerning appropriate discharge planning for all inpatient and residential mental health stays.

9. Periodic reporting, data analysis and consultation.

10. Provide training, support assistance to GBCH in of building core health plan core competencies, including training on management of medical review functions, quality improvement, credentialing and like health plan activities and functions.

BEHAVIORAL HEALTHCARE OPTIONS, INC.

a subsidiary of Sierra Health Services, Inc.

MANAGEMENT SERVICES AGREEMENT

In consideration of the payment of fees in accordance with the terms and provisions of this Utilization Management and Administrative Services Agreement (hereinafter called the "Agreement"), Behavioral Healthcare Options, Inc. (hereinafter called the "Company") and the Washington State Department of Social & Health Services – Division of Mental Health – Chelan-Douglas RSN (hereinafter called "CDRSN"), hereby agree that the Company shall provide, or arrange for the utilization management services, as described herein.

I. EFFECTIVE DATE AND TERM OF AGREEMENT

This Agreement shall be effective on September, 1st 20 05, at 12:01 AM Pacific Time and will remain in effect for an initial period of 24 consecutive months unless terminated by either party pursuant to the Termination provisions herein. Thereafter, the Agreement shall renew from year to year for additional twelve (12) month periods, subject to all terms and provisions of the Agreement or as amended after the initial period or as amended upon mutual agreement, unless terminated earlier by either party pursuant to the Termination provisions herein.

II. COVERAGE AND BENEFITS SUBJECT TO UTILIZATION MANAGEMENT

The benefits subject to utilization management by the Company (hereinafter referred to as the "Benefit Plans"), shall be provided to the Company for its review by CDRSN. Such services are for eligible Medicaid Consumers (hereinafter referred to as "Members") enrolled in the CDRSN Benefit Plans.

III. UTILIZATION MANAGEMENT SERVICES TO BE PROVIDED BY THE COMPANY

Company shall provide the services specified in Paragraph B of Attachment 1 to CDRSN for Members enrolled in the CDRSN Benefit Plan.

IV. FEE DUE DATE AND PAYMENTS

A. The fee due date is the first day of each month, following the month for which services were rendered. CDRSN will provide an initial payment to BHO in an amount equivalent to two months fees based upon an estimate of membership as of August 1, 2005. Fees will be paid on a monthly basis thereafter, based upon estimates of membership. All payments to BHO will be jointly reconciled against actual membership numbers no less than every six months

B. If such payment is not made in full by CDRSN on or prior to the fee due date, a thirty-one (31) day Grace Period shall be granted to CDRSN for payment without interest charged. If payment is not received by the expiration of the Grace Period, then the Agreement may be terminated by the Company. Fees outstanding subsequent to the end of the Grace Period shall be subject to a late penalty charge of 1.50% of the total fee amount due calculated for each thirty-one (31) day period or portion thereof the amount due remains outstanding.

C. If the Agreement is terminated for any reason, CDRSN shall continue to be held liable for all fees and invoices due and unpaid under the terms of this Agreement.

V. FEES AND FEE SCHEDULE CHANGES

The fees for the services described herein are specified in Paragraph A, Attachment 1. Such fees shall automatically increase by three percent (3%) upon each anniversary date throughout the term of this Agreement. Upon no less than 30 days prior written notice to CDRSN, the Company may change the fee schedule set forth in Attachment 1 if CDRSN's Membership decreases by more than 30%, or CDRSN Benefit Plans change in a manner that significantly increases the cost of administration, the services provided in Paragraph B of Attachment 1 change, or there are any other material changes affecting the Parties.

VI. MEMBER EFFECTIVE DATES

Subject to CDRSN's payment of applicable monthly fees, and other provisions of the Agreement, the special services to be provided under the Agreement shall become effective for Member(s) as set forth in the Benefit Plan.

VII. MEMBERS

Determination of the number of Members shall be based upon the Membership data posted by the Washington State Department of Social and Health Services - Mental Health Division for use in determining eligibility. "Members" shall be defined as Medicaid eligible consumers eligible for Title XIX in Washington State with the following exceptions:

- Residents of Intermediate Care Facilities for the Mentally Retarded
- Pregnant women with family planning only program code S, medical code P and Z
- Residents of the State Psychiatric hospital and Children's Long Term Inpatient Program
- Persons enrolled in the PACE program

VIII. SCOPE OF RELATIONSHIP

A. The Company is not, and shall not be, deemed to be a fiduciary of Insurer or Benefit Plan. Rather, the duties of the Company hereunder are ministerial in nature, and the Agreement shall not be deemed to confer or delegate any discretionary authority or discretionary responsibility in the administration of the Benefit Plan.

B. The Company shall be entitled to rely, without question, upon any written or oral communication of the Director of CDRSN, or its designee, which is believed by the Company to be genuine and to have been presented by a person having the apparent authority to do so.

C. The Agreement is between the Company and CDRSN, and does not create any rights or legal relationships between the Company and any of the Members or beneficiaries under the Benefit Plan or any individual member governments of CDRSN.

D. Company is not, and shall not be, deemed to be a "Designated Decision Maker" for CDRSN or CDRSN's Plan Document. As such, Company does not assume any authority under the Plan Document or from CDRSN to make medically reviewable decisions with respect to any of the Plan Participants or in the administration of the Plan Document. Such decisions and "Designated Decision Maker" status shall remain the exclusive authority of CDRSN.

IX. RESPONSIBILITIES OF CDRSN

CDRSN Agrees to:

A. Furnish to the Company on a monthly basis, on mutually agreed upon forms, such information as may reasonably be required by the Company for the administration of Company's management services provided hereunder.

B. Ensure eligibility information is received in an electronic format, on a monthly basis, and upon a mutually agreed upon day of each month.

C. Produce and distribute to Members at CDRSN's expense, notices, identification cards, and any other materials as may be reasonably necessary to advise Members of their obligations with respect to the utilization management of behavioral healthcare services.

D. Be the final arbiter as to the interpretation of the Benefit Plans and as to the payment of benefits thereunder.

E. Indemnify and hold harmless the Company, its agents and employees, against any and all liability, damages, expenses and costs, including, without limitation, court costs, attorney's fees and punitive and exemplary damages arising as a result of any act, error, or omission of CDRSN or CDRSN's agents and employees resulting in a claim, demand or legal or administrative proceeding made or brought against the Company by or on behalf of any person including, without limitation, any Member, Beneficiary or fiduciary under the Benefit Plan.

F. Unless otherwise directed by Washington State MHD or CMS, provide the Company with ninety (90) days advanced written notice of any changes to the CDRSN's Benefit Plans for which the Company is responsible to provide utilization management.

G. To be solely responsible for certifying eligibility for coverage and benefits with respect to those Members, the Company is providing the utilization management services described herein.

H. Any taxes, licenses, and fees levied, if any, by any Local, State or Federal authority in connection with the operation of the CDRSN's benefit plan or in connection with the duties of Company hereunder are to be paid by CDRSN. Company agrees to notify CDRSN and make arrangements for payment thereof if any such claim is made.

I. CDRSN agrees that its officers and employees will cooperate with Company in the performance of services under this Agreement and will be available for consultation with Company at such reasonable times with advance notice as to not conflict with their other responsibilities.

J. CDRSN understands and agrees that the only services covered under the terms of this Agreement are those services set forth herein and outlined in Paragraph B of Attachment 1. CDRSN further understands and agrees that any additional requests for services resulting from the Washington State Department of Social & Health Services – Mental Health Division Request For Qualifications process may be subject to additional fees other than those outlined in Attachment 1.

X. DUTIES OF THE COMPANY

A. The Company agrees to provide utilization and case management services to Members covered by Benefit Plans issued by CDRSN as set forth in Paragraph B of Attachment 1.

B. The Company also agrees to:

1. coordinate activities set forth in Attachment 1 with CDRSN and correspond with the Members and providers of services if additional information is deemed necessary in order to evaluate a request for behavioral healthcare services;

2. provide notice to Members and Providers as to the reason(s) for any proposed denial and provide for the review of denied authorizations as recommended by the Company, provided, however, that such review shall be advisory to CDRSN in accordance with the terms of this Agreement and shall not be deemed to be an exercise of discretion by the Company; and,

3. generate Company's standard utilization reports on a quarterly basis for the benefit of CDRSN, or if so directed by CDRSN, the Washington State Department of Social & Health Services - Mental Health Division.

4. provide to CDRSN the hard or electronic copy information reasonably necessary for CDRSN's reporting encounter data.

C. The Company shall establish and maintain a record-keeping system concerning the services to be performed hereunder. All such records shall be made available to RSN/PIHP upon reasonable notice and subject to state and federal laws relating to the confidentiality laws. All such records shall be available for inspection by CDRSN at any time during normal business hours at the offices of the Company in Las Vegas, Nevada. The Company agrees to provide documents upon request under the Washington State Public Disclosure Laws.

D. Upon reasonable request by CDRSN, Company will participate in educational presentations to Consumers.

E. The Company shall not be liable for any loss resulting from the performance of its duties hereunder, except for losses resulting directly from:

1. the willful misconduct of the Company; or

2. the fraudulent or criminal acts of the agents or employees of the Company, whether acting alone or in concert with others; except that if such act or acts shall have been performed in concert with an agent or employee of CDRSN, CDRSN shall bear its proportionate share of liability for the resulting loss.

F. The Company shall issue an oral and/or written disclaimer to providers and/or Members which states that the Company is not guaranteeing eligibility or payment to any providers in connection with the performance of its utilization management services functions under the terms of this Agreement.

G. The Company agrees to share in the preparation costs of the Washington State Department of Social & Health Services – Division of Mental Health Request for Quote. Such cost share shall be split equally up to a maximum cost share of ten thousand dollars ($10,000.00) on behalf of CDRSN.

H. Indemnify and hold harmless CDRSN, its agents and employees, against any and all liability, damages, expenses and costs, including, without limitation, court costs, attorney's fees and punitive and exemplary damages arising as a result of any act, error, or omission of Company or Company's agents and employees resulting in a claim, demand or legal or administrative proceeding made or brought against CDRSN by or on behalf of any person including, without limitation, any Member, Beneficiary or fiduciary under the Benefit Plan.

XI. GENERAL PROVISIONS

A. This Agreement may be modified at any time by mutual written agreement of the Parties.

B. In the event all or substantially all of the assets of either party to this Agreement are acquired by another party, all the rights and obligations under this Agreement shall inure to the benefit of such successor in interest.

C. This Agreement may not be assigned by either party without the express written consent of the other party. Any such assignment without the express written consent of either party shall be void.

D. As used in this Agreement, the term "Confidential Information" shall mean any and all data and information, whether printed, written, oral or electronically stored or reproduced relating to the business of both parties which is not generally known to each other's competitors and which is treated as confidential by the parties. Specifically, the agreements, terms, provisions and fee schedules between Company and its Participating Providers shall be considered Confidential Information. However, Confidential Information does not include any information which is already known by the receiving party at the time it is disclosed, or which (a) has become generally known or available to the public through no wrongful act of either party; (b) has been approved for release to the general public by written authorization of the party providing the information; (c) has been finally ordered to be disclosed by government authority, court order or duly authorized subpoena provided that each party shall first have given written notice to the other party of such ordered disclosure to the extent practicable and providing the other party the opportunity to seek to protect the confidentiality of the information required to be disclosed; (d) is required to be disclosed by any law, rule or regulation or by applicable regulatory or professional standards; or (e) is developed by either party independently or any disclosures of such information made by each other.

During the term of this Agreement and thereafter, CDRSN and Company shall ensure that directors, officers, employees, contractors and agents hold Confidential Information including but not limited to the content of this Agreement, of the other in the strictest confidence and in accordance with state and federal law, except as required in the performance of this Agreement. Both parties agree that disclosure of a party's Confidential Information other than in accordance with this section shall cause irreparable injury to such party, and the non-breaching party shall be entitled, without limitation, to injunctive relief to prevent the other party's breach of this section, in addition to such measurable damages as may be incurred. This section shall survive the termination of this Agreement. CDRSN

and Company agree that nothing in this Agreement shall be construed as a limitation of CDRSN's rights and obligation to discuss with any Plan Participant matters pertaining to the Plan Participant's Plan Document.

The parties shall maintain the confidentiality of the medical records of Plan Participants, and such information shall only be released or disseminated pursuant to the valid authorization of the Plan Participant whose medical condition is reflected in such medical records or as shall otherwise be permitted under applicable law. Company shall comply with any applicable state or federal law, including the Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Regulations"), promulgated under the Health Insurance Portability and Protection Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164. Company agrees that, to the extent that it may be considered a business associate under the HIPAA Privacy Regulations, it shall comply with the applicable sections of the HIPAA Privacy Regulations, including entering into a business associate contract with the CDRSN.

E. Any dispute, controversy or claim arising out of or relating to this Agreement between Company and CDRSN, or the breach thereof, shall be settled by binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. The arbitration shall be conducted at Wenatchee, Washington, and the parties shall jointly and equally bear all costs thereof, including the fees of the arbitrator(s), but each party shall pay its own costs and expenses incurred in the conduct of the arbitration including attorney's fees.

XII. TERMINATION

A. This Agreement may be terminated after its initial period for any reason by the Company or CDRSN by either party giving ninety (90) days written notice to the other party. In such event, benefits hereunder shall terminate for all Members as of the effective date of termination.

B. The Agreement may be terminated by the Company:

1. upon written notice, if any payment required to be made by CDRSN is not received by the end of the Grace Period;

2. upon written notice, in the event of insolvency or bankruptcy of CDRSN;

3. upon written notice, if CDRSN ceases to operate; and

4. upon thirty-one (31) days prior written notice to CDRSN in the event of CDRSN's material breach of any other terms or provisions of the Agreement and CDRSN has failed to reasonably cure such breach within twenty (20) days of notice of such breach.

C. The Agreement may be terminated by CDRSN:

1. upon written notice, in the event of insolvency or bankruptcy of the Company;

2. upon thirty-one (31) days prior written notice to the Company in the event of the Company's material breach of any other terms or provisions of the Agreement and the Company has failed to reasonably cure such breach within twenty (20) days of notice of such breach.

3. If the Funds which DSHS relied upon to establish the PIHP agreement with GBHC are withdrawn, significantly reduced or limited, and DSHS issues a notice of termination, CDRSN may terminate this agreement by providing at least five (5) business days written notice to the Company.

4. upon written notice, if CDRSN ceases to operate.

D. In the event of termination, Company agrees to perform contracted services only through the time period for which it receives payments.

XIII. ENTIRE AGREEMENT

This Agreement with its Attachments, if any, constitutes the entire agreement between the parties regarding the utilization management services described herein.

XIV. AMENDMENTS AND WAIVERS

Any amendments to the Agreement shall be in writing and must be approved and executed by the President or Vice-President for the Company and approved by the CDRSN Board of Directors and signed by its Chairman. No agent of the Company has the authority to change the Agreement, waive any of its provisions or restrictions or extend the time for making payment.

XV. CLERICAL ERROR

Clerical error, whether of CDRSN or the Company in keeping any record pertaining to the services under the Agreement, will not invalidate the Agreement.

XVI. NOTICE

Notices shall be written and personally delivered, effective on delivery or effective upon receipt by fax or e-mail, or sent by United States mail effective on the third (3rd) day following the date deposited in the mail, addressed to the parties at the address set forth below.

Any notice hereunder to be given to CDRSN shall be addressed to:

CHAIRMAN
Chelan – Douglas RSN
636 Valley Mall Parkway, Suite 200
East Wenatchee, WA 98802

Any notice hereunder to be given to the Company shall be addressed to:

PRESIDENT
Behavioral Healthcare Options, Inc.
2716 N. Tenaya Way
Las Vegas, NV 89128

XVII. APPLICABLE LAW

This Agreement and any construction thereof shall be governed by the laws of the State of Washington.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement, on the 15th day of AUG. 2005, and it shall become effective on the 1st day of September 2005.

The individuals signing below for their respective organizations (the parties) have been authorized by those organizations to enter into and be bound by this Agreement on behalf of the organization.

BEHAVIORAL HEALTHCARE OPTIONS, INC.

By: _____
Signature

Name: GREG RAMOS
Please Print

VP/COO
Title

2716 N. Tenaya Way
Las Vegas, NV 89128

CHELAN – DOUGLAS RSN

By: _____
Signature

Name: JAMES E. COLVIN
Please Print

ADMINISTRATOR
Title

636 VALLEY MALL PKWY. #200
Street

E. WENATCHEE WA 98802
City State Zip

Douglas County Board of County Commissioners

By: _____ 8-8-05
Ken Stanton, Chair Date

By: _____
Dane Keane, Vice-Chair Date

By: _____ 8-8-05
Mary Hunt, Member Date

APPROVED AS TO FORM

_____ 8/4/05
Douglas County Prosecuting Attorney Date

UTILIZATION MANAGEMENT SERVICES AGREEMENT

ATTACHMENT NO. 1

SERVICES PROVIDED AND FEES

A. FEES:

In consideration of the Company providing the management services described herein, the CDRSN agrees to pay the Company $_.30_ Per Member Per Month.

B. SPECIAL SERVICES:

Exclusive of the state of Washington's mental health inpatient facilities and Child long-term Inpatient Program facilities, the Company agrees to provide management services for all behavioral health care benefits for which CDRSN's Members are eligible. Such utilization and case management services shall include the following services:

1. Prior authorization of inpatient, residential and outpatient treatment for mental health as required in the benefit plan on a 24-hours a day, 7 days a week basis;

2. Prior authorization of major diagnostic and therapeutic services that are directly related to the treatment of mental health disorders.

3. Recommendations concerning the medical necessity of all services described in this paragraph, to include a review process.

4. Recommendations concerning the most appropriate level of care at which the requested mental health services could be provided.

5. Concurrent review of all prior authorized inpatient and residential mental health courses of treatment;

6. Notification for denials and appeals .

7. Upon reasonable request, review of non-authorized mental health courses of treatment to include the involvement of the Company's Medical Director and Peer Review staff;

8. Coordination and recommendations concerning appropriate discharge planning for all inpatient and residential mental health stays.

9. Periodic reporting, data analysis and consultation.

10. Provide training, support assistance to GBCH in of building core health plan core competencies, including training on management of medical review functions, quality improvement, credentialing and like health plan activities and functions.

Managed Care Accessibility Analysis

December 02, 2013

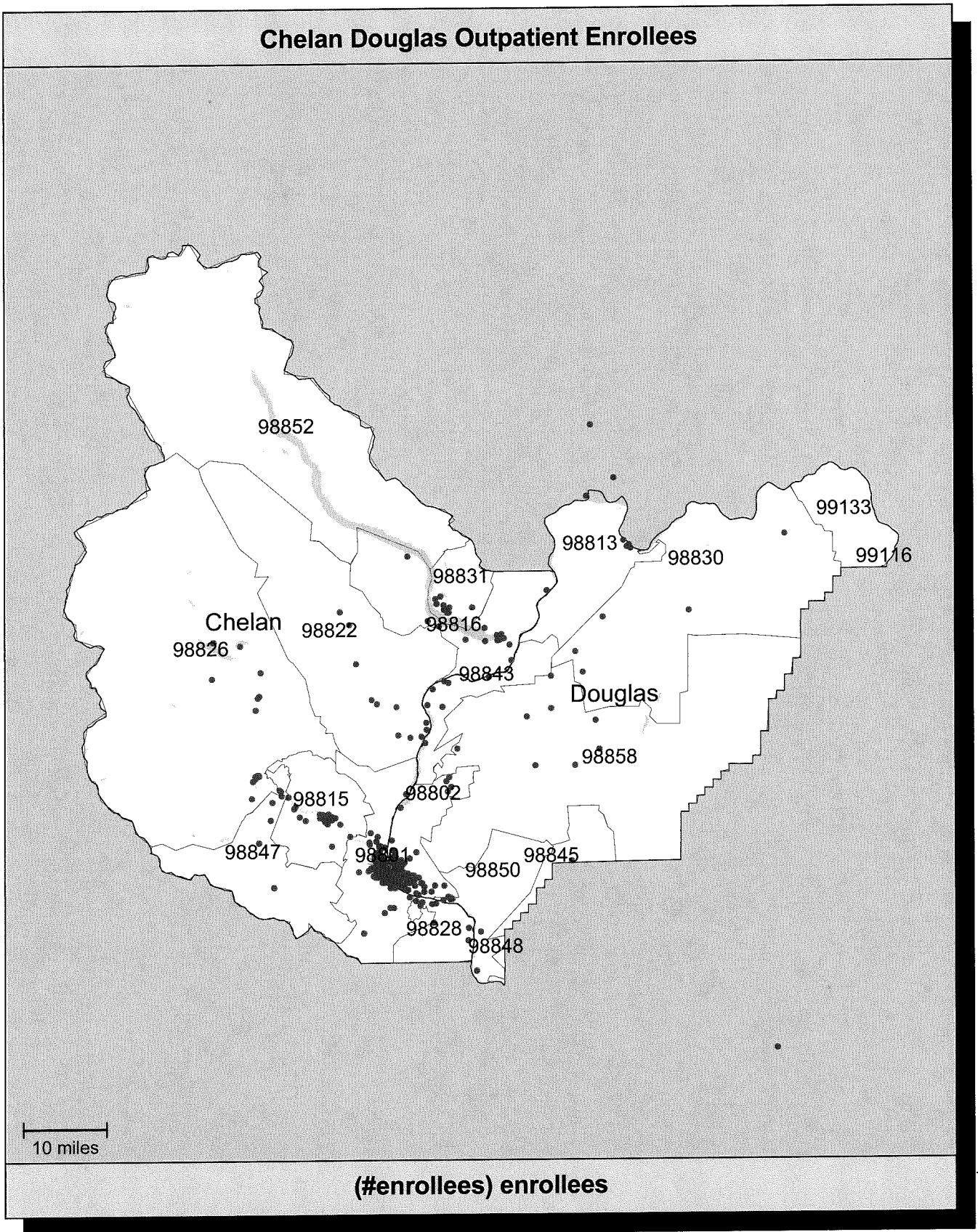
A report on the accessibility of the

Chelan Douglas Outpatient Network

for the enrollees of

Chelan Douglas RSN

Enrollees locations



● Enrollees locations (1,720)

