Section 8 Avg Clin/Grp							
Center for Human Services				1			
Compass Health				1			
Evergreen Manor		1	1	1	1		
Sunrise Services		1		1			
Catholic Community Svcs				1			
Totals							
Section 9 Avg Cost/Group							
Center for Human Services	-	-	-	$17.24	-	-	-
Compass Health	-	-	-	$34.09	-	-	-
Evergreen Manor	-	$23.35	$13.07	$10.55	$5.66	-	-
Sunrise Services	-	$14.86	-	$11.43	-	-	-
Catholic Community Svcs	-	-	-	$24.02	-	-	-
Totals	-	-	-	-	-	-	$18.51
Section 10 Grp FTEs							
Center for Human Services				6.50			6.50
Compass Health				2.00			2.00
Evergreen Manor		4.17	4.50	13.90	4.30		26.87
Sunrise Services		1.00		1.25			2.25
Catholic Community Svcs				29.00			29.00
Totals	-	5.17	4.50	52.65	4.30	-	66.62
Section 10 Grp FTE Weight							
Center for Human Services	-	-	-	0.10	-	-	0.10
Compass Health	-	-	-	0.03	-	-	0.03
Evergreen Manor	-	0.06	0.07	0.21	0.06	-	0.40
Sunrise Services	-	0.02	-	0.02	-	-	0.03
Catholic Community Svcs	-	-	-	0.44	-	-	0.44
Totals	-	0.08	0.07	0.79	0.06	-	1.00

DBHR Residential Bed Rates/Per day Per Client 2013-15 (Includes R & B @ $11.64)	
Adult Intensive Inpatient (IIP)	$ 90.18
Adult IIP Expanded Medical	$ 188.68
Adult IIP COD Pilot	$ 155.00
Adult IIP Deaf and Hard of Hearing	$ 139.20
Adult IIP Non-IMD Pilot (Ended 1/23/14)	$ 126.45
Adult IIP Non-IMD Rate	$150.00
Adult Long Term	$ 53.52
Adult Recovery House	$ 41.14
Adult Involuntary Tx - East	$ 128.28
Adult Involuntary Tx - North	$ 113.28
Housing Support Services	$13.79
Pregnant and Parenting Women (PPW) w/child(ren)	$ 126.45
PPW without child(ren)	$ 106.30
PPW w/child(ren) COD	$ 175.15
PPW w/o child(ren) COD	$ 155.00
Therapeutic Childcare (5 days per week max)	$ 49.60
Safe Babies Safe Moms (Per client/per month)	$ 511.00
PCAP (Per client/per month)	$ 356.00-516.00
Youth Level 1	$ 150.00
Youth Level 2	$ 188.68
Youth Recovery House	$ 128.40
Youth Acute Detox	$ 235.49
Youth Sub Acute Detox	$ 172.44
Youth Crisis Stablilization	$ 189.68

* Denotes Medicaid Rate

** Denotes Low Income Rate of Medicaid + 15%

Non-IMD's: 6 PPW Programs, 9 Youth Programs, 8 Adult IIP Programs

Adult Detox Rates (paid thru county contracted services) by County

DBHR Oupatient Rates 2013-15	Medicaid	**Low Income	County Specific	Unit Type
Intervention and Referral			30.00-85.00	Per Hour
Alcohol/Drug Information School			31.00-155.00	Per Hour
Opiate Dependency/HIV Services			26.00-75.00	Per Hour
Interim Services			15.00-85.00	Per Hour
Outreach			18.00-75.00	Per Hour
Brief Intervention			7.50-55.00	Per Hour
Crisis Services			22.00-55.00	Per Hour
Acute Detoxification Services	$ 252.00	$ 289.80	170.61-400.00	Per Day
Sub-Acute Detoxification Services	$ 108.36	$ 124.61	124.61-170.61	Per Day
Sobering Services (King, Spokane, Clark) 6/30/14			2.32-7.00 per hr	Per Hour
Involuntary Commitment				
Outpatient Treatment Adult-Group	$ 4.82	$ 5.54	6.00/9.00/12.00	Per 15 Min
Intensive Outpatient Tx Adult-Group	$ 4.82	$ 5.54	6.00/9.00/12.00	Per 15 Min
Outpatient Treatment Adult-Individual	$ 19.26	$ 22.14		Per 15 Min
Intensive Outpatient Tx Adult-Individual	$ 19.26	$ 22.14		Per 15 Min
Outpatient Treatment PPW-Group	$ 4.82	$ 5.54	6.00/9.00/12.00	Per 15 Min
Intensive Outpatient Tx PPW-Group	$ 4.82	$ 7.25	6.00/9.00/12.00	Per 15 Min
Outpatient Treatment PPW-Individual	$ 19.26	$ 22.15		Per 15 Min
Intensive Outpatient Tx PPW-Individual	$ 19.26	$ 22.15		Per 15 Min
Outpatient Treatment Youth-Group	$ 6.30	$ 7.25	7.00/10.00/13.00	Per 15 Min
Intensive Outpatient Tx Youth-Group	$ 6.30	$ 11.64	7.00/10.00/13.00	Per 15 Min
Outpatient Treatment Youth-Individual	$ 19.26	$ 22.15		Per 15 Min
Intensive Outpatient Tx Youth-Individual	$ 19.26	$ 22.15		Per 15 Min
Opiate Substitution Treatment	$ 12.79	$ 14.71		Per Day
Therapeutic Childcare Services	$ 49.60	$ 57.04		Per Day (5 Max)
Transportation			Actual Costs	Actual Costs
Case Management - Adult	$ 10.12	$ 11.64		Per 15 Min
Case Management - PPW	$ 10.12	$ 11.64		Per 15 Min
Case Management - Youth	$ 10.12	$ 11.64		Per 15 Min
Childcare Services		$ -		Per 15 Min
Assessment - Adult	$ 115.17	$ 132.45		Per Assesement
Assessment - PPW	$ 115.17	$ 132.45		Per Assesement
Assessment - Youth	$ 115.17	$ 132.45		Per Assesement
Assessment - DUI	$ 115.17	$ 132.45		Per Assesement
Brief Therapy	$ 53.52	$ 61.55		Per Hour
Screening Tests and Urinary Analysis	$ 8.74	$ 10.05		Per UA
Expanded Assessment	$ 177.69	$ 204.34		Per Assesement
TB Skin Tests	$ 5.01	$ 5.76		Per Test

Intensive Outpatient Average	Mix	Ad Rate	Yth Rate
Indiv	16.91%	$77.04	$77.04
Group	83.09%	$19.28	$25.20
Wtg Avg		$29.05	$33.97

Outpatient Average	Mix	Ad Rate	Yth Rate
Indiv	12.34%	$77.04	$77.04
Group	87.66%	$19.28	$25.20
Wtg Avg		$26.41	$31.60