★ Single Provider locations (4)

Provider group: Chelan Douglas Outpatient Providers (4)

Accessibility summary

Accessibility analysis specifications	
Provider group:	**Chelan Douglas Outpatient Providers** 4 providers at 4 locations (based on 4 records)
Enrollees group:	**Chelan Douglas Outpatient Enrollees** 1,720 enrollees
Access standard:	**1 Provider within 90 Minutes**
All enrollees:	1,720 (100%) 99.8% with access 0.2% without access

Average time to a choice of providers for all enrollees

Number of providers	1	2	3	4	5
Minutes	7.1	7.6	8.4	8.9	---

Key geographic areas

City	Total number of enrollees	All enrollees		
		Percent w	Percent wo	Average time to 1 provider
WENATCHEE	858	100	0	1.2
EAST WENATCHEE	432	100	0	3.7
CASHMERE	89	100	0	10.2
CHELAN	69	100	0	34.8
MALAGA	42	100	0	9.8
ROCK ISLAND	36	100	0	12.3
LEAVENWORTH	35	100	0	26.6
ORONDO	26	100	0	23.8
WATERVILLE	24	100	0	30.6
MANSON	23	100	0	33.9

Accessibility summary

Accessibility analysis specifications	
Provider group:	**Chelan Douglas Outpatient Providers** 4 providers at 4 locations (based on 4 records)
Enrollee group:	**Chelan Douglas Outpatient Enrollees** 1,720 enrollees
Access standard:	**1 Provider within 90 Minutes**
Enrollees with desired access:	1,716 (99.8%)

Average time to a choice of providers for enrollees with desired access					
Number of providers	**1**	**2**	**3**	**4**	**5**
Minutes	6.9	7.4	8.2	8.7	---

Key geographic areas				
City	**Total number of enrollees**	**Enrollees with desired access**		
		Number	**Percent**	**Average time to 1 provider**
WENATCHEE	858	858	100	1.2
EAST WENATCHEE	432	432	100	3.7
CASHMERE	89	89	100	10.2
CHELAN	69	69	100	34.8
MALAGA	42	42	100	9.8
ROCK ISLAND	36	36	100	12.3
LEAVENWORTH	35	35	100	26.6
ORONDO	26	26	100	23.8
WATERVILLE	24	24	100	30.6
MANSON	23	23	100	33.9

Accessibility summary

Accessibility analysis specifications	
Provider group:	**Chelan Douglas Outpatient Providers** 4 providers at 4 locations (based on 4 records)
Enrollee group:	**Chelan Douglas Outpatient Enrollees** 1,720 employees
Access standard:	**1 Provider within 90 Minutes**
Enrollees without desired access:	4 (0.2%)

Average time to a choice of providers for enrollees without desired access

Number of providers	1	2	3	4	5
Minutes	99.9	100.2	100.8	101.2	---

Key geographic areas

City	Total number of enrollees	Enrollees without desired access		
		Number	Percent	Average time to 1 provider
AUBURN	1	1	100	90.3
LAKE STEVENS	1	1	100	91.1
SEATTLE	1	1	100	91.0
SPOKANE	1	1	100	127.0

CDRSN Administrative Review Tool

Agency: Catholic Family & Child Service **Date: 8/28/2014** **Score: 98/122 (80.3%)**

Findings:

Finding #1: Excluded Individuals and Entities Checks – CFCS did not complete monthly exclusion checks for executive management and board members.

Finding #2: Excluded Individuals and Entities Checks – CFCS did not present primary source documentation of monthly exclusion checks using the System for Award Management (SAM) exclusions database (EPLS data).

Finding #3: Third Party Liability – CFCS continues to be unable to pursue all third party payers, most notably Medicare. The CDRSN acknowledges the work CFCS has completed to date to be able to bill Medicare. However, this remains an issue of concern. CFCS remains under an existing corrective action relative to failure to effectively pursue all third party liability. An updated corrective action plan is required.

Finding #4: Compliance Program – CFCS does not have an effective compliance program in place or in active development.

Finding #5: Breach Risk Assessment/HITECH Act Compliance – CFCS was unable to provide the breach risk assessment process. Additionally, it was determined that CFCS had not reviewed a likely breach to determine the need to provide notification to the consumer. CFCS was unable to provide a breach notification policy and procedure.

Finding #6: CFCS needs to provide stabilization services of a duration and scope that meets the needs of individuals requesting hospital diversion and/or post hospital stabilization.

Finding #7: Incident reported late on the day of the review. Incident policy needs to be update to reflect current contract elements.

Recommendations:

Recommendation #1: Clinician Credentials – Improve agency practices with regard to monitoring and documenting clinician credential status. #2: Documentation of required trainings is very fragmented. CFCS should develop a system that ensures training and credential information is present in all personnel files. #3: Grievance policy needs to be updated to reflect current contract requirements. #4: 20% of open consumers had not received the required minimum service frequency--this is at the lower limit of acceptable and is the lowest percentage among all contracted agencies. This is an indicator and charts will be selected for the September quarterly chart reviews to determine if this is a capacity issue or chart closure issue. Closer internal monitoring of this is recommended.

Score Key: Absent 0, Partial Compliance 1, Evidence of compliance 2.

Part I. Credentialing, Training, Supervision and Licenses.

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.1	Agency holds all necessary licenses, and certifications required by law.	Copy of License(s)	2
2.	3.1.3	Maintain current staff information in the Avatar EHR.	Report	1
3.	3.1.21	Criminal Background check though WSP for all employees with unsupervised access to vulnerable populations	Policy, Copy of background check	2
4.	12.1 13.1	Complies with nondiscrimination laws and policies.	Policy Posted placards	2
5.	3.1.2	Primary Source verification DOH current licensure documented	Policies Sample reviewed on site	1
6.	4.3.23	Documents training and training plans inclusive of the	Policies	2. Documentation of

		following topics as appropriate for each employee: 1. Confidentiality/HIPAA 2. Client rights 3. Complaint and grievance procedures. 4. Benefits described in the benefit package 5. Culturally competent service delivery 6. Advanced Directives and WRAP plans 7. Strength based assessment and treatment planning. 8. Recovery principles. 9. Service coordination for special needs/multisystem consumers and EPSDT 10. Safety Training—including RCW 71.05.700 and RCW 49.19.030 requirements as appropriate. 11. CDRSN policies and procedures 12. Medicaid Fraud and Abuse, including training specific to the False Claims Act. 13. Incident reporting and mandatory reporting of abuse.	Training logs Personnel files	required trainings is very fragmented and difficult to confirm without crossing over between personnel documents and several training logs. Most of the required trainings were verified for the sampled personnel files but it required finding things not present in them or tracking down the employee and copying their CPI card etc. Policy should be updated to include the new WAC 30 day training requirements. 388-877-0500 6) **Staff training.** A description of how the agency provides training within thirty days of an employee's hire date and annually thereafter: (a) Consistent with the agency's certified services. (b) On cultural competency that assists staff in recognizing when cultural barriers interfere with clinical care that includes a

				review of: (i) Populations specific to the agency's geographic service area; and (ii) Applicable available community resources. (c) On procedures for how to respond to individuals in crisis that includes a review of: (i) Emergency procedures; (ii) Program policies and procedures; and (iii) Rights for individuals receiving services and supports. (d) That addresses the requirements of this chapter.
7.	WAC 388-877-0500	Documentation of regular supervision and employee evaluation	Policies Supervision logs or random sample of personnel files	2
8.	3.1.22	Documentation of monthly checked for excluded individuals and entities using LEIE and EPLS databases, including staff, executive management and board members.	Search documentation or evidence of other process(es) used	1

Comments: 3.1.2, 3.1.3 – The accuracy of staff credential information maintained in Avatar is monitored monthly by CDRSN. Staff credentials have been found to not be current in Avatar, as well as agency files. Recently CDRSN found one CFCS staff member

whose agency affiliated counselor credential was expired. Upon discussion with CFCS staff, this occurred because the clinician did not submit all requirement information for renewal. It is recommended that CFCS's internal processes for monitoring and communicating credential status be reviewed.

Documentation of required trainings is very fragmented. CFCS should develop a system that ensures training and credential information is present in all personnel files

Part II. Enrollee Rights

	Requirement Origin	Requirement	Documentation	Score
1.	4.2.1	Agency posts written rights statements in all DSHS required languages.	Observed	2
2.	4.2.1	Agency policies and forms address all required enrollee rights inclusions and are available in prevalent languages. (See separate check off list)	Policies Forms	2 Rights and policy include all required citations. A little oddly organized. In fact the sentence above the Medicaid rights from the RSN is policy is pasted on the top and appears as a header—not really

				intended to be presented in this way.
3.	4.2.1	Consumers are informed of the availability of free interpreter services.	Posting in prevalent languages at front desk.	2
4.	4.3.20.1	Agency provides free interpretation and translation service to enrollees.	Billings or log of provided services.	2
5.	4.3.19	The agency's physical space is ADA accessible	Observation	2
6.	4.3.19	Alternative format materials and communication methods are available for enrollees with sensory impairments.	TDD/TDY available Other formats	2
7.	4.3.15	The agency maintains an advanced directives policy that respects the service recipients' advance directives for psychiatric care.	Policy Forms/literature distributed to enrollees	2
8.	4.3.15.1	Clinical charts contain copies of advanced directives and the agency has a means of making employees aware of consumers that have psychiatric or medical advanced directive.	Policy Chart review	2
9.	4.2.5.1	Agency maintains a record of enrollees that request second opinions.	Policy Quarterly report to RSN	2
10.	4.2.3 4.2.4	Right of enrollee concerning choice and change of provider.	Policy Staff interview	2
11.	CDRSN P&P	Agency has policies and procedures concerning restraint and seclusion. Agency follows policy and maintains records of any instance of use of restrain or seclusion.	Policy Clinical record	2
12.	4.2.2	Information on how to contact the Ombuds and how to file a complaint or grievance is readily available to consumers.	Policy Lobby materials Intake packet Consumer survey	2

Comments:

Part III. Grievance System

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.6	Agency maintains a grievance system that complies with 42CFR438.400.	Policy	2. Agency practice and training is in line with current RSN policy. Agency Policy needs to be updated to reflect this.
2.	3.1.6	Agency enters information related to all grievances into the Avatar EHR Complaint and Grievance form. The Agency enters all data elements required to CDRSN to determine compliance with the grievance system.	Records	2
3.	3.1.6	Agency has a process to monitor compliance with the grievance system.	Policy Report Definition/Monitoring	2

			procedure	

Comments: Grievance policy needs to be updated.

Part IV. Access and Capacity

	Requirement Origin	Requirement	Documentation	Score
1.	Access Standards	Routine intake appointments occur within 10 business days of the request for service	Report	2
2.	Access Standards	The time period from request to the first routine appointment offered does not exceed 28 days.	Report	2
3.	CDRSN P&P	Did the agency provide routine services at least once per month?	Report	2 80% is at the lower limit of acceptable and is the lowest percentage among all contracted agencies. This is an indicator and charts will be selected for the September quarterly chart reviews to

				determine if this is a capacity issue or chart closure issue. Internal monitoring of this is recommended.
4.	4.7.1.2	Agency brings services to the consumer, including intake assessments, if the consumers mental illness, lack of transportation or physical limitations prevent an office visit.	Policy Out of Office Services	2
5.	4.7.4.7	The first routine appointment following inpatient treatment must occur within 7 days of discharge.	Reports	2 This had been a finding earlier in 2014 but appears corrected now.
6.	3.1.3	Ensures number of qualified agency personnel sufficient to meet access/travel standards.	Case load Service locations	2
7.	4.4.2.5	Agency employs or contracts mental health specialists for children, elderly, ethnic minorities or persons who are deaf or developmentally disabled	Policy Personnel files Verify contracts and qualifications of contractors.	2
8.	4.2.5 4.2.5.1	Agency, upon consumer request, provides a second opinion from within the CDRSN service area. If an additional CMHA is not available, the agency will pay for a second opinion from a CMHA outside of the CDRSN service area at no cost to the enrollee.	Policy Quarterly reports Payment records	2
9.	4.3.21 4.3.22	Agency provides uninterrupted access to a range of activities identified in the Medicaid state plan and maintains for Medicaid enrollees, when deemed Medically Necessary, service delineated in the state plan.	Policy Payment records	1. The agency minimally provides Stabilization services and needs to improve 24 hour sustained capacity for this service.

10.	3.1.12	Make all efforts to collect and report 3rd party reimbursements rendered in the performance of the contract.	R&E Evidence of billings	1

Comments: Finding: The agency needs to provide stabilization services of a duration and scope that meets the needs of individuals needing hospital diversion and/or post hospital stabilization.

Part V. EPSDT and Service Coordination

	Requirement Origin	Requirement	Documentation	Score
1.	4.3.16	Agency ensures enrollees under 21 receive services that comply with the state EPSDT plan. • Child Specialist reviews intake/plan of care and makes level one or two assignments. • Close communication between mental health clinician and the PCP to include date of intake, primary diagnosis and level of care assignment.	Policy EPSDT files	2

		• Documentation of referral to PCP for Healthy Kids screening for children presenting for intake without referral from PCP. • CSP for Level two children.		
2.	4.3.24	GAIN is completed for all individuals 13 years of age and older.	POLICY GAIN report	2
3.	4.3.8	Agency ensures that referral is made to PCP within 30 days of intake and as needed thereafter when medical or dental needs are identified.	POLICY	2

Comments:

PART VI. Quality Assurance

	Requirement Origin	Requirement	Documentation	Score
1.	3.2.1	Provider will Notify CDRSN of any incident as defined in RSN policy 3.12 and comply with mandated procedures for reporting and follow up.	Sample of incidents Incident report Follow up reports	1. Incident reported late on the day of the review. Incident policy needs to be update to reflect current contract elements.

2.	6.1 6.1.5	The provider shall adopt and utilize a quality management system which: • Performs internal audits of medical records (no less than 10% annually) • Monitors access and appropriateness of services. • Monitors service recipient satisfaction.	Policy QM plan Satisfaction surveys Consumer complaint logs	2
3.	6.1.6 6.1.6.4 4.7.5.1	The provider will follow CDRSN practice guidelines and participate in implementing RSN wide evidenced based practices.	Chart review	2
4.	CDRSN P&P	Provider will participate in RSN bimonthly clinical team meetings to collaborate on Performance Improvement Projects and other system coordination concerns.	Attendance logs Submission of PIP data.	2

Comments: Finding: Incident reported late on the day of the review. Incident policy needs to be update to reflect current contract elements.

PART VII. Compliance Program

	Requirement	Requirement	Documentation	Score

	Origin			
1.	3.1.16	The agency maintains administrative and management policies, procedures and standards to guard against Medicaid fraud and abuse	Policies and procedures Informal procedures	2
2.	3.1.16.1	The agency maintains an effective Compliance Program	Compliance Plan Evidence of Operationalization of the Plan	0
3.	3.1.16.2	The agency has written policies, procedures and standards of conduct that articulate the CDRSN/PIHP commitment to comply with all applicable federal and state standards	Policy Standards of Conduct	0
4.	3.1.16.3	The agency has a designated Compliance Officer and Compliance Committee that meets regularly	Policy Compliance Committee Minutes	1
5.	3.1.16.4	The agency maintains an effective compliance education and training program,	Training records Education Plan	0
6.	3.1.16.5	The agency maintains an effective line of communication between the Compliance Officer and the CDRSN/PIHP	Policy	0
7.	3.1.16.6	The agency maintains enforcement standards through well-publicized disciplinary guidelines	Policy or other disciplinary standards	0

8.	3.1.16.7	The agency maintains procedures for internal monitoring and auditing to facilitate compliance	Policy Monitoring and Auditing Documentation	0
9.	3.1.16.8	The agency has provisions for the prompt response to detected offenses and for the development of corrective actions initiatives	Policy Documentation of internal corrective action activities	0
10.	3.1.16.9	The agency maintains a process to inform officers, employees, agents and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act.		2
11.	3.1.17	The agency has completed an annual compliance risk assessment	Risk assessment documentation	0
12.	3.1.19	The agency maintains policies and procedures prohibiting retaliation against individuals who make a good faith report of misconduct or unethical behavior.		2

Comments: Following discussion with CFCS staff, it is clear that CFCS does not maintain an active, effective compliance program. The compliance plan shown did not reflect actual practice, and references staff no longer with CFCS. There was no evidence of regular compliance committee meetings, internal monitoring/auditing activities or compliance education. A compliance risk assessment had not been completed. Staff acknowledged that little energy has been put into the development of an effective compliance program.

IX. FOCUS ISSUES

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.6	Successful reporting and logging of consumer grievances	Staff Interviews	2
2.	4.3.4	The Agency shall provide extended hours of operation beyond the standard work day.	Report Posted hours	2
3.	4.3.13	Service shall be provided in locations convenient to the consumer (out of facility)	Report Policy	2
4.	3.1.13	Agency maintains a disaster plan consistent with CDRSN policy 3.11, and operationalizes the plan in the event of an emergency situation.	Policy	2
5.	10	Subcontracts meet contract standards	Review of Sub-contracts	2
6.	7.1.5	The Agency conducts internal encounter data validations at least quarterly.	EDV audit summaries	2
7.	6.1	The agency maintain an active Quality Management Plan that addresses the minimum contract requirements	Review of QM Plan	
8.	7.1.12 7.1.13	The Agency maintains a breach risk assessment process that addresses required factors.	Copy of breach risk assessment tool Evidence of breach review tool use	0
9.	4.2.6	The Agency provides a Notice of Action to any consumer who will have their previously authorized	Policy Review of NOA	2

		services terminated, suspended, reduced, or provided at a scope, duration, type or intensity less than they are requesting (disagreement with recommended service plan).	Documentation	
10.	7.1.3	Agency maintains a current MIS Quality Control and Quality Assurance Plan	Review of Plan	2

Comments: 7.1.12, 7.1.13 – CFCS was unable to provide CDRSN with a breach risk assessment process. Over discussion of a recent grievance, it was determined that a likely breach had occurred, and had been grieved, but a breach risk assessment had not been completed. Additionally, CFCS staff were unaware of breach notification requirements. CFCS was unable to provide a breach notification policy/procedure.

CF&CS Provider Plan of Correction

Provider Name:	Catholic Family & Child Service		
Reviewing entity and type:	CDRSN		
Date of Request for Corrective Action:	August 27, 2014		
Due Date for Corrective Action Response:	October 1, 2014	Return Completed Report To:	Craig Mott

Administrative Review

PROVIDER PERFORMANCE	REMEDIAL ACTION PLAN	RESPONSIBLE PARTIES	COMPLETION DATE
1. CFCS did not complete monthly exclusion checks for executive management and board members.	Exclusion checks will be completed by executive assistant and HR staff.	Dorothy Morales Bill Hargrove Cheryl Otis	November 15, 2014
2. CFCS did not present primary source documentation of monthly exclusion checks using the System for Award Management (SAM) exclusions database (EPLS data).	Exclusion checks will be completed by executive assistant and HR staff.	Dorothy Morales Bill Hargrove Cheryl Otis	November 15, 2014
3. Third party liability: CFCS continues to be unable to pursue all third party payers, most notably Medicare. An updated corrective action plan is required.	Corrective action plan will be submitted. (Note: CFCS has hired an individual who is assisting with provider enrollment of licensed staff, specifically with Medicare and other third party payors. Once this is complete the payors will be back-billed for services rendered to individuals with insurance. A fee schedule that can be used to bill third parties for crisis services is in development.)	Robin Cronin Kathy Bensch	November 15, 2014
4. CFCS does not have an effective compliance program in place or in active development.	Compliance plan will be reviewed and revised to meet requirements. CFCS has hired a Quality Assurance Coordinator who will also be the Compliance Officer. This person is starting the week of Sept. 29, 2014.	Robin Cronin Kris Davis	November 30 2014
5. Breach Risk Assessment/HITECH Act Compliance: CFCS was unable to provide breach notification policy and procedure.	Breach risk assessment process to be reviewed and documented; training to be provided to staff.	Robin Cronin Jason Riel Kris Davis	November 30, 2014
6. CFCS needs to provide stabilization services of a duration and scope that meets the needs of individuals requesting hospital diversion and /or post hospital stabilization.	CFCS will make a plan to provide stabilization services and implement by December 31, 2014	Robin Cronin Kris Davis Eric Skansgaard	December 31, 2014
7. Incident policy needs to be updated to reflect current contract elements.	Incident Policy will be updated to reflect current contract elements and staff to be trained in incident reporting procedures.	Robin Cronin Kris Davis Eric Skansgaard Shirley Wilbur	November 1, 2014

CF&CS Provider Plan of Correction

Provider Name:	Catholic Family & Child Service		
Reviewing entity and type:	CDRSN		
Date of Request for Corrective Action:	August 27, 2014		
Due Date for Corrective Action Response:	October 1, 2014	Return Completed Report To:	Craig Mott

Part 1: Credentialing, Training, Supervision and Licenses

PROVIDER PERFORMANCE	REMEDIAL ACTION PLAN	RESPONSIBLE PARTIES	COMPLETION DATE
1. Improve agency practice with regard to monitoring and documenting clinician credential status.	CC/CFCS is in the process of implementing an agency wide HR system that will track necessary licenses and certifications. HR will provide regular reports to advise managers of pending license expirations. Managers and supervisors will notify staff of time frames for submitting new licenses. A policy and procedure will be written and reviewed with mental health managers and staff.	Bill Hargrove, Cheryl Otis Robin Cronin Kris Davis Eric Skansgaard Shirley Wilbur Shawn Delancy	October 31, 2014
2. Documentation of required training is very fragmented.	The agency has a training plan that describes the topics to be provided, the frequency of training and who the training applies to. Training documentation for MH staff is kept in a notebook, with a list of who was in attendance along with the date and time of the training. Initial training requirements will be added to the orientation checklist for new employees as a tracking mechanism that starts at hire. In the future each staff in attendance will be issued a training certificate when training is done. A file will be kept for each clinician with copies of the training certificates received when a training is completed.	Robin Cronin Kris Davis Eric Skansgaard Shirley Wilbur	November 30, 2014
3. Grievance policy needs to be updated to reflect current contract requirements.	Grievance policy will be updated to reflect current contract requirements.	Robin Cronin	October 31, 2014
4. 20% of open consumers had not received the required minimum service frequency. Closer internal monitoring is indicated.	"Engagement specialists" have been hired to assist with getting individuals to their appointments and have just recently started in this role. Management staff will review caseloads and productivity to determine why 20% of consumers have not received the minimum service frequency. Engagement will be monitored closely as well as the efforts of staff to follow-up with individuals who are not attending appointments. We are also moving to "same day intake" to provide immediate access to individuals when they reach out and are in need of assistance.	Robin Cronin Kris Davis Eric Skansgaard Shirley Wilbur	October 31, 2014

Chelan-Douglas
Regional Support Network

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01/28/2015

Robin Cronin
Catholic Family and Child Services
5301 Tieton Drive, Suite C
Yakima, WA 98908

RE: RSN Outpatient Chart Review

First, thank you to you and your staff for your hard work. I have attached a link that will take you to the results of my reviews both in aggregate and as individual chart note. Your password is CFCS. 35 outpatient charts were randomly selected (stratified to include charts across programs and service modalities). The items cited below score as out of compliance.

1. Six charts were missing specialist consultations.
2. Four charts did not include treatment plans that address the needs and desired outcomes assessed at intake and/or identified during the course of treatment.
3. One out of eight LRA charts did not document that the consumer had been assessed at least every 7 days in the first 14 day and every 30 days thereafter as to the need for psychotropic medications and other psychiatric services, unless the attending physician documents a reason for an alternate schedule.
4. Five out of eight LRA charts did not document that the consumer had been evaluated by an MHP at least every 30 days with regard to release from or continuation of an involuntary treatment order.

This is an improvement from your last review that had 12 review areas with findings. However, the LRA MHP review has not improved. Please be sure the reviews are every 30 days—not monthly and the notes include all of the required elements. The state licensing staff have been particularly adamant about this item in the past and given they have new staff again we are unsure of our risk in this area.

Also, please review items that did not score below the threshold of the criteria for findings but should still inform your quality improvement efforts. Please submit a plan of corrective action

that addresses each item cited above by February 15, 2015. The reports attached are de-identified and an excel report which attaches the consumer ID will be place on the FTP site.

Respectfully Submitted,

Debra J Murray, MSW
Clinical Director CDRSN

CC: Tamara Burns
Contract file

CDRSN Administrative Review Tool

Agency: Children's Home Society of Washington **Date: 8/18/2014** **Score: 118/122 (96.7%)**

Findings:

Finding #1: Compliance Program: CHSW has not completed a compliance risk assessment in accordance with contract subsection 3.1.17.

Recommendations:

Recommendation #1: Compliance Program: Two of three staff interviewed were not aware of who served as the compliance officer, and were unaware of processes to report non-compliance. Additionally, it was reported that no concerns relative to non-compliance had been received within the organization. It is recommended that CHSW review their compliance program relative to staff knowledge and reporting routes, including expectations for reporting, as well as improve and measure the effectiveness of training. #2: Training policy should be updated to reflect the new WAC 388-877-0500 requirements. It appears this is happening but not in the policy.

Score Key: Absent 0, Partial Compliance 1, Evidence of compliance 2.

Part I. Credentialing, Training, Supervision and Licenses.

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.1	Agency holds all necessary licenses, and certifications required by law.	Copy of License(s)	2
2.	3.1.3	Maintain current staff information in the Avatar EHR.	Report	2
3.	3.1.21	Criminal Background check though WSP for all	Policy, Copy of	2

		employees with unsupervised access to vulnerable populations	background check	
4.	12.1 13.1	Complies with nondiscrimination laws and policies.	Policy Posted placards	2
5.	3.1.2	Primary Source verification DOH current licensure documented	Policies Sample reviewed on site	2
6.	4.3.22	Documents training and training plans inclusive of the following topics as appropriate for each employee: 1. Confidentiality/HIPAA 2. Client rights 3. Complaint and grievance procedures annually. 4. Benefits described in the benefit package 5. Culturally competent service delivery annually 6. Advanced Directives and WRAP plans 7. Strength based assessment and treatment planning. 8. Recovery principles. 9. Service coordination for special needs/multisystem consumers and EPSDT 10. Safety Training—including RCW 71.05.700 and RCW 49.19.030 requirements as appropriate annually . 11. CDRSN policies and procedures 12. Medicaid Fraud and Abuse, including training specific to the False Claims Act. 13. Incident reporting and mandatory reporting of abuse.	Policies Training logs Personnel files	2. Policy should be update to reflect the new WAC 388-877-0500 requirements. It appears this is happening but not in the policy. 6) **Staff training.** A description of how the agency provides training within thirty days of an employee's hire date and annually thereafter: (a) Consistent with the agency's certified services. (b) On cultural competency that assists staff in recognizing when cultural barriers interfere with clinical care that includes a review of: (i) Populations specific to the agency's

				geographic service area; and (ii) Applicable available community resources. (c) On procedures for how to respond to individuals in crisis that includes a review of: (i) Emergency procedures; (ii) Program policies and procedures; and (iii) Rights for individuals receiving services and supports. (d) That addresses the requirements of this chapter.
7.	WAC 388-877-0500	Documentation of regular supervision and employee evaluation	Policies Supervision logs or random sample of personnel files	2
8.	3.1.22	Documentation of monthly checked for excluded individuals and entities using LEIE and EPLS databases, including staff, executive management and board members.	Search documentation or evidence of other process(es) used	2

Comments: Recommendation per above.

Part II. Enrollee Rights

	Requirement Origin	Requirement	Documentation	Score
1.	4.2.1	Agency posts written rights statements in all DSHS required languages.	Observed	2
2.	4.2.1	Agency policies and forms address all required enrollee rights inclusions and are available in prevalent languages. (See separate check off list)	Policies Forms	2
3.	4.2.1	Consumers are informed of the availability of free interpreter services.	Posting in prevalent languages at front desk.	2
4.	4.3.19.1	Agency provides free interpretation and translation service to enrollees.	Billings or log of provided services.	2
5.	4.3.18	The agency's physical space is ADA accessible	Observation	2
6.	4.3.18	Alternative format materials and communication methods are available for enrollees with sensory impairments.	TDD/TDY available Other formats	2
7.	4.3.14	The agency maintains an advanced directives policy that respects the service recipients' advance directives for psychiatric care.	Policy Forms/literature distributed to enrollees	2
8.	4.3.14.1	Clinical charts contain copies of advanced directives and the agency has a means of making employees aware of consumers that have psychiatric or medical advanced directive.	Policy Chart review	2

9.	4.2.5.1	Agency maintains a record of enrollees that request second opinions.	Policy Quarterly report to RSN	2
10.	4.2.3 4.2.4	Right of enrollee concerning choice and change of provider.	Policy Staff interview	2
11.	CDRSN P&P	Agency has policies and procedures concerning restraint and seclusion. Agency follows policy and maintains records of any instance of use of restrain or seclusion.	Policy Clinical record	2
12.	4.2.2	Information on how to contact the Ombuds and how to file a complaint or grievance is readily available to consumers.	Policy Lobby materials Intake packet Consumer survey	2

Comments:

Part III. Grievance System

	Requirement Origin	Requirement	Documentation	Score

1.	3.1.6	Agency maintains a grievance system that complies with 42CFR438.400.	Policy	2
2.	3.1.6	Agency enters information related to all grievances into the Avatar EHR Complaint and Grievance form. The Agency enters all data elements required to CDRSN to determine compliance with the grievance system.	Records	2
3.	3.1.6	Agency has a process to monitor compliance with the grievance system.	Policy Report Definition/Monitoring procedure	2

Comments:

Part IV. Access and Capacity

	Requirement Origin	Requirement	Documentation	Score
1.	Access Standards	Routine intake appointments occur within 10 business days of the request for service	Report	2
2.	Access Standards	The time period from request to the first routine appointment offered does not exceed 28 days.	Report	2

3.	CDRSN P&P	Did the agency provide routine services at least once per month?	Report	2
4.	4.6.1.2	Agency brings services to the consumer, including intake assessments, if the consumers mental illness, lack of transportation or physical limitations prevent an office visit.	Policy Out of Office Services	2
5.	4.6.4.7	The first routine appointment following inpatient treatment must occur within 7 days of discharge.	Reports	2
6.	3.1.3	Ensures number of qualified agency personnel sufficient to meet access/travel standards.	Case load Service locations	2
7.	4.5.12	Agency employs or contracts mental health specialists for children, elderly, ethnic minorities or persons who are deaf or developmentally disabled	Policy Personnel files Verify contracts and qualifications of contractors.	2
8.	4.2.5 4.2.5.1	Agency, upon consumer request, provides a second opinion from within the CDRSN service area. If an additional CMHA is not available, the agency will pay for a second opinion from a CMHA outside of the CDRSN service area at no cost to the enrollee.	Policy Quarterly reports Payment records	2
9.	4.3.20 4.3.21	Agency provides uninterrupted access to a range of activities identified in the Medicaid state plan and maintains for Medicaid enrollees, when deemed Medically Necessary, service delineated in the state plan.	Policy Payment records	2
10.	3.1.12	Make all efforts to collect and report 3rd party reimbursements rendered in the performance of the contract.	R&E Evidence of billings	2

Comments:

Part V. EPSDT and Service Coordination

	Requirement Origin	Requirement	Documentation	Score
1.	4.3.15	Agency ensures enrollees under 21 receive services that comply with the state EPSDT plan. • Child Specialist reviews intake/plan of care and makes level one or two assignments. • Close communication between mental health clinician and the PCP to include date of intake, primary diagnosis and level of care assignment. • Documentation of referral to PCP for Healthy Kids screening for children presenting for intake without referral from PCP. • CSP for Level two children.	Policy EPSDT files	2
2.	4.3.23	GAIN is completed for all individuals 13 years of age	POLICY	2

		and older.	GAIN report	
3.	4.3.7	Agency ensures that referral is made to PCP within 30 days of intake and as needed thereafter when medical or dental needs are identified.	POLICY	2

Comments:

PART VI. Quality Assurance

	Requirement Origin	Requirement	Documentation	Score
1.	3.2.1	Provider will Notify CDRSN of any incident as defined in RSN policy 3.12 and comply with mandated procedures for reporting and follow up.	Sample of incidents Incident report Follow up reports	2
2.	6.1 6.1.5	The provider shall adopt and utilize a quality management system which: • Performs internal audits of medical records (no less than 10% annually) • Monitors access and appropriateness of services. • Monitors service recipient satisfaction.	Policy QM plan Satisfaction surveys Consumer complaint logs	2
3.	6.1.6 6.1.6.4	The provider will follow CDRSN practice guidelines and participate in implementing RSN wide evidenced	Chart review	2

		based practices.		
4.	CDRSN P&P	Provider will participate in RSN bimonthly clinical team meetings to collaborate on Performance Improvement Projects and other system coordination concerns.	Attendance logs Submission of PIP data.	2

Comments:

PART VII. Compliance Program

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.16	The agency maintains administrative and management policies, procedures and standards to guard against Medicaid fraud and abuse	Policies and procedures Informal procedures	2
2.	3.1.16.1	The agency maintains an effective Compliance Program	Compliance Plan Evidence of Operationalization of the	1

			Plan	
3.	3.1.16.2	The agency has written policies, procedures and standards of conduct that articulate the CDRSN/PIHP commitment to comply with all applicable federal and state standards	Policy Standards of Conduct	2
4.	3.1.16.3	The agency has a designated Compliance Officer and Compliance Committee that meets regularly	Policy Compliance Committee Minutes	2
5.	3.1.16.4	The agency maintains an effective compliance education and training program,	Training records Education Plan	1
6.	3.1.16.5	The agency maintains an effective line of communication between the Compliance Officer and the CDRSN/PIHP	Policy	2
7.	3.1.16.6	The agency maintains enforcement standards through well-publicized disciplinary guidelines	Policy or other disciplinary standards	2
8.	3.1.16.7	The agency maintains procedures for internal monitoring and auditing to facilitate compliance	Policy Monitoring and Auditing Documentation	2
9.	3.1.16.8	The agency has provisions for the prompt response to detected offenses and for the development of corrective actions initiatives	Policy Documentation of internal corrective action activities	2

10.	3.1.16.9	The agency maintains a process to inform officers, employees, agents and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act.		2
11.	3.1.17	The agency has completed an annual compliance risk assessment	Risk assessment documentation	0
12.	3.1.19	The agency maintains policies and procedures prohibiting retaliation against individuals who make a good faith report of misconduct or unethical behavior.		2

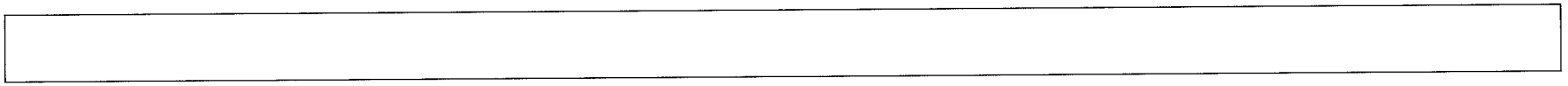
Comments: 3.1.16.1, 3.1.16.4 – Two of three staff interviewed were unaware of who was designated as the compliance officer or how to report non-compliance, despite reported recent training on that issue. Additionally, it was reported that there have been zero (0) reports of concerns relative to non-compliance. This leads to questions relative to the effectiveness of the program, as well as the effectiveness of training. 3.1.17 – CHSW was unable to provide documentation of a completed risk assessment.

IX. FOCUS ISSUES

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.6	Successful reporting and logging of consumer grievances	Staff Interviews	2

2.	4.3.3	The Agency shall provide extended hours of operation beyond the standard work day.	Report Posted hours	2
3.	4.3.12	Service shall be provided in locations convenient to the consumer (out of facility)	Report Policy	2
4.	10	Subcontracts meet contract standards	Review of Sub-contracts	2
5.	7.1.5	The Agency conducts internal encounter data validations at least quarterly.	EDV audit summaries	2
6.	6.1	The agency maintain an active Quality Management Plan that addresses the minimum contract requirements	Review of QM Plan	2
7.	7.1.11 7.1.13	The Agency maintains a breach risk assessment process that addresses required factors.	Copy of breach risk assessment tool Evidence of breach review tool use	2
8.	4.2.6	The Agency provides a Notice of Action to any consumer who will have their previously authorized services terminated, suspended, reduced, or provided at a scope, duration, type or intensity less than they are requesting (disagreement with recommended service plan).	Policy Review of NOA Documentation	2
9.	7.1.3	Agency maintains a current MIS Quality Control and Quality Assurance Plan	Review of Plan	2

Comments:



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07/13/2015

Alejandra Gonzalez
Children's Home Society of Washington
1014 Walla Walla Avenue
Wenatchee, WA 98801

RE: 2015 Credentialing Review

Hello Alejandra,

Thank you for your assistance in reviewing your credentialing processes prior to the scheduled EQRO review that would have occurred 6/29/2015 except for the fire and evacuation. As you know the RSN will be conducting their annual review in a few months. Children's Home did well last year and did not have any finding regarding credentialing. I have enclosed your last year's review as a reminder of the elements that we check. Since you have had a great deal of staff turnover this year, including administrative staff that maintain your credentialing files, I have included the WAC requirements that must be supported in your files.

"Mental health professional" means:
(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;
(2) A person with a masters degree or further advanced degree in counseling or one of the social 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;
(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or
(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

"Mental health specialist" means:

(1) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(a) 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

(b) 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) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(a) 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 years of age or older; and

(b) The equivalent of one 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.

(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 year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, **"disabled"** means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

Support for the requirements would be original source licensing documents, official transcripts for those staff with agency affiliated licenses, certificates for specialist training, letters from supervising MHP or specialist, certificates from DSHS licensing staff or confirmed references regarding supervised practice. If the specialist is a subcontractor please include the documentation in their contract file.

It appears your corporate office is sending the appropriate excluded provider reports monthly and your policies and staff supervision/training logs are up to date. If you need any assistance we will be happy to help.

Sincerely,

Debra Murray MSW
Clinical Director

CC: Contract File
Qualis Health
Tamara Cardwell- Burns

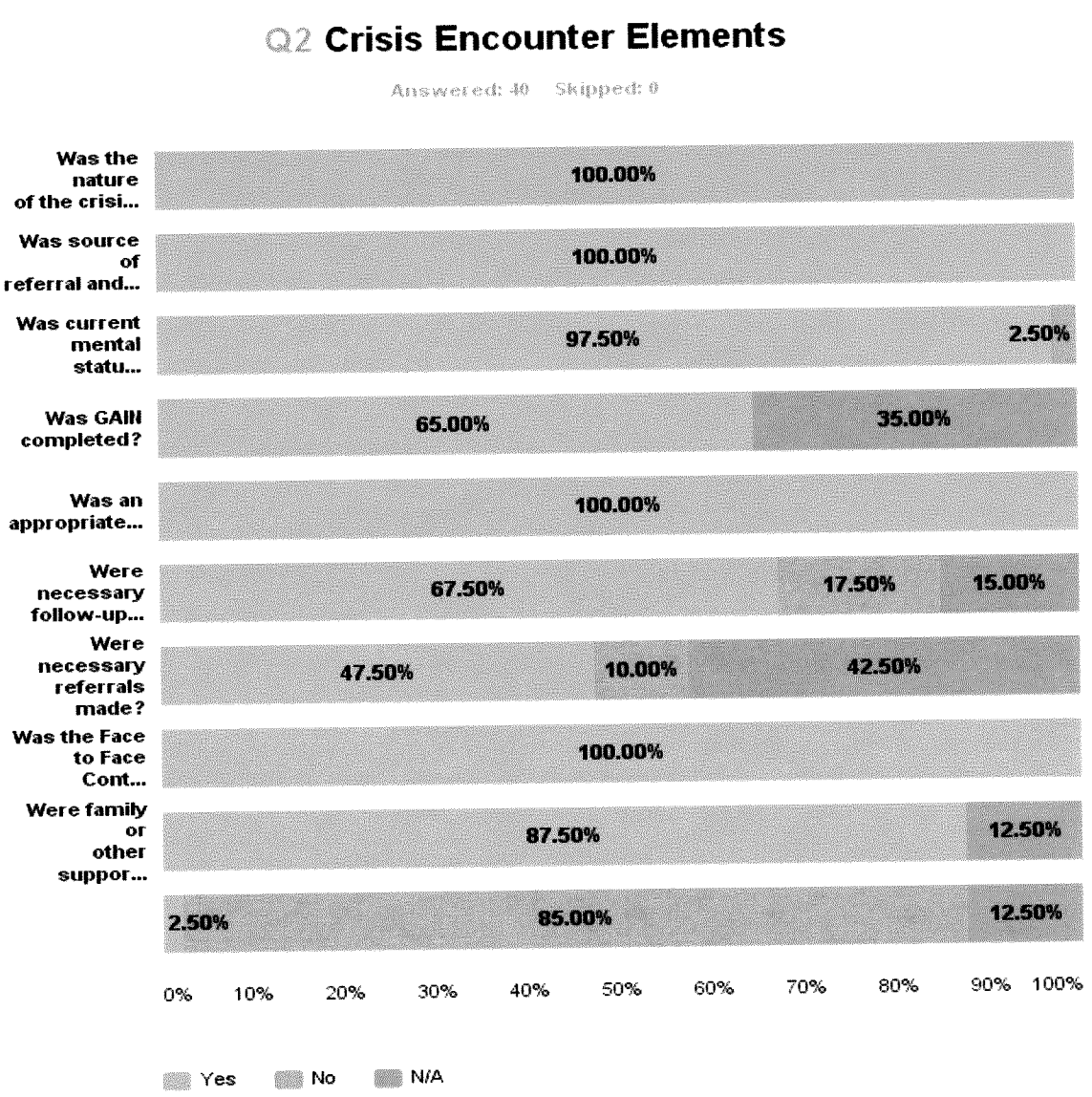
CDRSN annually conducts a comprehensive review of the crisis system. The review consists of four elements:

1. **Credentialing, supervision, and training record documentation** All 8 DMHPs have current valid licenses and have received required safety training. Training and supervision records were reviewed. The most recent hire was just designated last month and is still receiving close supervision.
2. **Data Profiling** indicates the number of services, the percentage of investigations to detentions, and access of EMR records. CDRSN data indicates a total of 673 ITA investigations to date in 2014. Of those 126 individuals were detained for an overall percentage of 18.72 %. Individual DMHP percentages vary from a low of 5% to a high of 40%. Access of crisis plans is monitored through data reports and chart review. This is a major concern as looking to every reasonable source for a history of violent acts is a DMHP protocol requirement. Crisis plans contain such information are available to all crisis responders. Lack of DMHP use of crisis plans was a finding in both crisis reviews in 2014 and needs to be addressed immediately.
3. **Clinical Record review** of 40 crisis episodes (five for each DMHP) is summarized on page two. Aside from the crisis plan issue cited above, follow-up remains a finding but is greatly improved from the baseline review for CFCS conducted in March 2014 (p3).
4. **Oral Interviews** All eight current DMHPs have been interviewed during 2014 with the interview tool described on page 4 which is intended to test their knowledge of DMHP protocols and RCW 71.05.