Revised Figures, Scenario 1	New Mix	2015 Cst	2016 Cst
Indiv	20%	$105.92	$109.63
Group	80%	$18.51	$19.16
Wtg Avg		$35.99	**$37.25**

Revised Figures, Scenario 2	New Mix	2015 Cst	2016 Cst
Indiv	30%	$105.92	$109.63
Group	70%	$18.51	$19.16
Wtg Avg		$44.73	**$46.30**

Revised Figures, Scenario 3	New Mix	2015 Cst	2016 Cst
Indiv	40%	$105.92	$109.63
Group	60%	$18.51	$19.16
Wtg Avg		$53.47	**$55.35**

Updated 6/30/14 DRAFT

Admission versus Caseload Numbers: August 2014 - July 2015

	Snohomish Admissions	Snohomish Caseload	Admit % of Caseload
Adult OP	350	740	47%
Adult IOP	1,250	1,715	73%
Total Adult	1,575	2,385	66%
Youth OP	170	250	68%
Youth IOP	165	230	72%
Total Youth	330	460	72%
Total Outpatient	1,900	2,840	67%

CCS Funded Outpatient Admissions Retention Analysis - Sept. 2014 - April 2015
Percent with Three Consequtive Months of Activities

	Adult Island	Adult San Juan	Adult Skagit	Adult Snohomish	Adult Whatcom	Adult Totals
September 2014	71.2%	75.6%	54.7%	79.5%	67.5%	
October	72.3%	82.8%	55.6%	81.0%	71.4%	
November	75.0%	78.6%	58.2%	81.6%	71.9%	
December	74.3%	74.1%	59.1%	83.3%	70.9%	
January 2015	77.3%	84.6%	59.5%	83.8%	73.2%	
February	73.2%	82.6%	58.8%	82.3%	75.1%	
March	70.5%	73.1%	57.8%	80.0%	77.7%	
April	72.8%	74.1%	60.4%	77.7%	78.8%	
Average	73.3%	78.2%	58.0%	81.2%	73.3%	
12 Month Admissions	146	56	768	1,606	655	3,231
County Mix	4.5%	1.7%	23.8%	49.7%	20.3%	
Weighted Retention	3.31%	1.36%	13.79%	40.34%	14.86%	73.66%
Agencies						
ACRS				1		1
CCS			55	518	511	1,084
Compass		56			44	100
Evergreen				800		800
Harborview				1		1
Phoenix			529			529
Sea Mar	145		67	216	100	528
St Peter			2			2
Stillaguamish				7		7
Sunrise	1		115			116
THS				63		63

	Youth Island	Youth San Juan	Youth Skagit	Youth Snohomish	Youth Whatcom	Youth Totals
September 2014	72.7%	33.3%	54.3%	71.9%	71.6%	
October	54.5%	0.0%	60.0%	77.4%	71.6%	
November	42.9%		62.2%	85.0%	71.0%	
December	42.9%	0.0%	66.2%	86.3%	71.2%	
January 2015	44.4%	0.0%	65.8%	86.4%	71.8%	
February	42.9%	0.0%	68.0%	86.7%	73.7%	
March	42.9%	0.0%	71.1%	88.2%	75.0%	
April	40.0%	0.0%	69.8%	86.7%	78.4%	
Average	47.9%	4.8%	64.7%	83.6%	73.0%	
12 Month Admissions	16	4	138	379	155	692
County Mix	2.3%	0.6%	19.9%	54.8%	22.4%	
Weighted Retention	1.11%	0.03%	12.90%	45.77%	16.36%	76.17%
Agencies						
CCS			69	221	155	445
Center for Human Services				25		25
Compass		4				4
Evergreen				2		2
NorthShore Youth & Family				1		1
Northwest ESD			23			23
Phoenix			25			25
Sea Mar	16		21	68		105
THS				62		62

Funding Source Analysis for the 12 Months Ended 7/31/2015 - Snohomish County Residence

	CCS	Sales Tx	Ag Fund	DOC	Fed Dir	St Dir	St DSHS	St NoDSHS	Tribal	Other	Private	Total
Outpatient												
Child/Adolescents	250	15	0	0	10	0	0	0	10	20	60	365
Adult	715	50	0	350	40	35	0	0	70	55	290	1605
Pregnant and Parenting Women	25	0	0	0	0	0	0	0	10	0	5	40
Total	990	65	0	350	50	35	0	0	90	75	355	2010
Intensive Outpatient												
Child/Adolescents	225	30	0	0	15	0	0	0	10	20	15	315
Adult	1670	215	0	800	70	0	0	0	335	15	80	3185
Pregnant and Parenting Women	45	5	0	0	0	0	0	0	10	0	0	60
Total	1940	250	0	800	85	0	0	0	355	35	95	3560
Totals	2930	315	0	1150	135	35	0	0	445	110	450	5570
Total Unduplicated	2840	310	0	1005	135	35	0	0	420	100	450	5295
% Duplication	3.2%	1.6%		14.4%	0.0%	0.0%			6.0%	10.0%	0.0%	5.2%
Unduplicated Ratios	54%	6%	0%	19%	3%	1%	0%	0%	8%	2%	8%	100%
Include for Calc	2,840	310			135	35						3320
Unduplicated Ratios	86%	9%			4%	1%						

DBHR SUD Funding Sheet 2013-2015 Biennium

General Fund - State (GFS, Gambling, Crim Just)	$153,526,000
General Fund - Federal (Medicaid, SAPT, Grants	$280,568,000
Local	$16,301,000
	$450,395,000

State Budget FY2016, FY2017 SUD

State GF FY2016	$64,766,000
State FG FY2017	$64,894,000
GF Federal Appropriation	$432,441,000
GF Private/Local Appropriation	$20,211,000
Crim Justice Tx Fund	$11,978,000
Problem Gambling	$1,453,000
Marijuana Account FY16	$10,736,000
Marijuana Account FY17	$24,802,000
Total	$631,281,000

FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—ALCOHOL AND SUBSTANCE ABUSE PROGRAM

CD Rates

CD Target Rate

First Iteration

	CD rate	people	Total $'s Monthly	Annual $'s
non-disabled children	$ 2.67	103,275	275,744	3,308,931
disabled children	$ 9.26	7,199	66,663	799,953
non-disabled adult	$ 12.51	32,607	407,914	4,894,963
disabled adult	$ 10.98	17,157	188,384	2,260,606
newly eligible	$ 14.36	71,277	1,023,538	12,282,453
	$ 8.48	231,515	1,962,242	23,546,906