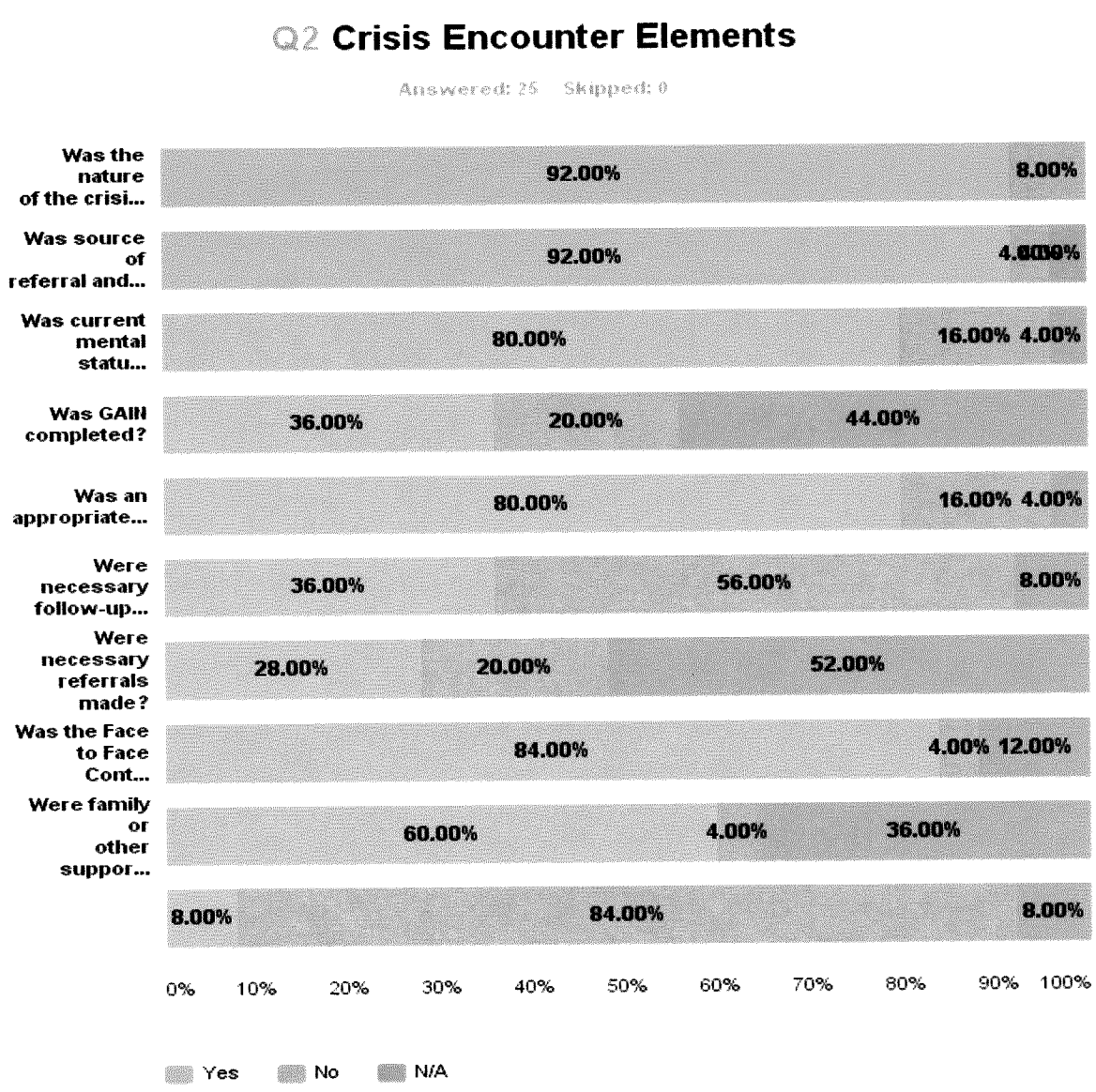
Compliance and Quality Improvement Activities

- **January 1, CDRSN started a new Performance Improvement Project (PIP) which developed a new Crisis Discharge policy and provided training for the new crisis provider on implementation. This does seem to have improved follow-up over the base line measure in March 2014 but inadequate follow-up remains a finding. CFCS and CDRSN will provide training to all DMHP by January 15, 2015.**
- **DMHPs must check MSO Crisis Plan Screens at each investigation. DMHPs will complete training by January 15. 2014 and Avatar MSO access reports will indicate at least a 75% rate of access for all DMHPs by March 1, 2015.**
- **The current note template has improved the quality of documentation but it is strongly recommended that CFCS adopt the use of a standardized risk assessment.**

1. Was the nature of the crisis documented?
2. Was the referral source and their concern documented?
3. Was mental status and risk documented per protocol?
4. Was the GAIN completed?
5. Was appropriate disposition documented?
6. Were needed follow-up contacts made?
7. Were necessary referrals made?
8. Was the 2 hour access timeframe met?
9. Were family or other support persons involved in reaching the plan?
10. Was the consumer's crisis plan accessed?



1. Was the nature of the crisis documented?
2. Was the referral source and their concern documented?
3. Was mental status and risk documented per protocol?
4. Was the GAIN completed?
5. Was appropriate disposition documented?
6. Were needed follow-up contacts made?
7. Were necessary referrals made?
8. Was the 2 hour access timeframe met?
9. Were family or other support persons involved in reaching the plan?
10. Was the consumer's crisis plan accessed?



1 Describe your process for taking information from family, other professionals, or the general public when they make contact with your agency to describe concern about an individual in crisis.

2 Describe your process for determining if a consumer has an Advanced Directive prior to final disposition of a crisis contact—chart, family/support person, Crisis Plan.

3 Describe how you advise a consumer of their rights.

4 Describe your process for involving family or other advocates/ surrogate decision makers in the crisis intervention process.

5 Describe your process for developing a less restrictive diversion from hospitalization.

6. Describe your process for following up with a consumer that you have seen for an ITA evaluation.

7. Describe how you keep up with changes in the law effecting your profession.

8. Describe what you know about parent initiated treatment. Difference in the ITA law for children?

9. What sources do you refer to in order to obtain history of violent acts.

CDRSN annually interviews all DMHPs that will be designated to work in the provider network for the next calendar year. Questions and two Case Scenarios are developed from the 2011 Designated Mental Health Professionals Protocol that is the excepted standard of practice in Washington State and based on RCW 71.05 and 71.34. The Questions presented at left along with two scenarios that represent complex cases involving an adult with developmental disabilities and an older adult in an assisted living facility comprised this year's interview questions.

The eight DMHP's that will go forward to provide services in 2015 were interviewed during the 2014 calendar year. All DMHPs, per their report, are advising consumers of their role, legal capacity, and right to remain silent prior to evaluation. This is required in the local community because our DMHPs do both crisis services and ITA evaluations.

1. All DMHPs acknowledged they do not access the MSO crisis plan report citing various problems and lack of quality in the crisis plans. Checking this is required in order to have a source for history of violent acts. This has been a problem for the past two years.

2. In discussions regarding follow-up, CDRSN is aware that meetings and pass down information occurs but diligence in making sure this information is included in the medical record is critical.

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For Mental Health

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9/3/2014

Tessa Timmons
Columbia Valley Community Health
504 Orondo Avenue
Wenatchee, WA 98801

RE: 2014 Administrative Review

Please find attached the CDRSN's 2014 administrative review conducted on August 18, 2014. Thank you and your staff for your assistance while we were on site. Please submit a plan of corrective action by October 1, 2014 to address the finding cited on the review form.

Sincerely,

Craig Mott, CHC
Contracts Manager/Compliance Officer

CC: Contract File
Tamara Cardwell- Burns

CDRSN Administrative Review Tool

Agency: Columbia Valley Community Health Date: 8/18/2014 Score: 118/120 (98.3%)

Findings: 1. Consumer rights policy is missing several of the required rights citations. RSN policy 8.1 is attached.

Recommendations:

Recommendation 1: Breach Risk Assessment (Focus Areas, #7) – The breach risk assessment tool reviewed by CDRSN was not updated to reflect the new breach standard of "low probability of compromise" defined in the HIPAA Omnibus Rule. The tool reviewed reflected to obsolete "harm" standard for determining a breach. It is recommended that CVCH update its breach risk assessment tool to reflect the updated standards and exceptions. 2. Policies should be updated to reflect the new WAC first 30 day requirements.

Score Key: Absent 0, Partial Compliance 1, Evidence of compliance 2.

Part I. Credentialing, Training, Supervision and Licenses.

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.1	Agency holds all necessary licenses, and certifications required by law.	Copy of License(s)	2
2.	3.1.3	Maintain current staff information in the Avatar EHR.	Report	2
3.	3.1.21	Criminal Background check though WSP for all employees with unsupervised access to vulnerable populations	Policy, Copy of background check	2
4.	12.1 13.1	Complies with nondiscrimination laws and policies.	Policy Posted placards	2

5.	3.1.2	Primary Source verification DOH current licensure documented	Policies Sample reviewed on site	2
6.	4.3.22	Documents training and training plans inclusive of the following topics as appropriate for each employee: 1. Confidentiality/HIPAA 2. Client rights 3. Complaint and grievance procedures. 4. Benefits described in the benefit package 5. Culturally competent service delivery 6. Advanced Directives and WRAP plans 7. Strength based assessment and treatment planning. 8. Recovery principles. 9. Service coordination for special needs/multisystem consumers and EPSDT 10. Safety Training—including RCW 71.05.700 and RCW 49.19.030 requirements as appropriate. 11. CDRSN policies and procedures 12. Medicaid Fraud and Abuse, including training specific to the False Claims Act. 13. Incident reporting and mandatory reporting of abuse.	Policies Training logs Personnel files	2. Very nice training logs and documentation. Required trainings are evident for both annual and first 30 day requirements. Policies should be updated to reflect the new WAC first 30 day requirements 6) **Staff training.** A description of how the agency provides training within thirty days of an employee's hire date and annually thereafter: (a) Consistent with the agency's certified services. (b) On cultural competency that assists staff in recognizing when cultural barriers interfere with clinical care that includes a review of: (i) Populations specific to the agency's geographic service area; and (ii) Applicable available community resources. (c) On procedures for how to respond to individuals in crisis that includes a review of: (i) Emergency procedures;

				(ii) Program policies and procedures; and (iii) Rights for individuals receiving services and supports. (d) That addresses the requirements of this chapter.
7.	WAC 388-877-0500	Documentation of regular supervision and employee evaluation	Policies Supervision logs or random sample of personnel files	2. Very nice documentation.
8.	3.1.22	Documentation of monthly checked for excluded individuals and entities using LEIE and EPLS databases, including staff, executive management and board members.	Search documentation or evidence of other process(es) used	2

Comments: Very nice documentation of training and supervision.

Part II. Enrollee Rights

	Requirement Origin	Requirement	Documentation	Score
1.	4.2.1	Agency posts written rights statements in all DSHS required languages.	Observed	2. Finding: The consumer rights policy is missing a few of the required rights. RSN policy 8.1 is attached.
2.	4.2.1	Agency policies and forms address all required enrollee rights inclusions and are available in prevalent languages. (See separate check off list)	Policies Forms	1. Finding: The consumer rights policy is missing a few of the required rights. RSN policy 8.1 is attached.
3.	4.2.1	Consumers are informed of the availability of free interpreter services.	Posting in prevalent languages at front desk.	2
4.	4.3.19.1	Agency provides free interpretation and translation service to enrollees.	Billings or log of provided services.	2
5.	4.3.18	The agency's physical space is ADA accessible	Observation	2
6.	4.3.18	Alternative format materials and communication methods are available for enrollees with sensory impairments.	TDD/TDY available Other formats	2
7.	4.3.14	The agency maintains an advanced directives policy that respects the service recipients' advance directives for psychiatric care.	Policy Forms/literature distributed to enrollees	2
8.	4.3.14.1	Clinical charts contain copies of advanced directives and the agency has a means of making employees aware of consumers that have psychiatric or medical advanced directive.	Policy Chart review	2
9.	4.2.5.1	Agency maintains a record of enrollees that request second opinions.	Policy Quarterly report to RSN	2

10.	4.2.3 4.2.4	Right of enrollee concerning choice and change of provider.	Policy Staff interview	2
11.	CDRSN P&P	Agency has policies and procedures concerning restraint and seclusion. Agency follows policy and maintains records of any instance of use of restrain or seclusion.	Policy Clinical record	2
12.	4.2.2	Information on how to contact the Ombuds and how to file a complaint or grievance is readily available to consumers.	Policy Lobby materials Intake packet Consumer survey	2

Comments: Rights policy needs to include all WAC, Medicaid, and CFR citations.

Part III. Grievance System

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.6	Agency maintains a grievance system that complies with 42CFR438.400.	Policy	2

2.	3.1.6	Agency enters information related to all grievances into the Avatar EHR Complaint and Grievance form. The Agency enters all data elements required to CDRSN to determine compliance with the grievance system.	Records	2
3.	3.1.6	Agency has a process to monitor compliance with the grievance system.	Policy Report Definition/Monitoring procedure	2

Comments:

Part IV. Access and Capacity

	Requirement Origin	Requirement	Documentation	Score
1.	Access Standards	Routine intake appointments occur within 10 business days of the request for service	Report	2
2.	Access Standards	The time period from request to the first routine appointment offered does not exceed 28 days.	Report	2
3.	CDRSN P&P	Did the agency provide routine services at least once per month?	Report	2

4.	4.6.1.2	Agency brings services to the consumer, including intake assessments, if the consumers mental illness, lack of transportation or physical limitations prevent an office visit.	Policy Out of Office Services	2
5.	4.6.4.7	The first routine appointment following inpatient treatment must occur within 7 days of discharge.	Reports	2
6.	3.1.3	Ensures number of qualified agency personnel sufficient to meet access/travel standards.	Case load Service locations	2
7.	4.5.12	Agency employs or contracts mental health specialists for children, elderly, ethnic minorities or persons who are deaf or developmentally disabled	Policy Personnel files Verify contracts and qualifications of contractors.	2
8.	4.2.5 4.2.5.1	Agency, upon consumer request, provides a second opinion from within the CDRSN service area. If an additional CMHA is not available, the agency will pay for a second opinion from a CMHA outside of the CDRSN service area at no cost to the enrollee.	Policy Quarterly reports Payment records	2
9.	4.3.20 4.3.21	Agency provides uninterrupted access to a range of activities identified in the Medicaid state plan and maintains for Medicaid enrollees, when deemed Medically Necessary, service delineated in the state plan.	Policy Payment records	2
10.	3.1.12	Make all efforts to collect and report 3rd party reimbursements rendered in the performance of the contract.	R&E Evidence of billings	2

Comments:

Part V. EPSDT and Service Coordination

	Requirement Origin	Requirement	Documentation	Score
1.	4.3.15	Agency ensures enrollees under 21 receive services that comply with the state EPSDT plan. • Child Specialist reviews intake/plan of care and makes level one or two assignments. • Close communication between mental health clinician and the PCP to include date of intake, primary diagnosis and level of care assignment. • Documentation of referral to PCP for Healthy Kids screening for children presenting for intake without referral from PCP. • CSP for Level two children.	Policy EPSDT files	2
2.	4.3.23	GAIN is completed for all individuals 13 years of age and older.	POLICY GAIN report	2 100%
3.	4.3.7	Agency ensures that referral is made to PCP within 30 days of intake and as needed thereafter when medical or	POLICY	2

		dental needs are identified.		

Comments:

PART VI. Quality Assurance

	Requirement Origin	Requirement	Documentation	Score
1.	3.2.1	Provider will Notify CDRSN of any incident as defined in RSN policy 3.12 and comply with mandated procedures for reporting and follow up.	Sample of incidents Incident report Follow up reports	2
2.	6.1 6.1.5	The provider shall adopt and utilize a quality management system which: • Performs internal audits of medical records (no less than 10% annually) • Monitors access and appropriateness of services. • Monitors service recipient satisfaction.	Policy QM plan Satisfaction surveys Consumer complaint logs	2
3.	6.1.6 6.1.6.4	The provider will follow CDRSN practice guidelines and participate in implementing RSN wide evidenced based practices.	Chart review	2
4.	CDRSN P&P	Provider will participate in RSN bimonthly clinical team meetings to collaborate on Performance	Attendance logs Submission of PIP data.	2

		Improvement Projects and other system coordination concerns.		

Comments:

PART VII. Compliance Program

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.16	The agency maintains administrative and management policies, procedures and standards to guard against Medicaid fraud and abuse	Policies and procedures Informal procedures	2
2.	3.1.16.1	The agency maintains an effective Compliance Program	Compliance Plan Evidence of Operationalization of the Plan	2
3.	3.1.16.2	The agency has written policies, procedures and	Policy	2

		standards of conduct that articulate the CDRSN/PIHP commitment to comply with all applicable federal and state standards	Standards of Conduct	
4.	3.1.16.3	The agency has a designated Compliance Officer and Compliance Committee that meets regularly	Policy Compliance Committee Minutes	2
5.	3.1.16.4	The agency maintains an effective compliance education and training program,	Training records Education Plan	2
6.	3.1.16.5	The agency maintains an effective line of communication between the Compliance Officer and the CDRSN/PIHP	Policy	2
7.	3.1.16.6	The agency maintains enforcement standards through well-publicized disciplinary guidelines	Policy or other disciplinary standards	2
8.	3.1.16.7	The agency maintains procedures for internal monitoring and auditing to facilitate compliance	Policy Monitoring and Auditing Documentation	2
9.	3.1.16.8	The agency has provisions for the prompt response to detected offenses and for the development of corrective actions initiatives	Policy Documentation of internal corrective action activities	2
10.	3.1.16.9	The agency maintains a process to inform officers, employees, agents and subcontractors regarding fraud and abuse policies and procedures and the False Claims		2

		Act.		
11.	3.1.17	The agency has completed an annual compliance risk assessment	Risk assessment documentation	2
12.	3.1.19	The agency maintains policies and procedures prohibiting retaliation against individuals who make a good faith report of misconduct or unethical behavior.		2

Comments:

IX. FOCUS ISSUES

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.6	Successful reporting and logging of consumer grievances	Staff Interviews	2
2.	4.3.3	The Agency shall provide extended hours of operation beyond the standard work day.	Report Posted hours	2
3.	4.3.12	Service shall be provided in locations convenient to the consumer (out of facility)	Report Policy	2
4.	10	Subcontracts meet contract standards	Review of Sub-contracts	N/A

5.	7.1.5	The Agency conducts internal encounter data validations at least quarterly.	EDV audit summaries	2
6.	6.1	The agency maintain an active Quality Management Plan that addresses the minimum contract requirements	Review of QM Plan	2
7.	7.1.11 7.1.13	The Agency maintains a breach risk assessment process that addresses required factors.	Copy of breach risk assessment tool Evidence of breach review tool use	1
8.	4.2.6	The Agency provides a Notice of Action to any consumer who will have their previously authorized services terminated, suspended, reduced, or provided at a scope, duration, type or intensity less than they are requesting (disagreement with recommended service plan).	Policy Review of NOA Documentation	2
9.	7.1.3	Agency maintains a current MIS Quality Control and Quality Assurance Plan	Review of Plan	2

Comments: 7.1.11, 7.1.13 – The breach risk assessment provided by CVCH referenced the "harm" standard to be used in determining a breach. The harm standard was removed in the HIPAA Omnibus Rule and was replaced with a new standard that presumed a breach occurred unless the entity can demonstrate that there was a low probability of compromise of the PHI.

CDRSN Administrative Review Tool

Agency: Columbia Valley Community Health Date: 8/18/2014 Score: 118/120 (98.3%)

Findings: 1. Consumer rights policy is missing several of the required rights citations. RSN policy 8.1 is attached.

Recommendations:

Recommendation 1: Breach Risk Assessment (Focus Areas, #7) – The breach risk assessment tool reviewed by CDRSN was not updated to reflect the new breach standard of "low probability of compromise" defined in the HIPAA Omnibus Rule. The tool reviewed reflected to obsolete "harm" standard for determining a breach. It is recommended that CVCH update its breach risk assessment tool to reflect the updated standards and exceptions. 2. Policies should be updated to reflect the new WAC first 30 day requirements.

Score Key: Absent 0, Partial Compliance 1, Evidence of compliance 2.

Part I. Credentialing, Training, Supervision and Licenses.