Latest Iteration

	CD rate	people	Total $'s Monthly	Annual $'s	Change

CD Lower Bound

	CD rate	people	Total $'s Monthly	Annual $'s
non-disabled children	$ 2.59	103,275	267,482	3,209,787
disabled children	$ 8.99	7,199	64,719	776,628
non-disabled adult	$ 12.13	32,607	395,523	4,746,275
disabled adult	$ 10.63	17,157	182,379	2,188,547
newly eligible	$ 13.91	71,277	991,463	11,897,557
	$ 8.21	231,515	1,901,566	22,818,794

	CD rate	people	Total $'s Monthly	Annual $'s	Change
	$ 2.94	103,275	303,629	3,643,542	13.5%
	$ 10.68	7,199	76,885	922,624	18.8%
	$ 13.04	32,607	425,195	5,102,343	7.5%
	$ 13.82	17,157	237,110	2,845,317	30.0%
	$ 14.65	71,277	1,044,208	12,530,497	5.3%
	$ 9.01	231,515	2,087,027	25,044,323	9.7%

CD Upper Bound

	CD rate	people	Total $'s Monthly	Annual $'s
non-disabled children	$ 2.80	103,275	289,170	3,470,040
disabled children	$ 9.66	7,199	69,542	834,508
non-disabled adult	$ 13.11	32,607	427,478	5,129,733
disabled adult	$ 11.51	17,157	197,477	2,369,725
newly eligible	$ 15.06	71,277	1,073,432	12,881,179
	$ 8.89	231,515	2,057,099	24,685,186

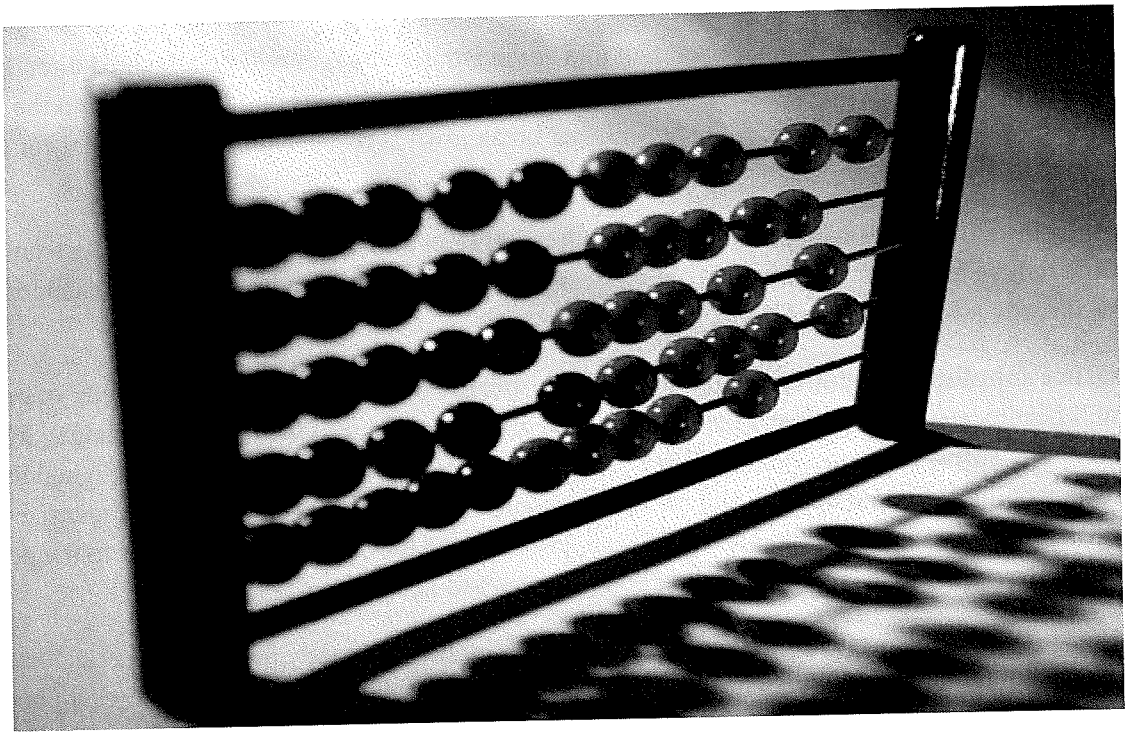
		people	Total $'s Monthly	Annual $'s	Change
	$ 3.18	103,275	328,415	3,940,974	13.6%
	$ 11.57	7,199	83,292	999,509	19.8%
	$ 14.11	32,607	460,085	5,521,017	7.6%
	$ 15.10	17,157	259,071	3,108,848	31.2%
	$ 15.86	71,277	1,130,453	13,565,439	5.3%
	$ 9.77	231,515	2,261,316	27,135,787	9.9%

North Sound Regional Support Network DBA

North Sound Mental Health Administration

Cost Allocation Plan 2015

Revised March 31, 2015



Purpose

The purpose of a cost allocation plan is to summarize in writing the methods, procedures, principals assumptions used to allocate costs to various programs and to ensure compliance.

NSMHA will follow the guidelines set out by the federal and state governments to insure compliance. The Office of Management and Budget (OMB) circular A-87 or its replacement 2 CFR 225 is the primary reference for cost principles for state, local Governments. The purpose of the circular is to establish principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments as well as federally recognized Indian tribal governments (governmental units). The state Budget Accounting and Review Manual (BARS) manual for mental health is the reference tool for defining revenue and expense categories.

1) Operating Budget

Most costs for the North Sound operating and administrative budget will be allocated directly to each team, or activity. Indirect costs like rents, supplies, and utilities will be allocated to the leadership team (general) budget unless further breakdown is requested by management for tracking projects or team costs.

Salaries and Wages will be allocated to each team. If an individual is on two separate teams their time will be allocated to each team on a percentage basis. Costs directly traceable to each team will be directly allocated to each team.

Office supplies and small tools purchased for a specific team function and are directly traceable will be allocated to that team. General office supplies will be put to the leadership budget. Most computer software is classified as office supplies and will be charged to the team assigned the responsibility of implementing and maintaining software (currently that is the IS\IT team). Professional services will be directly allocated to the team they are working with or to the general leadership category depending on the circumstances and budget.

Communication costs will be broken out to each team if it can easily be done. General costs for postage, internet and indirect phones are currently allocated to the leadership team. Cell phones can be easily traced to each team member and should be accounted for in that manner.

Travel will be directly allocated to each team based on team membership.

Advertising is allocated to the leadership team.

Operating rentals and leases will be allocated to the leadership team for the building, copier and postage machine. If a specific team rents a facility it will be allocated to that team.

Utilities will be allocated to leadership team.

Repair and maintenance will be allocated to leadership team including janitorial services

1) Operating Budget (continued)

Miscellaneous costs will be directly allocated to each team where appropriate.

Capital costs will be allocated to the leadership team unless the specific team is considered appropriate.

2) Contract costs allocations

North Sound uses a variety of cost reimbursement methods depending on the type and purpose of the program being contracted.

Fee for service is preferred method of payment for outpatient services because it varies directly with the amount of service being provided. Our case rates are a modified fee for service usually based on a day or month for the time period.

Cost reimbursement is used when a program is not reimbursed directly on usage of service. This method works well for administrative and indirect services. For example, you purchase a service and pay for the labor pool and associated costs for that program. This method is preferred over the capacity. We are currently using this method for the Program for Assertive Community Treatment (PACT), peer centers, county administration, flex funds, interpreter services, jail funds, central access, 24 hour inpatient authorization and 24 hour crisis phone line services.

Capacity payments are mostly used in the crisis system where you are needed to provide twenty four hour coverage seven days week. This method is primarily used for providing capacity coverage in crisis outreach, crisis stabilization, evaluation and treatment (E&T), mobile outreach teams and transitional housing rentals services.

3) Medicaid versus state funds allocation.

When determining the amount of funds to allocate to Medicaid some questions have to be answered. Is the service covered by Medicaid? If yes then we can allocate Medicaid funds to the program. If the service is not covered by Medicaid then the program needs to be funded from other sources. We have many programs funded without Medicaid funds like involuntary treatment act (ITA), mobile outreach teams, peer centers, court costs, flex funds, Medicaid Personal Care, Projects for Assistance in Transition from Homelessness (PATH) match.

Allocation of Medicaid funds will be done on a direct basis if possible. This method will works well for the fee for service program and inpatient hospital bills. Indirect services such as RSN administration, Ombuds, 24 hour access and crisis line will be allocated based on the general service percent of Medicaid services to non-Medicaid services. See the 2014 Crisis, Non Crisis Non-Inpatient, and E&T data sheets attached. 2015 Medicaid verses non-Medicaid budget tool document attached.

Crisis outreach services (excluding Snohomish county ITA services) are 69% Medicaid and 31% state funds based on historical utilization and ITA services.

3) Medicaid versus state funds allocation (continued).

Crisis stabilization services are 69% Medicaid and 31% state funds based on historical utilization of mental health services. Local county pass through funds are used to pay for social detox services.

Free standing evaluation and treatment (E&T) services are 61% Medicaid and 39% state funds based on historical utilization of 64.3% Medicaid and 35.7% state clients and a 5% allocation for room and board costs.

Residential services are 80% Medicaid funds and 20% state funds. On average about 15% of the residential funds are used for room and board. This is from the 2013 actuary rebase information turned in by our providers. The additional 5% of the state funds is to account for state clients and Medicaid clients on a spend down.

The PACT program is allocated the NSRSN average of Medicaid to non-Medicaid clients 91% Medicaid and 9% state funds.

Wraparound and wraparound with intensive services (WISe) services will be paid on a case rate will be converted to 100% Medicaid funds except where local pass through funds and state pilot funds are being provided. The WISe program is currently under redesign by DSHS/DBHR and may need further changes.

Out of network services are determined on a case by case basis depending on the type and or place of service and the client's eligibility.

Peer centers, court costs, flex funds, Medicaid personal Care and transitional housing costs are not covered services by Medicaid. These services are paid out of state funds.

4) Third Party Billings

Third party collections will be deducted from programs when setting the budgets. This was done when setting the budgets for the E&T, crisis triage centers and residential treatment facilities. The mental health residential treatment facility will collect and deduct client participation from the room and board costs of the program. The remaining room and board costs are covered by an allocation of state funds in the amount of 15% based on our last actuarial rebase process.

Third party collections have been factored into the outpatient fee for service rates. Providers need to try and collect the fees but do not need to turn them into the RSN. Third party collections have been deducted from our fee for service inpatient billings.

5) Allocations

Allocations are made depending on the type of service, funding rules and place of service institution for the Mental diseased (IMD). The appropriate funding rules are applied. The 2015 Estimated Budget tool lists the type of reimbursement in the second column. The third and fourth column show the Medicaid state funds mix.

5) Allocations (continued).

The Federal block and the Projects for Assistance in Transition from Homelessness (PATH) grants should be allocated based on actual costs and cost reimbursements or a fee for service basis. Each grant should have a budget basis of award and method of reimbursement stated in the contract.

6) Attachments: 2014 Crisis, Non Crisis Non-Inpatient, and E&T data sheets attached. 2015 Medicaid verses non-Medicaid budget tool document attached.

Total Hours of Non Crisis, Non-Inpatient Outpatient Services By Modality

data snapshot: 3/18/2015

Modality	Medicaid Status at time of service: med		state		Total percent hours	Total hour
	percent hours	hour	percent hours	hour		
2014	91%	240,632.5	9%	22,964.9	100%	263,597.4
Case Management	90%	386.2	10%	45.0	100%	431.2
Community Transition	64%	157.3	36%	89.0	100%	246.3
Engagement and Outreach	74%	436.6	26%	150.8	100%	587.5
Family Treatment	95%	15,640.2	5%	860.3	100%	16,500.5
Group Treatment Services	92%	10,796.4	8%	984.9	100%	11,781.3
Individual Treatment Services	91%	162,741.2	9%	15,257.9	100%	177,999.1
Intake Evaluation	91%	18,855.8	9%	1,867.0	100%	20,722.7
Interpreter Services	95%	1,070.9	5%	51.6	100%	1,122.5
Medication Management	91%	11,943.2	9%	1,171.4	100%	13,114.5
Medication Monitoring	88%	2,350.8	12%	316.9	100%	2,667.7
Peer Support	85%	3,029.4	15%	527.6	100%	3,557.0
Rehabilitation Case Management	79%	291.6	21%	76.2	100%	367.8
Request for Services	85%	3,206.5	15%	582.8	100%	3,789.3
Supported Employment	91%	2,073.0	9%	216.0	100%	2,289.0
Therapeutic Psychoeducation	90%	6,301.7	10%	679.7	100%	6,981.3
Wraparound	94%	1,154.8	6%	80.1	100%	1,234.9
Co-Occurring Treatment	100%	36.5	0%		100%	36.5
Telehealth	96%	160.5	4%	7.5	100%	168.0
Grand Total	**91%**	**240,632.5**	**9%**	**22,964.9**	**100%**	**263,597.4**