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.1	Agency holds all necessary licenses, and certifications required by law.	Copy of License(s)	2
2.	3.1.3	Maintain current staff information in the Avatar EHR.	Report	2
3.	3.1.21	Criminal Background check though WSP for all employees with unsupervised access to vulnerable populations	Policy, Copy of background check	2
4.	12.1 13.1	Complies with nondiscrimination laws and policies.	Policy Posted placards	2

5.	3.1.2	Primary Source verification DOH current licensure documented	Policies Sample reviewed on site	2
6.	4.3.22	Documents training and training plans inclusive of the following topics as appropriate for each employee: 1. Confidentiality/HIPAA 2. Client rights 3. Complaint and grievance procedures. 4. Benefits described in the benefit package 5. Culturally competent service delivery 6. Advanced Directives and WRAP plans 7. Strength based assessment and treatment planning. 8. Recovery principles. 9. Service coordination for special needs/multisystem consumers and EPSDT 10. Safety Training—including RCW 71.05.700 and RCW 49.19.030 requirements as appropriate. 11. CDRSN policies and procedures 12. Medicaid Fraud and Abuse, including training specific to the False Claims Act. 13. Incident reporting and mandatory reporting of abuse.	Policies Training logs Personnel files	2. Very nice training logs and documentation. Required trainings are evident for both annual and first 30 day requirements. Policies should be updated to reflect the new WAC first 30 day requirements 6) **Staff training.** A description of how the agency provides training within thirty days of an employee's hire date and annually thereafter: (a) Consistent with the agency's certified services. (b) On cultural competency that assists staff in recognizing when cultural barriers interfere with clinical care that includes a review of: (i) Populations specific to the agency's geographic service area; and (ii) Applicable available community resources. (c) On procedures for how to respond to individuals in crisis that includes a review of: (i) Emergency procedures;

				(ii) Program policies and procedures; and (iii) Rights for individuals receiving services and supports. (d) That addresses the requirements of this chapter.
7.	WAC 388-877-0500	Documentation of regular supervision and employee evaluation	Policies Supervision logs or random sample of personnel files	2. Very nice documentation.
8.	3.1.22	Documentation of monthly checked for excluded individuals and entities using LEIE and EPLS databases, including staff, executive management and board members.	Search documentation or evidence of other process(es) used	2

Comments: Very nice documentation of training and supervision.

Part II. Enrollee Rights

	Requirement Origin	Requirement	Documentation	Score
1.	4.2.1	Agency posts written rights statements in all DSHS required languages.	Observed	2. Finding: The consumer rights policy is missing a few of the required rights. RSN policy 8.1 is attached.
2.	4.2.1	Agency policies and forms address all required enrollee rights inclusions and are available in prevalent languages. (See separate check off list)	Policies Forms	1. Finding: The consumer rights policy is missing a few of the required rights. RSN policy 8.1 is attached.
3.	4.2.1	Consumers are informed of the availability of free interpreter services.	Posting in prevalent languages at front desk.	2
4.	4.3.19.1	Agency provides free interpretation and translation service to enrollees.	Billings or log of provided services.	2
5.	4.3.18	The agency's physical space is ADA accessible	Observation	2
6.	4.3.18	Alternative format materials and communication methods are available for enrollees with sensory impairments.	TDD/TDY available Other formats	2
7.	4.3.14	The agency maintains an advanced directives policy that respects the service recipients' advance directives for psychiatric care.	Policy Forms/literature distributed to enrollees	2
8.	4.3.14.1	Clinical charts contain copies of advanced directives and the agency has a means of making employees aware of consumers that have psychiatric or medical advanced directive.	Policy Chart review	2
9.	4.2.5.1	Agency maintains a record of enrollees that request second opinions.	Policy Quarterly report to RSN	2

10.	4.2.3 4.2.4	Right of enrollee concerning choice and change of provider.	Policy Staff interview	2
11.	CDRSN P&P	Agency has policies and procedures concerning restraint and seclusion. Agency follows policy and maintains records of any instance of use of restrain or seclusion.	Policy Clinical record	2
12.	4.2.2	Information on how to contact the Ombuds and how to file a complaint or grievance is readily available to consumers.	Policy Lobby materials Intake packet Consumer survey	2

Comments: Rights policy needs to include all WAC, Medicaid, and CFR citations.

Part III. Grievance System

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.6	Agency maintains a grievance system that complies with 42CFR438.400.	Policy	2

2.	3.1.6	Agency enters information related to all grievances into the Avatar EHR Complaint and Grievance form. The Agency enters all data elements required to CDRSN to determine compliance with the grievance system.	Records	2
3.	3.1.6	Agency has a process to monitor compliance with the grievance system.	Policy Report Definition/Monitoring procedure	2

Comments:

Part IV. Access and Capacity

	Requirement Origin	Requirement	Documentation	Score
1.	Access Standards	Routine intake appointments occur within 10 business days of the request for service	Report	2
2.	Access Standards	The time period from request to the first routine appointment offered does not exceed 28 days.	Report	2
3.	CDRSN P&P	Did the agency provide routine services at least once per month?	Report	2

4.	4.6.1.2	Agency brings services to the consumer, including intake assessments, if the consumers mental illness, lack of transportation or physical limitations prevent an office visit.	Policy Out of Office Services	2
5.	4.6.4.7	The first routine appointment following inpatient treatment must occur within 7 days of discharge.	Reports	2
6.	3.1.3	Ensures number of qualified agency personnel sufficient to meet access/travel standards.	Case load Service locations	2
7.	4.5.12	Agency employs or contracts mental health specialists for children, elderly, ethnic minorities or persons who are deaf or developmentally disabled	Policy Personnel files Verify contracts and qualifications of contractors.	2
8.	4.2.5 4.2.5.1	Agency, upon consumer request, provides a second opinion from within the CDRSN service area. If an additional CMHA is not available, the agency will pay for a second opinion from a CMHA outside of the CDRSN service area at no cost to the enrollee.	Policy Quarterly reports Payment records	2
9.	4.3.20 4.3.21	Agency provides uninterrupted access to a range of activities identified in the Medicaid state plan and maintains for Medicaid enrollees, when deemed Medically Necessary, service delineated in the state plan.	Policy Payment records	2
10.	3.1.12	Make all efforts to collect and report 3rd party reimbursements rendered in the performance of the contract.	R&E Evidence of billings	2

Comments:

Part V. EPSDT and Service Coordination

	Requirement Origin	Requirement	Documentation	Score
1.	4.3.15	Agency ensures enrollees under 21 receive services that comply with the state EPSDT plan. • Child Specialist reviews intake/plan of care and makes level one or two assignments. • Close communication between mental health clinician and the PCP to include date of intake, primary diagnosis and level of care assignment. • Documentation of referral to PCP for Healthy Kids screening for children presenting for intake without referral from PCP. • CSP for Level two children.	Policy EPSDT files	2
2.	4.3.23	GAIN is completed for all individuals 13 years of age and older.	POLICY GAIN report	2 100%
3.	4.3.7	Agency ensures that referral is made to PCP within 30 days of intake and as needed thereafter when medical or	POLICY	2

		dental needs are identified.		

Comments:

PART VI. Quality Assurance

	Requirement Origin	Requirement	Documentation	Score
1.	3.2.1	Provider will Notify CDRSN of any incident as defined in RSN policy 3.12 and comply with mandated procedures for reporting and follow up.	Sample of incidents Incident report Follow up reports	2
2.	6.1 6.1.5	The provider shall adopt and utilize a quality management system which: • Performs internal audits of medical records (no less than 10% annually) • Monitors access and appropriateness of services. • Monitors service recipient satisfaction.	Policy QM plan Satisfaction surveys Consumer complaint logs	2
3.	6.1.6 6.1.6.4	The provider will follow CDRSN practice guidelines and participate in implementing RSN wide evidenced based practices.	Chart review	2
4.	CDRSN P&P	Provider will participate in RSN bimonthly clinical team meetings to collaborate on Performance	Attendance logs Submission of PIP data.	2

		Improvement Projects and other system coordination concerns.		

Comments:

PART VII. Compliance Program

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.16	The agency maintains administrative and management policies, procedures and standards to guard against Medicaid fraud and abuse	Policies and procedures Informal procedures	2
2.	3.1.16.1	The agency maintains an effective Compliance Program	Compliance Plan Evidence of Operationalization of the Plan	2
3.	3.1.16.2	The agency has written policies, procedures and	Policy	2

		standards of conduct that articulate the CDRSN/PIHP commitment to comply with all applicable federal and state standards	Standards of Conduct	
4.	3.1.16.3	The agency has a designated Compliance Officer and Compliance Committee that meets regularly	Policy Compliance Committee Minutes	2
5.	3.1.16.4	The agency maintains an effective compliance education and training program,	Training records Education Plan	2
6.	3.1.16.5	The agency maintains an effective line of communication between the Compliance Officer and the CDRSN/PIHP	Policy	2
7.	3.1.16.6	The agency maintains enforcement standards through well-publicized disciplinary guidelines	Policy or other disciplinary standards	2
8.	3.1.16.7	The agency maintains procedures for internal monitoring and auditing to facilitate compliance	Policy Monitoring and Auditing Documentation	2
9.	3.1.16.8	The agency has provisions for the prompt response to detected offenses and for the development of corrective actions initiatives	Policy Documentation of internal corrective action activities	2
10.	3.1.16.9	The agency maintains a process to inform officers, employees, agents and subcontractors regarding fraud and abuse policies and procedures and the False Claims		2

		Act.		
11.	3.1.17	The agency has completed an annual compliance risk assessment	Risk assessment documentation	2
12.	3.1.19	The agency maintains policies and procedures prohibiting retaliation against individuals who make a good faith report of misconduct or unethical behavior.		2

Comments:

IX. FOCUS ISSUES

	Requirement Origin	Requirement	Documentation	Score
1.	3.1.6	Successful reporting and logging of consumer grievances	Staff Interviews	2
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3.	4.3.12	Service shall be provided in locations convenient to the consumer (out of facility)	Report Policy	2
4.	10	Subcontracts meet contract standards	Review of Sub-contracts	N/A

5.	7.1.5	The Agency conducts internal encounter data validations at least quarterly.	EDV audit summaries	2
6.	6.1	The agency maintain an active Quality Management Plan that addresses the minimum contract requirements	Review of QM Plan	2
7.	7.1.11 7.1.13	The Agency maintains a breach risk assessment process that addresses required factors.	Copy of breach risk assessment tool Evidence of breach review tool use	1
8.	4.2.6	The Agency provides a Notice of Action to any consumer who will have their previously authorized services terminated, suspended, reduced, or provided at a scope, duration, type or intensity less than they are requesting (disagreement with recommended service plan).	Policy Review of NOA Documentation	2
9.	7.1.3	Agency maintains a current MIS Quality Control and Quality Assurance Plan	Review of Plan	2

Comments: 7.1.11, 7.1.13 – The breach risk assessment provided by CVCH referenced the "harm" standard to be used in determining a breach. The harm standard was removed in the HIPAA Omnibus Rule and was replaced with a new standard that presumed a breach occurred unless the entity can demonstrate that there was a low probability of compromise of the PHI.

CHELAN-DOUGLAS REGIONAL SUPPORT NETWORK
300 S. Columbia St. 3rd Floor
Wenatchee, WA 98801

5- COLUMBIA VALLEY COMMUNITY HEALTH

MEDICAID ENCOUNTER AUDIT RESULTS

Dear: Jamie Allen,

CDRSN has completed the Encounter Data Validation Audit for consumers who received a service within the period of October 1, 2014 to April 30, 2015.

Attached please find the Encounter Data Elements that were audited and scored. CDRSN will also provide another report that will include the consumers audited, as well as the data elements reviewed and findings. This report will be placed out on the SFTP Site with an e-mail notification sent upon upload.

If your Met Score does not meet the 95% Encounter Data Validation Requirement, you are required to submit a Corrective Action Plan to CDRSN within 30 days of receipt of this letter.

Should you have any questions, please feel free to contact me at (509) 886-6318 and I will be glad to answer any questions or concerns you may have.

Sincerely,

Rosa Guerrero, CDRSN IS Administrator

CHELAN-DOUGLAS REGIONAL SUPPORT NETWORK
300 S. Columbia St. 3rd Floor
Wenatchee, WA 98801

5- COLUMBIA VALLEY COMMUNITY HEALTH
MEDICAID ENCOUNTER AUDIT RESULTS

SCORING BY DATA ELEMENT

	MATCH	ERRONEOUS	MISSING	UNSUBSTANTIATED
CLIENT NAME	321	0	0	0
SOCIAL SECURITY	321	0	0	0
DATE OF BIRTH	321	0	0	0
GENDER	321	0	0	0
ETHNICITY	321	0	0	0
DATE OF SERVICE	321	0	0	0
PROVIDER NAME	320	1	0	0
LOCATION	309	12	0	0
SERVICE CODE	320	1	0	0
SERVICE TIMES	320	1	0	0
SERVICE DURATION	320	1	0	0
PROVIDER TYPE	320	1	0	0
NOTE MATCH	309	12	0	0

SCORING TOTAL

TOTAL ENCOUNTERS AUDITED: 321

MATCH: 4144

ERRONEOUS: 29

MISSING: 0

UNSUBSTANTIATED: 0

TOTAL DATA ELEMENTS: 13

POSSIBLE POINTS: 4173

MET: 99.31%

NOT MET: 0.69%

TOTAL NOT MET: 29

Scoring Criteria:
1- MATCH (No Findings Found, Complete Match)
2- ERRONEOUS (Encounters that occurred and are presented by an electronic record, but contain incorrect data or missing any of the minimum data elements.
3- MISSING (Clinical record contains evidence of a service but is not represented by an electronic record, i.e., Not in Encounter Record)
4- UNSUBSTANTIATED (Encounters submitted by the Subcontractor but either cannot be verified in the clinical record or is duplicated, i.e., Not in Encounter Record)

NEVADA MARKET

Information Systems Security Policy

As of 07/10/2012

UnitedHealthcare – Nevada
Information Systems Security Policy

Table of Contents

UnitedHealthcare – Nevada
Information Systems Security Policy

1.0 INTRODUCTION

UnitedHealthcare Nevada (UHC-NV) adheres to all UnitedHealth Group security policies as stated in their Information Risk Management (IRM) Policies published on SPARK. The UHC-NV Information Systems Security Policy documents key policies that all employees should know as well as the additional security controls that UHC-NV has implemented due to features that are specific to the UHC-NV IS environment. In the event there is an overlap and a discrepancy in policy statements between IRM Policies and UHC-Nevada policies, enterprise-level IRM policies will take precedence.

The Information Systems Department of UnitedHealthcare Nevada is responsible for all aspects of information systems security within the UHC Nevada environment. The goal of the UHC-NV information systems security program is to ensure the confidentiality, integrity, and availability of data utilized by UnitedHealthcare Nevada.

All information systems security policies will be in compliance with federal, state, and local laws. The information residing in the UHC-NV environment is considered sensitive and is protected under the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and state laws. Due to this sensitivity, specific security measures and procedures must be implemented to protect the information that is processed and stored in the UHC-NV information systems environment.

This set of policies applies to all technology and information resources utilized in the UHC-NV environment. Any change to the UHC-NV IS policies must be approved by the CIO for UHC-Nevada.

2.0 IS SECURITY MANAGEMENT RESPONSIBILITY AND ENFORCEMENT

The CIO for UHC Nevada has primary responsibility for administering all information systems security for UHC-NV in accordance with federal and state legislation, including HIPAA and Sarbanes-Oxley requirements. Staff members designated by the CIO for UHC Nevada are responsible for the daily review of all systems security practices within UHC-NV including the management of access to all systems within UHC-NV.

2.1 ENFORCEMENT AND PENALTIES

Failure to comply with any of the policies in this document may expose the information maintained by UHC Nevada to the unacceptable risk of loss of confidentiality, integrity or availability. Violations of standards, procedures or guidelines in support of this policy will be brought to the attention of management for action and will result in disciplinary action up to and including termination of employment.

UnitedHealthcare – Nevada
Information Systems Security Policy

3.0 GENERAL INFORMATION SYSTEM POLICIES

3.1 PURPOSE

The purpose of this policy is to set forth standards for maintaining the security and confidentiality of information owned and maintained by UHC-NV. ***All users are responsible for maintaining security and confidentiality***. UHC-NV employees and business partners are responsible for maintaining the security and confidentiality of UHC-NV systems and the data handled by UHC-NV.

3.2 GENERAL POLICIES

3.2.1) User-IDs and passwords are unique to each user and are not to be shared or disclosed. Passwords must be changed at least every 90 days. All passwords for applications that support complex passwords will be at least eight characters long and include at least three of the following types of characters:

- **A.** Upper-case letters
- **B.** Lower-case letters
- **C.** Numbers
- **D.** Non-alphanumeric characters (!@#$%^)

3.2.2) All employees and contractors covered by BAA agreements are required to report security related issues immediately to the UHC-NV IS Help Desk or the UHG IT Help Desk (United Support Center). Security related issues are defined as follows:

i. Security Incidents - These are defined as computer virus warnings/incidents, etc., or any unauthorized acquisition of computerized data that materially compromises the security, confidentiality, or integrity of personal information maintained by the data collector. The term does not include the good faith acquisition of personal information by an employee or agent of the data collector for the legitimate purpose of the data collector, so long as the personal information is not used for a purpose unrelated to the data collector or subject to further unauthorized disclosure.

ii. Security Violations – Disclosure of a user password, illegal software installation, introduction of anything from the Internet, illegal/improper use of UHC-NV information systems network, acts that violate local, state, federal laws or company policies regarding privacy of information contained on the network.

iii. Technical Vulnerabilities – Discovery of any flaw that allows a user to bypass the security mechanism placed on the UHC-NV information systems network.

3.2.3) If, for any reason, IS personnel access confidential data, they will adhere to the policies and procedures that are set forth by owner(s) of the data.

3.2.4) Users are not permitted to use service or generic accounts to login to production systems without documented prior authorization.

3.2.5) Each PC/laptop should be rendered inaccessible to ensure that access to the system is protected if the device is left unattended for more than fifteen minutes.

3.2.6) Any device that connects to the internal UHC-NV network must have current security software and relevant security patches installed.

3.2.7) All personnel assigned a UHC-NV-managed laptop are required to bring their laptop into a UHC-NV facility and have them inspected to ensure that all recent anti-virus and security application updates are applied. These inspections must be verified by personnel from PC Services who will schedule the dates for inspections on a quarterly basis.

3.2.8) To protect UHC-NV technology from computer viruses, no data or software should be downloaded from the Internet or from e-mails unless they are from a known and trusted source. If you are unsure of the integrity of the source, please contact the UHC-NV IS Help Desk.

3.2.9) Disposal of media containing confidential information, whether paper or electronic, need to be rendered useless prior to their disposal following detail procedures for disposal defined by UHG enterprise policies.

3.2.10) All private or confidential information contained on the UHC-NV information systems network is protected by the Privacy Act of 1974, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and state laws. As such, any materials that may contain aforementioned information, such as forms, diskettes, CDs/DVDs, facsimiles, etc. must be labeled as such.

3.2.11) Due diligence must be exercised to prevent the disclosure or dissemination of private or confidential information to unauthorized parties via the use of Internet-based e-mail or personal messaging services (e.g. personal email, personal text messaging, web conferencing, instant messaging, etc).

3.2.12) The use of unapproved Internet-based information storage facilities and non-UnitedHealth Group owned/contracted networks, including file transfer services, automated backup services, and similar off-system storage (e.g. Dropbox) of UHC-NV information are prohibited.

3.2.13) No UHC-NV workstation shall have installed any program or utility that enables remote control of any non-UHC-NV workstation, server, or device, either external to the company or owned or controlled by IS unless approved by the CIO for UHC-NV.

3.2.14) USB port access for storage devices is disabled by default on all UHC-NV-managed systems unless approved by the CIO. All exceptions are logged.

3.2.15) Recordable optical drives (CD / DVD) are prohibited from all UHC-NV-managed systems unless approved by the CIO. All exceptions are logged.

3.2.16) When a company-owned laptop, tablet, or PC is lost or stolen, the employee or contractor to whom the device has been assigned must immediately contact both the United Support Center (888-848-3375) and the UHC-NV IS Help Desk (702-242-7621) to report the loss of the device.

3.3 SYSTEMS MAINTENANCE AND OPERATION

3.3.1) Systems maintenance and operation is performed by UHC-NV IS personnel and contracted personnel. UHC-NV personnel are responsible for the day-to-day operations of UHC-NV information systems, to include account management, system back-up operations, etc. Maintenance on some aspects of the UHC-NV information systems is provided by outside contractor personnel supporting specific maintenance contracts on the piece of equipment used by UHC-NV information systems.

3.3.2) All sensitive, valuable, or critical information residing on UHC-NV computer systems must be periodically backed up, except for email which is regulated by the Electronic File Retention Policy. The default data retention periods for production data are as follows:

a. Daily backups are retained for 14 days
b. Monthly backups are retained for 90 days
c. Annual backups are retained for 7 years

3.3.3) Exceptions to the above default retention periods may be justified by legal and/or other business requirements. Furthermore, selected files from backups must be periodically restored to demonstrate the effectiveness of every backup process.

3.3.4) Backup tapes are stored in facilities separate from where the production systems are located until their retention period has expired.

3.3.5) All computer media must be rendered useless prior to disposal following UHG enterprise policies for electronic media disposal.

3.4 WORKSTATION SECURITY

3.4.1) All workstations are placed in secure areas and monitored by staff during business hours.
3.4.2) All PC users are required to store all data on a network drive, not on the local machine, with the exception of laptop or tablet users work routinely work remotely without a connection to the UHG network.
3.4.3) All laptop computers are required to be physically secured with a cable-lock when not in the immediate possession of the owner.

3.5 APPLICATIONS MAINTENANCE AND OPERATION

3.5.1) Any and all applications or software used by UHC-NV information systems will be appropriately licensed to include the correct number of seats. Unlicensed or illegal copies of software and applications are not permitted.

3.6 EMAIL SECURITY

3.6.1) To prohibit exploitation of the UHC-NV email system, incoming and outgoing messages from outside of the UHC-NV email systems containing attachments exceeding 10MB in size will be blocked.
3.6.2) All outgoing email containing Protected Electronic Information (PEI) must be encrypted before leaving the UHG network.

3.7 TRANSMISSION SECURITY

3.7.1) All remote access connections must be encrypted. All electronic information leaving the UHG network that contains PEI must be encrypted.

3.8 CELL PHONE AND PDA SECURITY

3.8.1) Enable User Authentication
Requiring PINs or passwords to access data on the device must be enabled if supported by the cell phone or PDA. All passwords must comply with the password policy if supported by the device.

3.8.2) Reduce Data Exposure
Sensitive information, such as personal and financial account information, should not be maintained on a handheld device. Maintaining PINs, passwords, user IDs, and account numbers for other devices or applications on a handheld device is prohibited.

3.8.3) Use Caution with Unknown Communications
Malicious programs are spread to mobile phones mainly through communications channels such as multimedia messages or Bluetooth connections. Any messages or contacts received on a mobile phone from an unknown number or device should be treated with suspicion. Messages should be destroyed without opening and connections denied. Even content received from a friend or acquaintance should be suspect, since malware can take advantage of address book entries and message exchange capabilities to propagate themselves, often in the guise of an interesting attachment or link.

3.8.4) Disable Unnecessary Wireless Interfaces
A simple defense against many forms of malware is to turn off Bluetooth, Wi-Fi, infrared, and other wireless interfaces until they are needed. This is particularly important for Bluetooth devices due to the increased risk of encountering mobile malware in crowded settings, such as an airport, sports event, or concert, which offer a target-rich environment for an attack.
If needed for some purpose, the Bluetooth wireless interface should be set in discoverable mode only temporarily, until pairing with another device is completed. This measure helps to avoid discovery attempts by malware attempting to spread itself. Where possible, Bluetooth settings should be configured to notify the user of incoming connection requests and to receive confirmation before proceeding.
Since Bluetooth keys normally reside on paired devices, those devices should be password protected to defend against lost, stolen, or compromised units. As an added measure, defining a list of known trustworthy devices with which the device can connect via Bluetooth should be possible.

3.8.5) Lost or Stolen Devices
If a Company-provided device is lost or stolen, notify the UHC-NV IS Help Desk immediately.

3.9 INTERNET-FACING WEB APPLICATION SECURITY

3.9.1) As defined by the Web Application Security Consortium, "Information Leakage" is when a web site reveals sensitive data, such as developer comments or error messages, which may aid an attacker in exploiting the system. UHC-NV will follow industry best practices for restricting information leakage on our Internet-facing websites:

- All web applications will be reviewed by the developers to verify sensitive information is not present within HTML comments, error messages or source code as part of the standard testing process. An automated vulnerability scan is a requirement prior to implementation.
- All errors within the application will be directed to a standard error page which will not expose verbose error messages; errors encountered within a webpage will be logged to the respective server and reviewed periodically.
- All information displayed on the pages will be reviewed by the IS Security department and/or Corporate Legal department to determine if masking or omission of certain key data is necessary prior to being deployed.

3.10 PHYSICAL SECURITY

3.10.1) Access to the IS workspace is restricted to authorized IS employees, temporary employees, and subcontractor personnel. All other personnel (guests, visitors) must check in at the guard desk, receive a "visitor" badge, and be escorted at all times while in IS workspaces. There are no exceptions to this policy.

3.10.2) All IS datacenters are secured by locked doors which require key-card or key access. The use of keys to enter a data center is restricted to emergency use only and keys are kept by UHC-NV IS management. Access to datacenters is granted using role-based authorization levels.

3.10.3) All doors accessing the datacenters are monitored via surveillance cameras.

3.11 IS ASSET MANAGEMENT

3.11.1 The Information Systems Department within UHC Nevada is responsible for maintaining the inventory of IT hardware and software assets, including PCs, laptops/tablets, bricks/dumb terminals, printers, and servers. Software assets purchased and maintained by UHC Nevada will be maintained by the UHC Nevada IS Department while software assets licensed and maintained by UHG will be the responsibility of UHG IT to inventory.

3.11.2 Various tools and databases will be used to track inventories. These include Altiris for desktop, laptop and tablet hardware and software, ISR (Information Systems Repository) for application inventory, including vendor information, version information, license information, database locations and server locations, Xenoss for production server and storage monitoring, plus various spreadsheets that manually track development, test and inactive equipment in storage.

3.11.3 Inventory levels and changes are reported to UHC Nevada senior management on a monthly basis as part of the IS Data and Trend Charts spreadsheet.

3.11.4 IS hardware disposal follows the UHG policies for secure disposal and re-cycling of hardware assets.

3.12 RECORD RETENTION POLICIES and RETENTION SCHEDULES

3.12.1) UHC-NV follows the record retention policies and the record retention schedule published by Enterprise Records Management for UHG.

3.13 TRAINING

3.13.1 Employees responsible for the management, operations, and use of UHC-NV information systems will receive training on computer security awareness and acceptable computer practices as provided by UHG ULearn programs

3.13.2 All personnel are given initial training on information systems security during their orientation. Personnel are also given additional training on an as-needed basis.

4.0 INFORMATION SYSTEM ACTIVITY REVIEW POLICY

4.1 PURPOSE

The purpose of this policy is to set forth standards for creating, storing, and auditing system activity information within UHC NV Information Systems.

4.2 SCOPE

This policy applies to all employees, contractors, and vendors who have been granted access to UHC-NV Information Systems.

4.3 POLICY

4.3.1) Data transfer, copying, downloading, or printing of protected electronic information is prohibited from remote desktop clients. This eliminates the risk of EPHI leaving the protected environment within the UHG network and Company-managed workstations for remote access users.

4.3.2) Outbound email is monitored for EPHI and will be blocked unless it is sent using secure delivery and encryption.

4.3.3) Remote access connections are monitored and logged. Tripwire tools are being evaluated to provide alerts to IS management for certain remote access attempts and failures.

4.3.4) UHC-NV Information Systems personnel with privileged access rights will be subject to security audit at any time. Audits are conducted by the CIO and facilitated through the use of reports based on the following events:

- Changes to Active Directory (AD) GPO policies
- Changes to the Domain Admins and Administrators groups in AD
- All activities performed by members of the Domain Admins and Administrators groups
- Changes to local server security settings for critical applications and servers

Access to the audit data and reports are limited to personnel designated by the CIO for UHC-NV.

4.3.5) All Windows servers are configured to log activity in accordance with the UHG Enterprise Information Security Standards.

4.3.6) Applications are purchased from vendors or developed internally with various audit trail capabilities. Where vendor provided software lacks adequate audit trails, internal development efforts will be made to add audit capabilities where technically feasible.

4.3.7) Auditing of UHC-NV Information Systems is done periodically to provide a sentinel effect to protect the confidentiality of information contained in the systems and to comply with security standards as outlined in HIPAA and state and federal laws.

4.3.8) All system-generated logs are kept in a "live" state for at least 3 months and are also included in the scope of the server data back-ups which are administered and retained according to the UHC-NV policy for Retention of Server Back-Up Media.

4.4 EMPLOYEE INVESTIGATIONS

4.4.1) All investigations of employee conduct, including email reviews, Internet usage reports, and log reviews, must have documented approval from Human Capital prior to the investigation.

4.4.2) All access to an employee's system, either remotely or physically, without the employee's consent must have documented Human Capital approval prior to access.

UnitedHealthcare – Nevada
Information Systems Security Policy

5.0 DATA ASSURANCE POLICY FOR PROTECTED ELECTRONIC INFORMATION

5.1 PURPOSE

The purpose of this policy is to clearly state the requirements associated with handling protected electronic information, which includes HIPAA-defined ePHI. These requirements are designed to minimize the potential exposure to the company from damages which may result from uncontrolled use or disclosure of protected electronic information.

5.2 SCOPE

This policy applies to all employees and contractors who have been granted access to UHC-NV protected electronic information.

5.3 DEFINITION

As used in this policy, protected electronic information (PEI) is defined as:

- Any information defined by HIPAA as Electronic Protected Health Information (45-CFR §160.103);
- Any information capable of being used to identify an individual;
- Any information designated by UHC-NV as proprietary or confidential in nature (e.g. fee schedules, customer lists, employment records, broker agreements).

5.4 POLICY

5.4.1 General Requirements for Handling Protected Electronic Information

All protected electronic information must be handled in accordance with these requirements:

5.4.1.1) In general, protected electronic information is most secure while in its electronic form. To help ensure the continued security of protected electronic information, every effort must be made to refrain from printing and distributing hard copies and to facilitate sharing or viewing of protected electronic information in an electronic format.

5.4.1.2) All protected electronic information must be stored on the appropriate secured, access-controlled systems within UHC-NV data centers. No protected electronic information is to be stored on the local machine for any reason with the exception of portable devices where all locally-stored information is placed in an encrypted form by default. Some examples of what are considered "portable devices" include laptops and PDA phones. A "local machine" is considered to be whatever device is being used to access information outside of a UHC-NV data center.

5.4.1.3) Unnecessary distribution of protected electronic information is prohibited and any distribution must be limited to the minimum necessary information. For the distribution of protected electronic information among UHC-NV employees with active network accounts, email only a link to the document stored in a protected, access-controlled location rather than emailing copies of the document to every employee.

5.4.1.4) No protected electronic information is to be placed on removable media for any reason with the exceptions of:

- legitimate business needs (e.g. for Business Continuity Planning purposes) with the approval of a

Vice President or higher

- removable media (backup tapes) used during normal IS-managed backup processes

5.4.1.5) Removable media that contains protected electronic information for approved business purposes must be kept in a secure environment. Do not store or transport removable media that contains protected electronic information in a laptop or in the same container as a laptop or any other portable device. Some examples of removable media include USB storage devices (e.g. "thumb drives"), CD-RWs, writable DVDs, backup tapes, and floppy disks. Removable media used during the normal IS-managed backup processes are audited quarterly and destroyed when their lifecycle has expired.

5.4.1.6) If hard copies of protected electronic information are created because of a business necessity, they must be clearly labeled as "confidential" and/or "proprietary".

5.4.1.7) Any distribution of protected electronic information must use secure channels (e.g. United States Postal Service, FedEx, UPS, fax, encrypted email).

- All distributions of protected electronic information via email or fax must include a disclaimer which clearly states that the information contained within the document may be confidential and/or proprietary in nature and should be handled accordingly and, in the event the wrong person receives the email or fax, that all documents must be destroyed and the sender notified of the error.

- All Fax machines produce a Transmission Report page which may include a portion of the faxed document. This needs to be treated in the same manner as the faxed document.

- All distributions of hard copies of protected electronic information via United States Postal Service, FedEx, UPS, or any other similar carrier must clearly state on the envelope and/or on the first page of the document that the information contained within the document is confidential.

5.4.1.8) Hard copies of protected electronic information not distributed to clients or business associates are for internal use only, cannot be removed from UHC-NV premises and must be destroyed after use in accordance with the destruction procedures outlined below.

5.4.1.9) Users who are accessing UHC-NV systems remotely are prohibited from printing hard copies of protected electronic information. Remote desktop clients are also prohibited from any data transfer, copying or download of data in order to keep PEI within the protection of the UHG network and Company-managed workstations.

5.4.1.10) If hard copies are required for business purposes, the user must keep the documents in a secure environment and properly destroy the documents after use in accordance with the destruction procedures outlined below. If the user does not have access to a shredder at the remote location, hard copies of protected electronic information must be securely transported to a location where shredding services are provided.

5.4.2 Requirements for the Destruction of Hard Copies of Protected Electronic Information
Placing documents containing protected information in the trash is prohibited. Shredding is required to ensure the complete destruction of all hard copies of protected electronic information. Locked containers have been placed around UHC-NV properties for the purpose of holding documents that are to be shredded.

6.0 NOTIFICATION OF BREACH OF ELECTRONIC PERSONAL INFORMATION

6.1 PURPOSE

This policy requires UHC-NV and its subsidiaries (the "Company") to notify certain persons if personal information included in electronic data was, or is reasonably believed to have been, acquired by an unauthorized person.

6.2 DEFINITIONS

As used in this policy:

6.2.1) "Personal Information" means a natural person's first name or first initial and last name in combination with any one or more of the following data elements, when the name and data elements are not encrypted:

a. Social security number or employer identification number.
b. Driver's license number or identification card number.
c. Account number, credit card number, or debit card number, in combination with any required security code, access code, or password that would permit access to the person's financial account.

The term does not include company-generated identification numbers or publicly available information that is lawfully made available to the general public.

6.2.2) "Data Collector" means any governmental agency, institution of higher education, corporation, financial institution, or retail operator or any other type of business entity or association that, for any purpose, whether by automated collection or otherwise, handles, collects, disseminates, or otherwise deals with nonpublic personal information.

6.2.3) "Breach" means unauthorized acquisition of computerized data that materially compromises the security, confidentiality, or integrity of personal information maintained by the data collector. The term does not include the good faith acquisition of personal information by an employee or agent of the data collector for the legitimate purpose of the data collector, so long as the personal information is not used for a purpose unrelated to the data collector or subject to further unauthorized disclosure.

6.3 PROTECTION AND NOTIFICATION REQUIREMENTS

6.3.1 Data Elements to be Protected

Any database containing records that include Personal Information (as defined above) constitute a restricted database and must be managed and protected according to the guidelines in the policy.

6.3.2 Legal Notification Requirements

Some states have laws requiring notification of a breach to state residents whose unencrypted personal information was or is reasonably believed to have been, acquired by an unauthorized person. The disclosure will be made in the most expedient time possible and without reasonable delay, but not less than 30 days, consistent with the legitimate needs of law enforcement, or any measures necessary to determine the scope of the breach and restore the reasonable integrity of the system data.

6.3.2.1) Notification will be provided by one of the following methods:

a. Written notification, or
b. Electronic notification, which shall be consistent with the provisions of the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. §§ 7001 et seq. The Legal Department will assist with these requirements.

6.3.2.2) If the Company determines that it would have to provide the notice required to more than 500,000 persons, and if it does not have sufficient contact information to provide the notice by the methods above, or the cost of providing the notice by the methods above would be more than $250,000, the Company may provide notice by all of the following methods:

a. Notification by electronic mail if the Company has electronic addresses for the subject persons,
b. Conspicuous posting of the notification on the Company website, and
c. Notification to major statewide media.

6.3.2.3) If a law enforcement agency determines that the notice required may impede a criminal investigation, the Company shall delay such notice until the law enforcement agency determines that the notice will not compromise the criminal investigation.

6.3.2.4) If the Company determines that it must provide notification to more than 1,000 persons as a result of the breach, the Company shall, without unreasonable delay, inform each consumer reporting agency, as defined in 15 U.S. C. § 1681a(p), in writing, of the timing, distribution, and contents of that notification.

6.4 PROCEDURES FOR RESPONSE TO A BREACH OF SECURITY

6.4.1 A Security Breach is Suspected or Detected

The following procedures must be implemented upon detection or suspicion of a breach of system security and in accordance with the UHC-NV Disaster Recovery Plan:

a) Immediately inform Information Systems.

The person who discovers or suspects a security breach must call the UHC-NV IS Help Desk at 702-242-7600 and must complete an online IS Security Incident Report form. This will serve as notification to the CIO that an incident has occurred. The CIO will review the form to decide if the appropriate course of action in consultation with the Privacy Officer for UHC Nevada. A person may also report anonymously by calling the UHG Ethics Line at 1-800-637-4454.

b) Collect information supporting the observation of a real or suspected breach.

Under the direction of the CIO, IS personnel will collect all information that relates to a possible security breach and store it safely off-line. It is critical that log files and all other records pertaining to the security breach be preserved in a manner that prevents their being modified or lost. These data may also be requested by law enforcement. All such records must be retained for a minimum of six years, or if there is any pending litigation involving the particular breach, until the litigation is finally concluded, whichever is longer.

c) If warranted by the investigation, isolate the breached system

Based on the analysis of the suspected breach the CIO, in consultation with the Privacy Officer, may take the actions necessary to prevent further loss or corruption of data, up to and including isolating the system from the rest of the network by unplugging the network cable(s). Power to the server must not be turned off unless requested to do so by the CIO. Turning off power to a compromised system may destroy any evidence that can assist in conducting an investigation.

6.4.1a SPECIAL CASE: Unencrypted Database Security Breach

If an unencrypted database has been successfully breached and personal information was, or is reasonably believed to have been acquired by an unauthorized person, notification to affected state residents is required and shall be made in the most expedient manner possible. If law enforcement is involved in the investigation of a breach, the required notification should be delayed until the law enforcement agency determines that such notification will not impede or compromise its criminal investigation.

6.4.2 Incident Review and Final Report

The system owner, together with the CIO and the Privacy Officer, must assess the likelihood and potential scope of any security breach. The CIO and Privacy Officer shall notify the Corporate Compliance Officer and the General Counsel of the investigation results. If it is determined that unencrypted personal information was acquired by an unauthorized person, affected state residents will be notified in accordance with section 3.0 of this policy.

Upon completion of the investigation, including restoring all affected systems to an operating condition, the CIO shall prepare a final report outlining all procedures and remedies taken, whether successful or not, along with all relevant documentation.

7.0 REMOTE ACCESS POLICY

7.1 PURPOSE

The purpose of this policy is to define standards for connecting to the company's network from any external host. This policy sets forth the requirements for obtaining and utilizing the remote access services provided by UHC-NV IS. These standards are designed to minimize the potential exposure to the company from damages which may result from unauthorized use of company resources. Damages include the loss of electronic private healthcare information (ePHI), sensitive or company confidential data, intellectual property, damage to public image, damage to internal technology, etc.

7.2 SCOPE

This policy applies to all company employees, contractors, vendors and agents who have been granted remote access privileges to UHC-NV systems. This policy applies to remote access connections used to do work on behalf of the company, including (but not limited to) reading or sending e-mail, viewing intranet web resources, and accessing internal applications.

7.3 GENERAL POLICIES

7.3.1) Access to additional internal resources via remote access is to be established by submitting a properly approved Security Access Request (SAR) form and will be controlled using an Active Directory account. All requests must present a justified business need for remote access.

7.3.2) Remote access connections will be monitored and logged.

7.3.3) All remote access connections must be encrypted.

7.3.4) All users granted remote access privileges must follow the standards of behavior outlined in this *IS Security Policy*.

7.3.5) At no time should a user granted remote access privileges provide their login credentials to anyone, including family members.

7.3.6) General access to the Internet for recreational use by immediate household members through the company's network is not permitted.

7.3.7) Printing UHC-NV information from the local device is prohibited.

7.3.8) Saving of UHC-NV Confidential Information and/or Protected Information to the local device is prohibited.

7.3.9) Memory copy and paste, screen clipping, and/or screen capture functions must be disabled.

7.3.10) All tablets, laptops, and PCs that use the company-provided remote access portal must have the following software installed and operational:

a. Anti-virus software with the most up-to-date virus information files
b. Local firewall software
c. The most current Operating System patches, hot-fixes, and service packs

7.3.11) Remote access to the UHC-NV network from public terminals is strongly discouraged due to the prevalence of various malware applications that can be easily installed on unsecured public terminals.

7.4 PERSONAL DEVICE SUPPORT POLICY

A Personal Device is defined as any network-capable electronic device that is not owned and managed by UnitedHealth Group. Examples of Personal Devices include mobile phones, tablets, and PCs and laptops.

Due to security and legal requirements, access to company information by Personal Devices must adhere to the following policies:

- The Personal Device must be password protected.
- Access to company applications and data must be password protected.
- Where technically feasible, all Personal Devices should enable screen locking and screen timeout functions in accordance with those detailed in UHG's Information Risk Management Policies.
- The installation of rootkits, such as "jailbreak" software, are not allowed.
- Access to company information by personal mobile phones will be limited to email access using either BlackBerry or Good messaging applications.
- Personal Devices will only be able to access company applications and information by using the Juniper Remote Access portal, either through the encrypted website or by the use of an IS-approved, Juniper-compliant VPN client application. Once the company network has been accessed through Juniper, further access to company information will be allowed only through the use of Remote Desktop sessions.
- All personal tablets, PCs and laptops used for remote access will be scanned for an up-to-date antivirus application and the latest OS Service Pack release before being allowed to connect to the company network.
- No company information will be allowed to be copied, saved, or stored on a tablet, PC or laptop.

7.5 MOBILE PHONE PROTECTION POLICY

7.5.1) Mobile Phone Exchange or Disposal

Protected or Confidential Information must be removed from a mobile phone before it is disposed of, returned, or exchanged. The employee or contractor to whom the mobile phone has been assigned, or who owns a mobile phone that contains company information, must notify the UHC-NV IS Help Desk **prior to** returning, exchanging or disposing of the mobile phone.

Mobile phones that are no longer used to access company information (e.g. terminated or retiring employee's or contractor's phone) must be removed using the appropriate process for the specific phone. The manager of the employee or contractor leaving the company who has a mobile phone that has had access to company information must notify the UHC-NV IS Help Desk **prior to that person's departure** to ensure the appropriate process is used to remove company information from the phone.