Total Hours of Crisis, Investigation and Stabilization Services by episode type

data snapshot: 3/18/2015

Modality	Medicaid Status at time of service: med percent hours	med hour	state percent hours	state hour	Total percent hours	Total hour
2014	69%	110,416.2	31%	48,778.7	100%	159,194.9
Children's High Intensity Wraparound Program	0%		100%	1.0	100%	1.0
Crisis Services	0%		100%	1.0	100%	1.0
Court Ordered	59%	893.1	41%	616.8	100%	1,509.9
Crisis Services	66%	15.8	34%	8.1	100%	23.9
Investigations	59%	877.2	41%	608.7	100%	1,485.9
Crisis Appointment	63%	505.8	37%	300.5	100%	806.3
Crisis Services	65%	294.4	35%	156.1	100%	450.5
Investigations	59%	211.4	41%	144.4	100%	355.9
Crisis Respite	75%	54,316.2	25%	17,652.1	100%	71,968.4
Crisis Services	60%	263.1	40%	173.8	100%	436.9
Stabilization Services	76%	54,053.1	24%	17,478.3	100%	71,531.4
ICRS Investigation Episode	67%	50,611.6	33%	25,416.5	100%	76,028.2
Crisis Services	64%	2,780.8	36%	1,567.9	100%	4,348.7
Investigations	62%	3,973.1	38%	2,450.4	100%	6,423.5
Stabilization Services	67%	43,857.7	33%	21,398.3	100%	65,256.0
Jail Services Episode	14%	0.2	86%	1.5	100%	1.7
Crisis Services	14%	0.2	86%	1.5	100%	1.7
Program for Assertive Community Treatment	95%	136.6	5%	6.9	100%	143.6
Crisis Services	95%	136.6	5%	6.9	100%	143.6
Volunteers of America Crisis Line	40%	2,809.7	60%	4,136.4	100%	6,946.1
Crisis Services	40%	2,809.7	60%	4,136.4	100%	6,946.1
(blank)	64%	1,142.8	36%	646.8	100%	1,789.7
Crisis Services	95%	11.9	5%	0.7	100%	12.5
Stabilization Services	64%	1,131.0	36%	646.2	100%	1,777.1
Grand Total	**69%**	**110,416.2**	**31%**	**48,778.7**	**100%**	**159,194.9**

Appendix, Section VI-02

admit_Hospital Compass - Mukilteo E&T

data snapshot 3/10/2015

E&T / year of admit	Medicaid Status Med	State	Grand Total
2012			
admit	250	211	461
admit %	54.23%	45.77%	100.00%
bed days	3,049	2,162	5,211
bed day %	58.51%	41.49%	100.00%
2013			
admit	206	200	406
admit %	50.74%	49.26%	100.00%
bed days	2,727	2,532	5,259
bed day %	51.85%	48.15%	100.00%
2014			
admit	210	121	331
admit %	63.44%	36.56%	100.00%
bed days	2,537	1,410	3,947
bed day %	64.28%	35.72%	100.00%
Total admit	**666**	**532**	**1198**
Total admit %	**55.59%**	**44.41%**	**100.00%**
Total bed days	**8,313**	**6,104**	**14,417**
Total bed day %	**57.66%**	**42.34%**	**100.00%**

		% of Population
Region 2012 Estimated population	1,139,625	100%
Dec 2013 Region Monthly Medicaid Eligible	147,000	12.9%
Jan 2015 Region Monthly Medicaid Eligible	231,515	20.3%
		7.4%

2015 Budget Estimates

	Fund	Program	Medicaid	State Funds	Total	
		Crisis Outreach				
1	Cap	Snohomish - Compass	623,928	280,308	904,236	69%/31%
2	Cap	Snohomish - Compass - Add	555,396	54,924	610,320	69%/31%
3	Cost	Snohomish - County ITA		2,014,068	2,014,068	100% state
4	Cap	Skagit - Compass	801,360	360,024	1,161,384	69%/31%
5	Cost	Skagit - Compass - Add	455,345	204,575	659,920	69%/31%
6	Cap	Whatcom - WCPC	689,844	309,924	999,768	69%/31%
7	Cost	Whatcom - WCPC - Add	516,432	232,020	748,452	69%/31%
8	Cap	Island County - Compass	369,732	166,116	535,848	69%/31%
10	Cap	San Juan - Compass	180,360	81,024	261,384	69%/31%
		Crisis Stabilization -				
11	Cap	Snohomish Stabilization	731,400	328,596	1,059,996	69%/31%
12	Cost	Snohomish Stabilization - Nursing	667,740	300,000	967,740	69%/31%
13	Cap	Skagit Stabilization	329,908	148,220	478,128	69%/31%
14	Cost	Skagit Stabilization - Nursing	667,740	300,000	967,740	69%/31%
15	Cap	Whatcom Stabilization	363,564	163,332	526,896	69%/31%
16	Cost	Whatcom Stabilization - Nursing	667,740	300,000	967,740	69%/31%
17	FFS	Inpatient Community Hospital	8,500,000	3,000,000	11,500,000	History
		Evaluation & Treatment				
18	Cap	Mukilteo	2,202,866	1,408,390	3,611,256	61%/39%
19	Cap	Sedro Woolley	2,804,356	1,792,916	4,597,272	61%/39%
20	Cost	Sedro Woolley Rent	88,824	56,796	145,620	61%/39%
21	Cost	VOA Crisis and Triage	863,025	387,736	1,250,761	69%/31%
22	Cap	Mobile Outreach - Whatcom	-	-	-	69%/31%
23	Cap	Mobile Outreach - Skagit	105,912	47,592	153,504	69%/31%
24	Mix	Transition Care Services	528,656			100% Med
25	Cost	Geriatric Outreach	618,840	279,000	897,840	69%/31%
		Child Outpatient				
26	FFS	Snohomish - CCS	1,079,352	105,816	1,185,168	91%/9%
27	FFS	Snohomish - Compass	3,134,856	304,980	3,439,836	91%/9%
28	FFS	Snohomish - Sea Mar	413,232	36,540	449,772	91%/9%
29	FFS	Snohomish - Center for HS	471,108	55,980	527,088	91%/9%
30	FFS	Snohomish - Northwest ESD	113,256	6,996	120,252	91%/9%
31	FFS	Whatcom - CCS	1,310,892	125,964	1,436,856	91%/9%
32	FFS	Whatcom - WCPC	421,476	34,344	455,820	91%/9%
33	FFS	Whatcom - Sea Mar	45,132	5,580	50,712	91%/9%
34	FFS	Whatcom - Northwest ESD	113,256	13,992	127,248	91%/9%
35	FFS	Skagit - Sea Mar	73,032	9,024	82,056	91%/9%
36	FFS	Skagit - Compass	428,436	41,016	469,452	91%/9%
37	FFS	Skagit - CCS	629,868	70,428	700,296	91%/9%
38	FFS	Skagit - Northwest ESD	129,672	13,992	143,664	91%/9%
39	FFS	Island - Compass	304,860	37,680	342,540	91%/9%
40	FFS	Island - Northwest ESD	183,876	6,996	190,872	91%/9%
41	FFS	Island - Sea Mar	23,160	2,280	25,440	91%/9%
42	FFS	San Juan - Compass	169,884	13,992	183,876	91%/9%
		Children's High Intensity (WISe or Wraparound)				
43	Cap	Snohomish - WRAP - Compass	1,468,800		1,468,800	100% Med
44	Cap	Whatcom - WRAP - CCS	1,142,400		1,142,400	100% Med
45	Cap	Skagit - WISe - CCS	979,200		979,200	100% Med
46	Mix	Island - IWRAP - Compass	122,400		122,400	100% Med
47	Mix	Island - WRAP - Compass	204,000		204,000	100% Med
48		WISE - expansion 88 slots	3,590,400			100% Med
49	Cost	Child Wrap/CHAP Respite Pool		5,000	5,000	100% state
		Adult Outpatient				
50	FFS	Snohomish - Compass	5,942,064	517,872	6,459,936	91%/9%
51	FFS	Snohomish - Sunrise	2,773,380	274,608	3,047,988	91%/9%
52	FFS	Snohomish - Sea Mar	1,135,884	68,448	1,204,332	91%/9%
53	FFS	Snohomish - Bridgeways	235,572	27,984	263,556	91%/9%
54	FFS	Whatcom - Interfaith	678,972	50,388	729,360	91%/9%
55	FFS	Whatcom - WCPC	2,804,496	248,436	3,052,932	91%/9%
56	FFS	Whatcom - Sea Mar	395,436	38,484	433,920	91%/9%
57	FFS	Whatcom - Lake Whatcom	986,484	93,360	1,079,844	91%/9%
58	FFS	Whatcom - Sunrise	339,768	41,976	381,744	91%/9%
59	FFS	Skagit - Sea Mar	299,100	23,244	322,344	91%/9%
60	FFS	Skagit - Sunrise	1,679,508	68,160	1,747,668	91%/9%
61	FFS	Skagit - Compass	1,611,660	190,296	1,801,956	91%/9%
62	FFS	Skagit - Bridgways	117,792	13,992	131,784	91%/9%
63	FFS	Island - Compass	884,280	75,180	959,460	91%/9%
64	FFS	Island - Sunrise	452,988	55,980	508,968	91%/9%
65	FFS	Island - Sea Mar	92,640	9,180	101,820	91%/9%
66	FFS	San Juan - Compass	244,152	28,692	272,844	91%/9%