7.5.2) Lost or Stolen Mobile Phones

When a mobile phone that contains company information or connects to the company network is lost or stolen, the employee or contractor to whom the mobile phone has been assigned or who owns the phone must **immediately** contact the UHC-NV IS Help Desk (702-242-7600) to report the loss of the phone.

8.0 IS SECURITY ADMINISTRATION POLICIES

8.1 ACCOUNT MANAGEMENT

8.1.1) Existing personnel who need additional security access to the UHC-NV information systems network will have their manager or designated staff member submit a Security Access Request (SAR) form via the company Intranet home page (InSite). This request will include the specific types of access requested along with other specific information, i.e. licensing information. No accounts will be modified without a SAR form. There are no exceptions to this rule.

8.1.2) After an employee's manager or designated staff member initiates the access control approval process, the privileges granted remain in effect until the worker's security access requirements change or the worker leaves UHC-NV. If either of these two events occur, the manager must notify the UHC NV IS Help Desk immediately. All non-employees, contractors, consultants, temporaries, and outsourcing organizations must also go through a similar access control request and authorization process initiated by the appropriate manager.

8.1.3) All non-UHG employees whose accounts are not managed through PeopleSoft, Fieldglass, or Contractor Express will be assigned temporary accounts that are configured to expire on the 28th day of every month. The relevant supervisor for these accounts must review the need for the continuing privileges of these users and notify the UHC NV IS Help Desk to extend these accounts prior to the 28th day of the month or the accounts will be disabled.

8.1.4) All user accounts in Active Directory are reviewed for current use. Any account that has not been used within the last 30 days will be disabled.

8.1.5) A member of the Security Administration (SA) staff within UHC-NV IS will assign all user accounts. Accounts will be assigned individually. Group/Multi-user accounts are not authorized.

8.1.6) Each person assigned an account on the UHC-NV information systems domain shall have his or her own user-share assigned on the network server. Personnel are required to utilize this user-share for storing of all information they create and maintain as these user-shares are backed up on a daily basis and any lost information could then be recovered in the event of a system failure. The only exception to storing data on the local device is for laptop users who are routinely working remotely without a connection to the UHG network.

8.1.7) In the case of shared directories, the designated director shall also indicate what types of privileges shall be given to each person having access to the directory.

8.1.8) All accounts on the UHC-NV information systems network require password control for access. Accounts without passwords are not authorized.

8.1.9) All accounts will have a unique system name created within a specific naming convention. All user account names will utilize the first initial of the first name and the full last name. Certain applications will only allow the first initial of the first name and the first four letters of the last name. Those applications are the only exception to this rule. For example, an account for John Doe would be *jdoe*. In the event of duplicate user ID's, a number will follow after the last name. For example, an account for Jane Doe would be *jdoe1* since the user ID *jdoe* already exists.

8.1.10) IS Security Administration will require documented security account setting verification from an employee's present and, if necessary, former supervisor when IS Security Administration receives notification that the employee's job code, GL code, or location has changed.

8.1.11) Accounts are disabled when IS Security Administration receives either a SAR or a notification from UHG HR systems listing personnel that are departing. The alert contains the notified termination date and the projected termination date. IS Security will disable the account on the projected termination date unless otherwise notified. The disablement will be performed within two business days from the receipt of the notification. All disabled accounts remain on the systems for 30 days, after which time they will be permanently removed from all systems.

8.2 ENTITLEMENT REVIEW POLICY

8.2.1 PURPOSE

The purpose of this policy is to define the process for conducting annual entitlement reviews for critical systems, applications and accounts considered within the scope of mandatory audits. Critical systems, applications, or accounts include AD accounts for the Sierra domain and any system/application maintained by UHC-NV IS that has more than 100 authorized, active user accounts and which contains Protected Electronic Information.

8.2.2 GENERAL POLICIES

1. UHC Nevada IS performs an entitlement review with UHC-NV supervisors and management on an annual basis for critical applications, systems and accounts to confirm that user access is limited to just those individuals who have a legitimate role that requires such access. The entitlement review process includes any development/test or training environments for critical applications/systems that utilize production data for development/test or training. Discrepancies are corrected by UHC-NV IS Security Administration. Business Owners do not serve as administrators to the application.

2. UHC Nevada IS performs an entitlement review on an annual basis to confirm that access to modify and implement production executable code is limited to a select group of individuals who have primary accountability for performing such function. Segregation of duties exists between application developers and users with the ability to implement executables into production. Any deviations have been approved by management and a mitigating control has been identified. Business owners do not have access to promote changes to production.

3. The CIO will review all Administrator-level accounts with privileged access on a quarterly basis and recommend any changes deemed necessary.

9.0 SECURITY PATCHING POLICY

9.1 PURPOSE

The purpose of this policy is to provide a standard process for managing security patching and to establish Service Level Agreements for completing the work.

9.2 BACKGROUND

Security patches from Microsoft are usually released as a group on a monthly basis. Oracle has recently committed to a quarterly patch release cycle. However, there have been exceptional situations where additional security patch releases have been published when necessary. Other vendors (e.g., Cisco, Foundry, HP) also announce security patches periodically as issues are discovered.

9.3 VULNERABILITY SEVERITY RATING PROCESS

UHC-NV IS uses the following factors, established by the Information Risk Management group in UHG in their document "UnitedHealth Group Vulnerability Severity Level Definitions", to establish the priority of security patches:

- Is the vulnerability remotely exploitable or does it require valid user credentials
- Does exploitation require user interaction
  - Opening an attachment to an email
  - Opening a link to a website
- Are vulnerable systems exposed to hostile environments (Internet / DMZ / Extranet)
- Is there an active incident on the internet or internally
- Technology environment:
  - Prevalence of operating system/service/application in the environment
  - Default configurations of operating system/service/application in the environment
  - Desktop firewall configurations
  - Antivirus
  - System permissions
  - Perimeter defenses
  - Router/Switch Access Control Lists (ACLs)
- Gaps in coverage of support for operating systems and service packs
- What is the impact if the vulnerability is exploited (system compromise, Denial of Service (DoS), Information Gathering, etc)
- Complexity of successful exploitation
  - Elevated user rights on target systems
  - Unusual applications/services running on target systems
  - Outdated versions of services/applications on target systems
- Availability of exploit code

9.4 VULNERABILITY SEVERITY RATING DEFINITIONS

Priority 1 = 48 hours for deployment for Microsoft Security Patches, 48 hours for all others
- Active incident internally or on the internet
- Remotely exploitable – Does not require valid user credentials

- Requires no user interaction for exploitation to occur
- The vulnerability would allow an exploit to self-propagate over the network
- Exploit code has been released and is in active use

Priority 2 = 6 days for deployment for Microsoft Security Patches, 30 days for all others
- No active incident
- Remotely exploitable – Does not require valid user credentials
- Requires no user interaction for exploitation to occur
- The vulnerability would allow an exploit to self-propagate over the network
- Exploit code is has been released

Priority 3 = 15 days for deployment for Microsoft Security Patches, 60 days for all others
- No active incident on the network or the internet
- Remotely exploitable - Does not require valid user credentials
- Requires no user interaction for exploitation to occur
- The vulnerability would allow an exploit to self-propagate over the network
- No exploit code has been released

Priority 4 = 90 days for deployment (regularly scheduled deployments) for Microsoft Security Patches, 90 days for all others
- No active incident
- Locally or remotely exploitable
- May require user interaction

Priority 5 = 180 days for deployment for all
- No active incident

9.4 PATCHING PROCEDURES

9.4.1) All patches must be tested on existing test systems before they are applied to the production environment. No patches will be applied to production servers that have not been tested and verified to cause no interruption of normal services.

9.4.2) To the extent that critical patches can be addressed faster than these SLA targets, priority will be placed on completing them as soon as possible.

9.4.3) Vendor supported systems will be patched after the Vendor provides their approval and certification that the patches will have no adverse affect upon their application architecture. Until vendors approve the work, their name will appear on the daily progress report as an exception.

9.4.4) While the patching work is in progress and until the work is complete, SNA and PC Services will issue a daily status report of the progress made to the CIO.

10.0 ANNUAL RISK ASSESSMENT AND POLICY REVIEW

10.1) The CIO will review the function and validity of all policies, procedures and security controls as part of the annual IS Risk Assessment process. The annual risk assessment process will be conducted concurrent with the annual Sarbanes-Oxley audit and other external (customer or department of insurance) or internal audits. Evaluation of current policies, procedures and auditor findings will drive the recommendation of changes to be made in the UHC Nevada IS environment. Any changes recommended will be implemented following a formal review and acceptance process by the CIO and his direct reports.

10.2) The CIO will review the validity of the IS Security Policy on an annual basis and recommend any changes deemed necessary.

10.3) Furthermore, in the event that one or more of the following events occur, the policy will be subject to immediate review:

10.4.1) Changes to the HIPAA Security or Privacy Regulations.
10.4.2) New Federal, State, or local laws or regulations affecting the confidentiality or integrity of electronic data.
10.4.3) Changes in technology, environmental processes or business processes that may affect IS Security Policies or procedures.
10.4.4) The occurrence of a serious security violation, breach or other relevant incident.

10.4) The CIO and direct reports shall review and approve all changes before publication. The publication of the IS Security Policy on the company Intranet website constitutes official acceptance of the Policy.

11.0 SECURITY POLICY REVISION HISTORY

Review Date	Reviewer
02/20/2007	Kyle Ginney
05/09/2007	Bob Schaich
10/05/2007	Bob Schaich
10/30/2007	Bob Schaich
10/21/2008	Bob Schaich
03/18/2009	Bob Schaich
08/06/2009	Bob Schaich
10/25/2011	Bob Schaich
02/03/2012	Bob Schaich
02/09/2012	Bob Schaich
03/14/2012	Bob Schaich
05/01/2012	Bob Schaich – Add DevTest and Training Environments to entitlement review scope for critical applications that use production data.
07/10/2012	Bob Schaich – Clarified IS System Activity Review policies and procedures.

Chelan-Douglas RSN

Provider Network Adequacy Assessment

Completed By: Craig Mott, CHC

1/28/2014

Scope

The purpose of the current assessment is to review the adequacy of the Chelan-Douglas Regional Support Network (CDRSN) provider network to comply with the State's standards for access to care, and to provide timely, adequate access to all services covered under the contract with DBHR. Service and caseload data was reviewed for the service period of 1/1/2013 to 6/30/2013. The rationale for said timeframe is to establish a baseline for the calendar months that would correspond to the months to be reviewed following the removal of Recovery Innovations from the CDRSN provider network. Additionally, data related to network capacity for the full calendar year 2013 (CY 2013) was reviewed to facilitate forecasting of expected caseloads and utilization for calendar year 2014 (CY 2014).

The current assessment was completed in accordance with requirements delineated in the CDRSN contract with DBHR, 42 CFR 438.206 and 42 CFR 438.207.

Access

Number of RFS in period under review: **273**

Number of Intake Assessments offered within 10 Business days of RFS: **273**
Number of Intake Assessments not offered within 10 business days of RFS: **0**
Percentage in compliance: **100%**

Number of intakes completed: **141**
Number of RFS with no intake assessment completed: **132**
Percentage of RFS that result in intake assessment: **51.6%**

Number of first routine service within 28 days of RFS: **132**
Number of first routine service not within 28 days of RFS: **9**
Percentage in compliance: **93.3%**

Number of consumers with no post-intake routine appointment: **74**
Percentage of consumers who received an intake but no routine appointment: **52.5%**

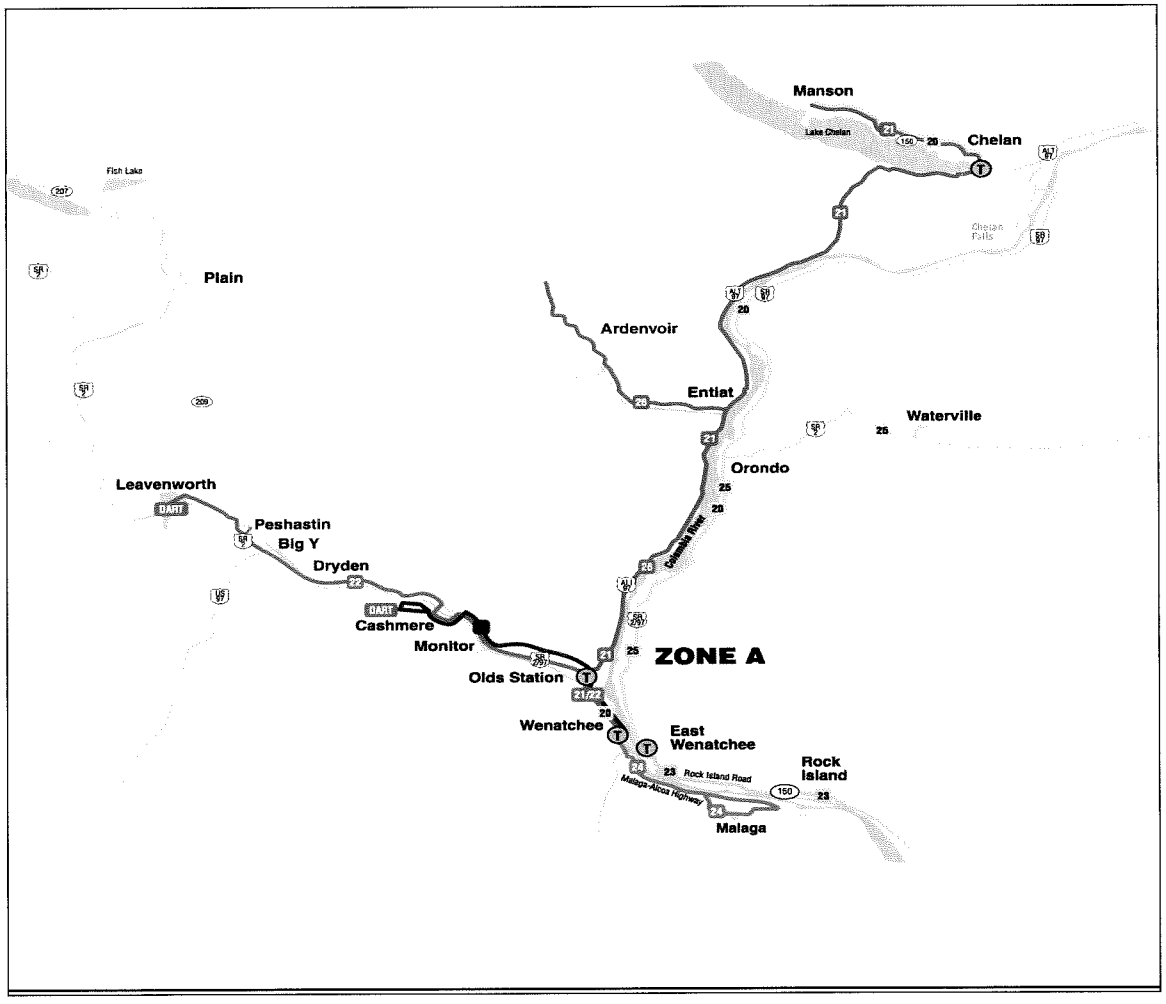
Percentage of intake services provided in the community: **0.5%**
Percentage of intake services provided in consumer's residence: **0.5%**
Percentage of intake services provided in SNF/assisted living: **1.1%**

Percentage of outpatient services provided in the community: **5.8%**
Percentage of outpatient services provided in consumer's residence: **2.8%**
Percentage of outpatient services provided in SNF/assisted living: **0.5%**

Percentage of enrollees requesting service living greater that 90-minute drive to a service location: **0 (see "Managed Care Accessibility Analysis")**

Describe any geographical barriers to access (e.g. mountain pass, river, man-made obstruction, etc.): **The Columbia River separates Chelan and Douglas Counties, but multiple crossing points exist.**

Public transportation resources available: **Link Transit provides public transportation within the major population centers of Chelan and Douglas Counties, namely Wenatchee and East Wenatchee. Link Transit also provides inter-city public transportation along the Columbia River Corridor from Malaga to the South to Chelan and Manson to the North, as well as to the West of Wenatchee along Highway 2 to Leavenworth (see service area map below).**



Service sites allow physical access to enrollees with disabilities: **All outpatient service sites are ADA accessible. ADA accessibility is reviewed annually by CDRSN**

Cultural and Linguistic Competency

Number of network clinicians that speak a language other than English: **9**

Language 1: **Spanish**
Language 1 Clinician Count: **9**

Language 2: **None**
Language 2 Clinician Count: **N/A**

Language 3: **None**
Language 3 Clinician Count: **N/A**

Number of Medicaid enrollees identified as Hispanic in the 834 Benefit Enrollment File: **10881**
Number of Hispanic Specialists employed/contracted within the provider network: **3**
Number of Medicaid enrollees identified as Native American in the 834 Benefit Enrollment File: **239**
Number of Native American Specialists employed/contracted within the provider network: **1**
Number of Medicaid enrollees identified as Asian/Pacific Islander in the 834 Benefit Enrollment File: **156**
Number of Asian/Pacific Islander Specialists employed/contracted within the provider network: **1**
Number of Medicaid enrollees identified as African American in the 834 Benefit Enrollment File: **94**
Number of African American Specialists employed/contracted within the provider network: **2**

Percentage of clinician's with cultural competency training: **100%**

Network Capacity

Number of provider by CIS provider type:

DOH Credentialed Certified Peer Counselor: **14**
Non-DOH Credentialed Peer Counselor: **0**
Below Master's Degree: **16**
MA/PHD: **37**
RN/LPN: **5**
ARNP/PA: **1**
Psychiatrist/MD: **4**
Other: **6**

Provider credentialing: **CDRSN regularly monitors subcontractor credentialing processes and assesses subcontractor provider type mix to ensure availability of services to meet member needs. For the period under review, the CDRSN provider network had an adequate number and mix of clinical staff to provide required state plan services to enrollees requesting service.**

Lowest c subcontractor clinician caseload size for full-time staff: **18**
Highest subcontractor clinician caseload size: **55**
Average subcontractor clinician caseload: **34**

Total caseload: **1,656**[1]
Total hours of service: **16,137.90**

Total annual caseload for CY 2013: **2,287**[2]
Total annual hours of service: **31,889.93**

Number of providers at capacity: **0**

Anticipated Medicaid enrollment (CY 2014): **30,188**[3]
Expected services utilization in total members (CY 2014): **3019**[4]
Expected service utilization in service hours (CY 2014): **42,084.86**[5]

Number of second opinion requests: **0**
Number of out of network referrals: **0**

Perception of Care/Satisfaction

Consumer Perception of Care:

The CDRSN utilizes Question #6 from the Consumer Outcome Self-Rating Scale as a Regional Performance Measure to evaluate consumer perception of care (see table below):

[1] Total caseload is the total number of consumers who received a routine service between 1/1/2013and 6/30/2013.
[2] Total annual caseload is the total number of consumers who received a routine service in CY 2013
[3] The anticipated Medicaid enrollment is based on forecasts presented by Washington State relative to RSN rate development. The anticipated Medicaid enrollment incudes both the traditional and newly eligible caseloads.
[4] Expected utilization assumes that the same percentage of Medicaid eligibles that received services within the period under review will be applicable to the anticipated Medicaid enrollment.
[5] Expected utilization assumes that the same average number of service hours per person will be applicable to the anticipated Medicaid enrollment.

Over the past six months: (if this is your first appointment please answer N/A.)

Answer Options	Not at all	A little	Somewhat	A lot	N/A	Rating Average	Response Count
How much were you helped by the services that you received?	10	29	89	321	481	3.61	930
					answered question		930
					skipped question		0

Consumer Satisfaction:

The CDRSN evaluates consumer satisfaction with mental health services on an ongoing basis, including with regard to several key questions related to network sufficiency (see table below):

In the past six months,

Answer Options	Never	Sometimes	Usually	Always	Rating Average	Response Count
Was the location of services convenient?	10	52	205	585	3.60	852
Were the times that services were offered good for you?	1	41	226	590	3.64	858
Were you able to get all of the services that you needed?	1	45	216	591	3.64	853
Were you given information about your rights?	7	22	94	728	3.81	851
Did you feel free to complain?	13	40	132	668	3.71	853
Did you feel respected by staff?	4	13	73	761	3.87	851
Did you feel that staff were sensitive to your cultural background (race, religion, language, etc)?	22	18	68	741	3.80	849
Did you feel as involved as you would like in making treatment goals/decisions?	10	41	158	649	3.69	858
					answered question	859
					skipped question	2

Notes/Comments

Based on a review of the data contained herein, the CDRSN network maintained adequate capacity during the period under review to serve the Medicaid population in accordance with the State's standards for access to care, and to provide timely, adequate access to all services covered under the contract with DBHR. The CDRSN

actively promotes culturally competent services, as evidenced by network provider staff training activities, as well as the availability of Mental Health Specialists to provide consultation with regard to care provided to specified ethnic populations. Consumers hold a generally positive view of the provider network, as evidenced by consumer satisfaction with services, including service location, hours of availability and perception of cultural sensitivity.

Planning

In addition to standard, ongoing network adequacy monitoring activities, CDRSN shall conduct a follow-up assessment no later than August 31, 2014 to review network adequacy for the period of January 1, 2014 to June 30, 2014. Data from monitoring activities shall be aggregated to allow for comparison to the baseline assessment described herein.

CHSW Wenatchee Region - Risk and Compliance Self-Assessment
September 2014

This form is used in conjunction with the CHSW statewide Compliance Self-Assessment and "Compliance Program" policy and procedures.

Person completing assessment: Alejandra González
Title: Community Director Wenatchee Region
Date: Assessment Completed September 30, 2014

Element 1: Standards of Conduct and Policies and Procedures

	Description	Yes	No	GOALS/ACTIONS/EVIDENCE for 2014-15
1.1	Does the Organization have written standards of conduct or **code of ethics**?	X		• P & P "Code of Ethics" , • P&P "Employment & Hiring Practices" • CHSW Code of Ethics form & other Dept-specific Codes of Ethics • Staff Handbook • CDRSN Code of Ethics and Standards of Conduct
1.2	Are **compliance expectations included** in the written code of conduct or code of ethics?	X		(same)
1.3	Do the standards of conduct include statements that clearly express **commitment to compliance** by the board of directors, senior management, employees, contractors, and agents?	X		(same)
1.4	Is there a process being followed to **distribute** the standards of conduct to all employees?	X		Staff, student interns and volunteers receive training and continued education • P&P "Staff Training" Initial at hire orientation within the first five days of employment. Topics include but are not limited to: 1. Code of Ethics 2. Cultural competency 3. Confidentiality 4. mandated child abuse reporting 5. CHSW mission /vision 6. System overviews

1.5	Is a **signature acknowledging receipt** required?	X		• Code of Ethics Acknowledgement form • 60-Day Orientation Checklist acknowledgement **GOALS/ACTIONS/EVIDENCE**
1.6	Are the standards of conduct **reviewed and revised** as new laws and regulations are passed and current law and regulations modified?	X		Goal: Review CHSW Code of Ethics form for updates needed to new WAC 388-877. HR reviewing other professional Code of Conduct forms on-file for needed updates.
1.7	Has the **compliance program** been implemented within the organization?	X		• P&P "Compliance Program" • Strategic Leadership team (SLT) • Strategic Operations team (SOT) Meets monthly to discuss focus issues from each region and community.
1.8	Does the compliance program provide guidance to employees and others associated with the Medicaid provider (RSN) on **how to identify and communicate compliance issues** to compliance personnel?	X		• P&P "Compliance Program" • Staff receives as needed remedial training in a timely manner. Trainings in both new and corrective action policies, procedures and funder compliance responses may be accomplished in staff/team meetings, record review, individual supervision or other in service method. Goal • In the process of developing Reference List for staff of the designated CHSW Compliance Officers and leadership specialists by name, location and topic area. • New training will be provided when new forms are finalized.
1.9	Does the compliance program describe how	X		Information & procedures

	potential compliance problems are **investigated and resolved**?			available in the following policies: • "Compliance Program" • "Performance Planning" • "Progressive Discipline • Staff Handbook • "Consumer Rights" • "Consumer Complaint & Grievance Procedures" In consumer package • Consumer rights • Benefit Booklet • Notice of Privacy practice • CDRSN uses and Disclosures • Acts of unprofessional conduct • Right to a second opinion, changing primary care provider • Counseling or hypnotherapy clients Available in the office s as of August 2014 • Posted information in English and Spanish about process for complains and grievances with contact phone number and addresses. • Consumer Satisfaction surveys in main lobby.

Element 2. Compliance Officer / Compliance Committee

	Description	Yes	No	**GOALS/ACTIONS/EVIDENCE for 2014-15**
2.1	Is the responsible compliance position an **employed position**?	X		
2.2	Is the compliance officer a **high-level official** in the Organization with direct access to the governing board or CEO?	X		• Compliance team has direct access to board and CEO
2.3	Do the responsible compliance positions have responsibility for **day to day operation of the**	X		• Goal is to update job Descriptions to clarify

	compliance program?			
2.4	Do the people responsible for the day to day operation of the compliance program have **responsibilities other than compliance**?	X		• Compliance team is made of various members with various jobs responsibilities.
2.5	If the answer to questions 2.4 is "Yes", are **sufficient resources made available** to the people with responsibility for the day to day operation of the compliance program to satisfactorily carry out their compliance duties?	X		• Designated monthly meetings allocate time in addition to urgent issues.
2.6	Does the compliance officer **independently investigate and act on matters** related to compliance, including designing and coordinating internal investigations and any resulting corrective action with all Organization departments, providers, agents and independent contractors?	X		In the process of Clarifying this in the "Compliance Program" policy and procedures.
2.7	Does the compliance officer have the **authority to review all documents and other information** that are relevant to compliance activities, including medical records, billing records, marketing documents, contracts with providers and referral sources, etc.	X		• P&P "Fraud Prevention & Reporting Policy/Plan • P&P "Compliance Program"
2.8	Is there a **compliance committee** established to advise the compliance officer and assist in the implementation of the compliance program?	X		SLT and SOT teams are standing teams. Compliance Officer(s) may assemble ad-hoc response team(s) as necessary.
2.9	Does the compliance committee **analyze the Organization's environment** including the legal requirements with which it must comply, and specific risk areas?	X		• P&P "Compliance Program" lists the designated leadership specialists who work with the Compliance Officers to promote awareness and implement new or revised P&P • In the process of designing a visual chart structure.
2.1.1	Does the compliance committee **assess the existing policies and procedures** that address these areas for possible incorporation into the compliance program?	X		P&P "Compliance Program"
2.1.2	Does the compliance committee **recommend and monitor**, in conjunction with relevant depts. the development of internal systems and controls to carry out the Organization's standards, policies	X		(same)

	and procedures as part of its daily operations?			
2.1.3	Does the compliance committee determine the **appropriate strategy/approach** to promote compliance with the program and detection of any potential violations?	X		(same)
2.1.4	Does the compliance committee develop a system to solicit, evaluate and respond to **complaints and problems**?	X		Goal is to Centralize reporting process will resume as part of PQI Program on hire of new Quality Manager
2.1.5	Does the compliance committee **document meetings**?	X		• Minutes and reports are kept. • Goal is to Centralized reporting process will resume as part of PQI Program on hire of new Quality Manager

Element 3. Education and Training

	Description	Yes	No	GOALS/ACTIONS/EVIDENCE for 2014-15
3.1	Is there evidence of a **compliance training program** which includes the Code of Conduct/Ethics; expectations of the compliance program; and how the compliance program operates?	X		• Sample from personnel files to confirm our procedures are functioning properly. • Goal is to provide new training as soon as the compliance structure is updated.
3.2	Is the compliance training made part of **orientation** for new employees, board members and affiliates?	X		P&P " Staff Training" • Trainings provided at hire. • Review of policies and procedures are done yearly.
3.3	Does the Organization provide training on **compliance issues as they arise**? (and remedial)	X		• P&P "Compliance Program" addresses ongoing & remedial training is provided during the year.
3.4	Who maintains **records of compliance training** of employees, including attendance logs and materials distributed at the training session?	X		• Community Offices keep information on sites. • HR Corporate keeps copy of information

Training plan for Wenatchee Site team 2014-15

CHILDREN'S HOME SOCIETY OF WASHINGTON
STAFF CONTINUING EDUCATION & TRAINING PLAN

The Continuing Education & Training Plan addresses:

- Pre-determined training plans or courses that the staff members has developed
  - to maintain professional credentials
  - for future professional and career developmental growth
- It is not tied to the Performance Evaluation process.

STAFF MEMBER:

PROGRAM/DEPARTMENT: **POSITION:**

TRAINING PLAN DATES: 1/2014 **to** 12/2014 **(1 year)**

Training Planned	Training Received	Presenter/ Organization	Date	Location	Hours
	Client rights & grievances	Kristi Karpenko	1/30/14	Wenatchee site	.5
	Safety training	Jaime Robison/Bob King WSD Director of Safety	3/13/14	Wenatchee site	1
	Practice guidelines for ADHD & Depression	Kristi Karpenko	3/13/14	Wenatchee site	.5
	Customer service	Alejandra Gonzalez & Sonia Reyes	4/3/14	Wenatchee site	1.5
	Advanced directives	Kristi Karpenko	4/10/14	Wenatchee site	.5
	HIPPA	Bev Parks	4/17/14	CHSW	1
	Compliance	RSN	6/6/14	RSN	2
	Child and Family Team meetings	Deb Murray	6/12/14	CVCH	2
	CPS & critical incident reporting	Kristi Karpenko	6/19/14	Wenatchee site	.5
	Safety Training/Risk issues	Jaime Robison/Alejandra Gonzalez	6/19/14	Wenatchee site	1
	Visitation	Anne Crain	6/20/14	Wenatchee site	2

	In home behavioral interventions	Pat Mullen	6/26/14	Wenatchee site	3.5
	Behavior intervention principles	Pat Mullen	6/26/14	Wenatchee site	2.5
	LEARN in the lobby	Pat Mullen	6/26/14	Wenatchee site	1.5
	Boundaries	Kris Collier	7/18/14	Wenatchee site	1
	Strength based assessment & treatment planning	Kristi Karpenko	7/24/14	Wenatchee site	.5
	EPSDT & Multisystem involvement	Kristi Karpenko	7/24/14	Wenatchee site	.5
	Recovery Principles	Kris Collier	7/31/14	Wenatchee site	.5
	"Be the Change" Cultural Self-Awareness and competency in the context of poverty	Dr. Donna M. Beegle And Pastor Alex Schmidt Community Foundation of NCW/United Way, city of Wenatchee Diversity Advisory committee, Chelan Douglas Developmental disability board, and together for a Drug Free Youth	9/23/2014	Convention Center Wenatchee	5.5
	Overcoming childhood Trauma: The power of Resilience	CHSW	9/25/14	Convention Center	1.5
	Talking Circles on Racial Equity	CHSW	9/25/14	Convention Center	1.5
	HIPPA And Confidentiality	Ogden Murphy Wallace Julie Norton CHSW	9/25/14	Convention Center	1.5
	Ongoing Performance Management for Supervisors and Employees	CHSW Alyson Olson	9/25/14	Convention Center	1.5
	Toxic stress prevention	CHSW	9/25/14	Convention Center	1.5
	Youth Suicide Prevention QPR	CHSW	9/25/14	Convention Center	1.5
	Creating Safer Spaces for LGBTQ clients	CHSW	9/25/14	Convention Center	1.5
	The 7 Cs of Resiliency	CHSW	9/25/14	Convention Center	1.5

	Maximizing Teamwork	CHSW	9/25/14	Convention Center	1.5
	Difficult conversations	CHSW	9/25/14	Convention Center	1.5
	Talking circles on Racial Equity	CHSW	9/25/14	Convention Center	1.5
	Introduction to positive discipline	CHSW	9/25/14	Convention Center	1.5
	Program databases Evidence-based data-drivers for success	CHSW	9/25/14	Convention Center	1.5
	Stress burnout and vicarious trauma	CHSW	9/26/14	Convention Center	1.5
	Assuring diversity and equality in your work with children and families	CHSW	9/26/14	Convention Center	1.5
	Overcoming ethical challenges to achieve racial equity	CHSW	9/26/14	Convention Center	1.5
	Dual Language learners	CHSW	9/26/14	Convention Center	1.5
	Enhance your career	CHSW	9/26/14	Convention Center	1.5
Safety		CDRSN/Deb Murray and Craig Mott	10/16/12	Wenatchee site	3
The Impact of ACE's		Laura Porter The coalition for children and families of NCW	11/6/14	PAC	

STAFF MEMBER SIGNATURE: _____ **DATE:**

_____

SUPERVISOR SIGNATURE: _____ **DATE:**

_____

Form #0005F-101-10/02
Original to Human Resources
Copies to Staff Member and Supervisor as requested
X:\Forms\Department Forms\Human Resources\Performance Planning Forms\5. Staff Continuing Education & Training Plan.doc

Element 4. Monitoring and auditing

	Description	Yes	No	GOALS/ACTIONS/EVIDENCE for 2014-15

4.1	Does the system exist with the Organization compliance plan to **routinely identify compliance risk areas** specific to the type of service provided? (as part of the PQI Program)	X		• P&P "Performance and Quality Improvement Program" • SLT and SOT team
4.2	Does a system exist within the compliance plan to routinely conduct **self-evaluation** of risk areas, including internal audits and as appropriate external audits?	X		P&P "Fraud Prevention & Reporting" lists multiple avenues, i.e: • Staff trainings • Internal and external audits • Facility Review • Safety teams • Critical incident reporting
4.3	Does the Organization have **sampling protocols** that permit the compliance officer to identify and review variations from an **established baseline on issues not already routinely audited**?	X		• Emergency Response and Disaster Protocol • Goal is to clarify this in the "Compliance Program" and/or "PQI Program" policies as part of a formal goal-setting and analysis process.
4.4	Does the Organization have a system to determine that its employees, contractors, providers, are **not submitting false claims** as that may be defined under the federal False Claims Act?	X		• Level II Record reviews • Accounting Internal Controls
4.5	Does the Organization **document its efforts to comply** with applicable statutes, regulations, and federal health care program requirements?	X		• Consistent policy & procedure updates • Staff trainings

Element 5 Reporting

5.1	Are there **accessible mechanism(s) for communicating compliance related concerns** for the governing board, management, employees and others associates with the Medicaid provider?	X		A consumer complaint may be made to CHSW, the RSN and/or the county Ombudsman service. Information is provided and available in our office in the following forms. • Consumers Rights form • Notice of Privacy • Acts of unprofessional conduct

				• Consumer rights • Benefit Booklet • Notice of Privacy practice • CDRSN uses and Disclosures • Acts of unprofessional conduct • Right to a second opinion, changing primary care provider • Counseling or hypnotherapy clients
5.2	Do the accessible mechanism referred to in 2.1.1.1 include methods for **anonymous or confidential** communication?	X		• P&P "Compliance Program" • P&P "Fraud Prevention and Reporting" • Client Package • Staff handbook
5.3	Are there clear procedures so that personnel may **seek clarification from the compliance officer** or compliance committee in the event of confusion or questions regarding a policy?	X		Goal is to Re-educate Community Offices and staff through the Reference List of 1.8
5.4	Are **significant** questions and responses **documented and dated** and, if appropriate, shared with other staff so that the standards, policies & procedures can be updated and improved?	X		P&P "Compliance Program" and "Policy Development & Administration" • A variety of means (i.e. emails, meeting minutes) would funnel to the Community Director, Core Service Director, and ultimately to the Policy Manager. • WAC revision notebook
5.5	Do the compliance officers **document** their reports, including the nature of any investigation and its results?	X		P&P "Compliance Program"
5.6	Does the compliance officer **report to the Board**? Is this documented?	X		P&P "Compliance Program"
5.7	Does the Organization explicitly communicate that although it will strive to maintain confidentiality, there may be a point where an **individual's identity may become known** or may have to be revealed in certain circumstances when **governmental authorities** become involved?	X		• P&P "Fraud and Prevention" and "Compliance Program"

Element 6 Enforcement and Discipline

	Description	Yes	No	GOALS/ACTIONS /EVIDENCE for 2014-15
6.1	Do disciplinary policies exist which encourage **good faith participation** in the compliance program?	X		P&P "Compliance Program" and "Progressive Discipline"
6.2	Do disciplinary policies set out **expectations for reporting** compliance issues and for assisting in their resolution?	X		P&P "Compliance Program" and "Progressive Discipline"
6.3	Do disciplinary policies outline **sanctions** for failing to report suspected problems; participating in non-compliant behavior; or encouraging, directing, facilitating or permitting non-compliant behavior?	X		
6.4	If disciplinary action is taken, is it fairly and consistently applied, regardless of the perpetrator's **position with the Organization**?	X		• Goal "Compliance Policy" needs modifying to specifically address if a Compliance Officer or the President/CEO is the object of an investigation.
6.5	Are managers/directors aware that they have a responsibility to **discipline employees** in an appropriate and consistent manner and will be held accountable for foreseeable failure of their subordinates to adhere to standards and laws?	X		P&P "Supervision Practices" and "Compliance Program"
6.6	Do policies and practices prohibit **employing individuals convicted of a criminal offense** related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in federal health care programs? (With the exception of "veteran parents" in select programs)	X		• P&P "Employment & Hiring Practices" and "Staffing Requirements for CFC Services" • Intellicorp and DSHS background checks
6.7	Is there a policy prohibiting execution of **contracts with companies** that have been convicted of a criminal offense related to health care or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal health care programs?	X		P&P "Contract Management"
6.8	Are federal **Exclusion Lists** checked monthly?	X		P&P "Employment & Hiring Practices"
6.9 CHSW	Is there a written procedure for checking "Excluded Parties" **website and how to report findings discovered**?	X		Policy "Human Resources Hiring and Recruiting procedures"

Element 7. Response and Prevention

	Description	Yes	No	GOALS/ACTIONS/EVIDENCE for 2014-15
7.1	Does a system exist within the Organization's compliance plan for **responding to compliance issues as they are raised**?	X		P&P "Compliance Program"
7.2	Does a system exist within the Organization's compliance plan for **investigating potential** compliance issues?	X		P&P "Compliance Program
7.3 CHS W	Does a system exist with the Organization's compliance plan to respond to compliance issues **as they are identified in the course of self-evaluation?** (pro-active)? In response to findings in **audits/reviews**?	X X		Yearly risk assessments are completed within communities and additionally through-out year during staff meetings.
7.4	Does a system exist within the Organization to **correct compliance issues** promptly, thoroughly and implement procedures, policies and systems that may be necessary to mitigate recurrence?	X		P&P "Compliance Program"
7.5	Does a system exist within the Organization's compliance plan for identifying and reporting compliance issues to the **Medicaid Fraud and Control Unit?**	X		P&P "Fraud Prevention & Reporting Plan". Clarify this expectation more specifically in the "Compliance Program" policy.
7.6	Does the Organization maintain **records** demonstrating reasonable reliance and due diligence in **developing procedures that implement such advice?**	X		The Policy Manager's working files for all P&P's would document input at policy level.
7.7	**Non-retaliation**: Does the compliance plan or organization policy state intimidation or retaliation will not be permitted against individuals who in good faith participate in the compliance program (including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial action and reporting to the appropriate officials?)	X		P&P "Compliance Program"
7.8	Are **allegations of intimidation or retaliation** fully and completely investigated?	X		P&P "Harassment & Discrimination Resolution"
7.9	**Is disciplinary action uniformly and consistently applied** across the organization regardless of title or position?	X		Goal: Expectation set in P&P "Progressive Discipline". Clarify policy as in #6.4

Wenatchee Specific Identified Issues and Actions Taken

Date identified	• Hazard/Issue	Action taken	Date accomplished/FU

1/9/14	• Health and Safety team get new group elective	• Health and Safety Team elected. • Wellness and self-care committee Will meet monthly	1/24/14 Wellness committee will resume monthly meetings when whole MH team is hired
1/9/14	• Managers supervision	Implemented monthly supervision for managers. We meet as needed or weekly	Supervision started January 2014
2/27/14	Safety issues • Missing evacuation plan • missing fire drills, floor plans, • first aid kits, • exit doors, • No use of badges • No sign in sheets • Evacuation signal	• Wenatchee Fire Marshall Mark Yaple and WSD Safety Director inspected the building • Emergency kits done • Sign in sheets implemented • Id badges use implemented • Exit signs posted • Emergency tree created	3/25/14
3/6/14	• Copier/Fax needed relocation to comply with HIPPA regulations	Copier/fax was relocated	3/25/14
3/6/14	• Staff mail boxes/ HIPPA and confidentiality	relocated	3/25/14
3/6/14	• Exterior lights, • Staff and customer safety	New exterior lights were installed around the perimeter of the building and is activated by motion detectors. Provides adequate lighting for the various work areas	3/25/14
3/6/14	• Floor at PIRC room health concerns	Carpet was replaced by tile	3/25/14
3/6/14	• Door Locks not in compliance with Fire Department	Main door locking mechanisms were replaced to follow fire department standards. Deb Murray	3/25/14
3/6/14	• Electrical Outlets not working	Electrical boxes, outlets and switches were updated	3/25/14
3/6/14	• Safety protocol with old information	Protocol updated	• Protocol was updated as of March 2014 but it will Need new

			updates as of September 2014 will be finished by the end of March 2015
3/6/14	• Offices spaces • Compliance with RSN • Liability and Breach of Confidentiality	• Telemedicine system was installed • New CIP team get an office • Relocation of files to room with locks to comply with RSN contract. • Basement has security key. Access limited. Files and IT system secured.	Tele health equipment work and running properly June 23 2014
3/6/14	• Lobby rules • Safety for children liability issues for organization.	• Implemented new set of rules for lobby area.	Done June 2014
6/30/14	• Location of lobby creates challenges • Distance from door to reception creates too much separation • Children's' Playroom very close to outside door • Liability issues	• Reception area will be relocated and new playroom will be designed	By the end March 2015
September 2014	• Unusual reduction in staff, low staffing levels, clinical manager leaving. • Be in compliance with RSN Contract. Maintain a cohesive supervision for MH team; provide consistent services	• Statewide aggressive recruitment plan • Interviewing applicants • Redistribute caseload with therapist and case managers • Susan Maney and Libby Hein will provide clinical	

	with same therapist for clients. • Telemedicine concern that Eva is asked by Dr. Myers to perform beyond her scope of knowledge • Telemedicine contract review is someone else can cover for Eva is the only one in the site with nursing background. • New signal during evacuation drill, emergency, lock down needs to be implemented • Use of telephones to page everyone in the office. System is not working properly in every extension	supervision and continues support to MH staff • Review of contract, Discuss with Susan and Libby • Review of contract discuss with Libby and Susan. • Discussed in June 5th during safety meeting • Contact Fuse for technical support	• Phrase need to be implemented such as "Ale can you please reschedule my next appointment"