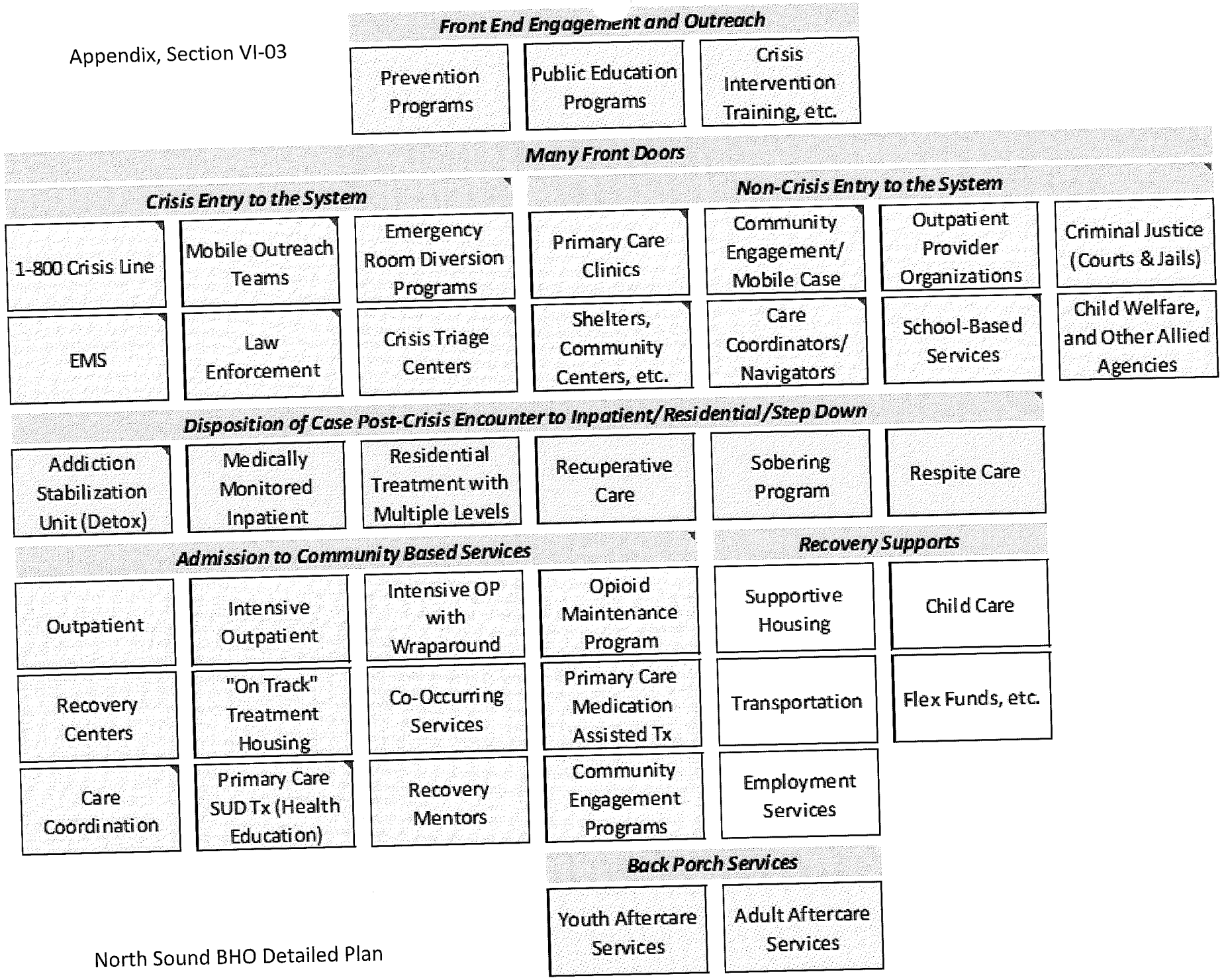
2015 Budget Estimates

		Adult IOP	-	-		
67	FFS	Snohomish - Compass	926,220	69,984	996,204	91%/9%
68	FFS	Snohomish - Sunrise	705,732	69,984	775,716	91%/9%
69	FFS	Snohomish - SeaMar	298,980	36,948	335,928	91%/9%
70	FFS	Whatcom - WCPC	378,840	33,456	412,296	91%/9%
71	FFS	Whatcom - Lake Whatcom	520,404	61,836	582,240	91%/9%
72	FFS	Skagit - Compass	447,984	50,916	498,900	91%/9%
73	FFS	Skagit - Sunrise	339,768	41,976	381,744	91%/9%
74	FFS	Island - Compass	216,300	26,736	243,036	91%/9%
		IDDT				
75	Cost	Skagit - Sunrise	240,120	107,880	348,000	91%/9%
76	FFS	Snohomish - Sunrise	450,000		450,000	100% Med
		Housing Support (Residential)				
77	Cap	Snohomish - Aurora	877,980	219,492	1,097,472	80%/20%
78	Cap	Snohomish - Haven	470,400	117,600	588,000	80%/20%
79	Cap	Snohomish - Green	763,956	193,152	957,108	80%/20%
80	Cap	Whatcom - Lake Whatcom	1,124,148	281,052	1,405,200	80%/20%
81	Cap	Discharge Housing - Sno Co - CH		31,800	31,800	100% State
82	Cap	Discharge Housing - Whatcom -LKW		36,000	36,000	100% State
		PACT				
83	Cost	Snohomish	1,305,648	129,132	1,434,780	91%9%
	Mix	Snohomish - Incentive	97,923	9,685	107,608	91%9%
84	Cost	Whatcom	797,160	78,840	876,000	91%9%
	Mix	Whatcom - Incentive	93,814	9,278	103,092	91%9%
85	Cost	Skagit	775,320	76,680	852,000	91%9%
	Mix	Skagit - Incentive	58,149	5,751	63,900	91%9%
		Peer Centers				
86	Cost	Snohomish - Compass		75,000	75,000	100% State
87	Cost	Whatcom - WCPC		75,000	75,000	100% State
88		Skagit - placeholder		75,000	75,000	100% State
89	Cap	San Juan Rate Premium Compass	90,516	10,380	100,896	% of fees
90	Cap	San Juan Subsidy - Compass Health		105,108	105,108	100% State
91	FFS	Out of Network Services	80,000	-	80,000	100% Med
92	Cap	Expanded Community Services		187,500	187,500	100% State
93	Cost	Information Services Subsidy	109,218	10,802	120,020	91%9%
		County Administration Funding				
94	Cost	Snohomish	1,025,148		1,025,148	100% Med
95	Cost	Skagit	228,492		228,492	100% Med
96	Cost	Whatcom	275,964		275,964	100% Med
97	Cost	Island	190,416		190,416	100% Med
98	Cost	San Juan	196,214	3,898	200,112	100% Med
99	Cost	Jail Funding		373,104	373,104	100% State
100	Cost	Interpreter Services	220,800	19,200	240,000	91%9%
101	Cost	North Sound RSN operations	4,290,790	424,364	4,715,154	91%9%
102	Cost	VOA Access Authorization	421,138	41,651	462,789	91%9%
103	Cost	VOA Inpatient Certification	785,771	77,714	863,485	91%9%
104	Case	Court Costs		750,000	750,000	100% State
105	Cost	Flex Funds		450,000	450,000	100% State
106	Cost	Ombuds	154,560	13,440	168,000	91%9%
107	FFS	Medicaid Personal Care		125,000	125,000	100% State
108	Cost	PATH Match and Additional Costs		202,851	202,851	100% State
109	Cost	Additional housing Services		490,440	490,440	100% State
		Total	$ 79,517,565	$ 20,131,071	$ 95,529,580	
		Estimated Revenue *	$ 71,938,525	$ 17,240,700	$ 89,179,225	
		Additional Revenue **	$ 3,940,866	$ 3,240,152	$ 7,181,018	
		Balance	$ (3,638,174)	$ 349,781	$ 830,663	

* Medicaid revenue estimated at lower rate range starting 7/1/15

* State revenue estimated at actual amount 7/1/14 to 6/30/15

** Additional revenue Medicaid WISe funds, State funds ESB5400 nursing, geriatric and HARPS


Front End Engagement and Outreach
Prevention Programs
Public Education Programs
Crisis Intervention Training, etc.
Many Front Doors
Crisis Entry to the System
1-800 Crisis Line
Mobile Outreach Teams
Emergency Room Diversion Programs
EMS
Law Enforcement
Crisis Triage Centers
Non-Crisis Entry to the System
Primary Care Clinics
Community Engagement/ Mobile Case
Outpatient Provider Organizations
Criminal Justice (Courts & Jails)
Shelters, Community Centers, etc.
Care Coordinators/ Navigators
School-Based Services
Child Welfare, and Other Allied Agencies
Disposition of Case Post-Crisis Encounter to Inpatient/Residential/Step Down
Addiction Stabilization Unit (Detox)
Medically Monitored Inpatient
Residential Treatment with Multiple Levels
Recuperative Care
Sobering Program
Respite Care
Admission to Community Based Services
Outpatient
Intensive Outpatient
Intensive OP with Wraparound
Recovery Centers
"On Track" Treatment Housing
Co-Occurring Services
Care Coordination
Primary Care SUD Tx (Health Education)
Recovery Mentors
Opioid Maintenance Program
Primary Care Medication Assisted Tx
Community Engagement Programs
Recovery Supports
Supportive Housing
Child Care
Transportation
Flex Funds, etc.
Employment Services
Back Porch Services
Youth Aftercare Services
Adult Aftercare Services

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 3000 – Fiscal: Third Party Resources Requirements

Authorizing Source:
Cancels:
See Also:
Responsible Staff: Fiscal Officer

Approved by: Executive Director
Motion #:

Date: 11/29/2005

POLICY #3044.00

SUBJECT: THIRD PARTY RESOURCES REQUIREMENTS

PURPOSE

To clarify how NSMHA complies with third-party liability requirements.

POLICY

NSMHA will comply with MHD contract requirements regarding the need to identify, pursue and record Third Party liability in accordance with Medicaid being the payer of last resort.

PROCEDURE

NSMHA will identify MHD contract requirements regarding the need to identify, pursue and record Third Party liability and include the requirements in its contracts with providers. NSMHA will monitor providers' compliance with these requirements during on-site reviews of provider agencies.

NSMHA will ensure that providers have adequate mechanisms at the point of initiation of service to determine whether third party liability exists. NSMHA will ensure that providers have adequate mechanisms in place during the course of client treatment to determine whether third party liability status has changed. NSMHA will ensure that providers have adequate billing and collection mechanisms for third party liability obligations. NSMHA will ensure that providers have adequate mechanisms for recording third party liability collections. Monitoring requirements are specified in Policy 5001.00, Administrative, Fiscal and Quality Assurance/Improvement Contract Compliance Monitoring.

NSMHA will ensure that it collects third party information from providers and properly reports the information on MHD Quarterly Reports.

ATTACHMENTS

None

Effective Date: 6/12/2014; 5/29/2009; 9/11/2008; 6/19/2008
Revised Date: 5/28/2014
Review Date: 6/11/2014

North Sound Mental Health Administration

Section 1500 – Clinical: State Only Funding Plan – Mental Health Services

Authorizing Source: SMH Contract; NSMHA
Cancels:
See Also:
Providers must "comply with" this policy and individualized implementation guidelines may be developed by CMHAs
Approved by: Executive Director: Date: 6/12/2014

Responsible Staff: Deputy Director

POLICY 1574.00

SUBJECT: STATE ONLY FUNDING PLAN – MENTAL HEALTH SERVICES

PURPOSE

To identify the individuals eligible for and services covered by State funds in the North Sound region. For individuals eligible for services covered by State funds and within available resources, this policy is also meant to ensure consistent application of standards region-wide for access to medically necessary outpatient mental health services.

POLICY

North Sound Mental Health Administration (NSMHA) utilizes State funds, as long as available, to provide services to specific populations of individuals with insufficient funding as well as pay for certain programs and services. The use of State funds may be revised as State funding availability changes. Any changes to these categories shall be effective immediately upon written notification.

NSMHA funds a variety of outpatient and inpatient services including the following with State funds:

A. Access and authorization
B. Court filing fees
C. Crisis Services including Mobile Outreach Teams
D. Evaluation & Treatment Facilities (E&Ts) including out of region E&T costs
E. Flex Funds
F. Inpatient Psychiatric Hospitalization costs
G. Involuntary Treatment Act (ITA) Services
H. Jail Services
I. Medicaid Personal Care
J. Ombuds Services
K. Out of Network Services
L. State Plan Outpatient Services to identified populations (see Procedure section below)
M. Peer Centers
N. Residential Room and Board costs

NSMHA shall allocate a proportionate and fixed amount of State funds to each Community Mental Health Agency (CMHA) on an annual basis to provide State Plan outpatient services to individuals with insufficient funding. Each CMHA is responsible for management of their allotted funds. If providers exceed their allotted amount, they run the risk of not receiving payment for services provided.

State funds payment by NSMHA for individuals receiving State Plan services shall be considered payment in full as long as they meet State funding qualifications, per State guidelines and this policy, and do not

have third party resources. Additionally, payments of State funds for individuals on a spenddown shall be considered qualifying medical expenses that have been paid on behalf of the individual by a publicly administered program per Washington Administrative Code (WAC) 182-519-0110(9).

Community Mental Health Agencies (CMHAs) shall work with individuals to apply for Washington Apple Health and/or meet their spenddowns. For individuals who are not eligible for Washington Apple Health, consideration shall be given to transitioning them to other programs/services.

PROCEDURE

State Plan Outpatient Services

The following populations of individuals are eligible for medically necessary, State Plan outpatient treatment services under State funding.

A. Individuals making a request for NSMHA initial authorization or reauthorization and individuals in a current NSMHA authorization period regardless of NSMHA outpatient episode status who are:

1. Discharging, or discharged within the past 30 days, from a Children's Long-Term Inpatient Program (CLIP) facility or Western State Hospital (WSH).
2. Currently on a Less Restrictive Alternative (LR) court order or Conditional Release (CR).

NSMHA-contracted Community Mental Health Agencies (CMHAs) shall serve the individuals identified in this section (A 1-2). It is NSMHA's expectation that State funds are prioritized for these individuals and that there are enough available resources to serve all individuals who meet one or both criteria. For initial and reauthorizations, NSMHA shall provide authorization for a period not to exceed 3 months*. For individuals in a current authorization, NSMHA shall allow for continuation of the current authorization for a period not to exceed 3 months*.

B. Individuals with a current NSMHA authorization ***and*** in a current NSMHA outpatient episode who:

1. Are funded by Washington Apple Health, but currently subject to a spenddown from the Department of Social and Health Services (DSHS).
2. Lose their Washington Apple Health coverage and do not fit any of the previously identified categories.

For individuals identified in this section (B 1-2), NSMHA shall allow for continuation of the current authorization for a period not to exceed 3 months from when Washington Apple Health is not active or end of the current authorization period, whichever is sooner*. Due to limited funding, individuals identified in this section are not eligible for initial authorization of outpatient services unless they qualify on some other basis. See below regarding the reauthorization process.

C. Individuals 18 and older, with an income up to 200% of the Federal Poverty Level, may be served in PACT (Program of Assertive Community Treatment) as long as they were in the

program as of October 7, 2011 and have not closed their PACT treatment episode since that time.

D. Individuals, in a current NSMHA outpatient episode or not, admitted to CLIP (Children's Long-Term Inpatient Program) facilities or WSH (Western State Hospital), returning to or entering NSMHA services upon discharge, and who are in need of care coordination from the CMHA to facilitate inpatient treatment and discharge planning.

    1. CMHAs should use the Rehabilitation Case Management CPT (Current Procedural Terminology/HCPCS [Healthcare Common Procedure Coding System]) code.

Reauthorization

A. NSMHA shall authorize eligible individuals for medically necessary, State-funded services for a period not to exceed 3 months per reauthorization*.

B. The determination whether to request reauthorization for an individual covered by State funding is the responsibility of the CMHA to be made in the context of medical necessity and availability of resources with the exception of individuals currently meeting one or both of the criteria in State Plan Outpatient Services – Section A above; a reauthorization is expected for these individuals.

    1. Examples of when it may be appropriate to request reauthorization may include, but not be limited to:

        i. Individual at imminent risk of psychiatric hospitalization.
        ii. Individual on a complex psychotropic medication regimen for which no prescriber outside the CMHA can be located.
        iii. Individual improving in intensive services, but who needs time to transition in to a lower level of care prior to discharge from treatment.

***Re/Authorization Limit Exceptions**

A. Providers may determine there are exceptional cases for which they want an authorization period longer than 3 months. This determination is left to the provider, but the rationale for the exception must be noted in the electronic authorization request in order for NSMHA to provide authorization for a period longer than 3 months.

B. For individuals who become State-funded during their authorization period, it is the responsibility of the CMHA to request termination of the authorization from NSMHA. For termination of an authorization, see the Change in Mental Health Coverage (Loss of Coverage/Change in Payer) section of NSMHA Policy 1505 Authorization for Ongoing Outpatient Services.

Transfers and Coordination of Care

A. For State-funded individuals where transfer or coordination of care with another CMHA is requested by the individual or appears clinically appropriate, the MHCP shall contact the second CMHA to determine if they have the funds to accept an individual covered by State funding.

    1. The MHCP shall have assisted the individual in attempting to obtain Washington Apple Health prior to transfer or coordinated of care whenever possible.

2. The MHCP shall give consideration to the length of the remaining authorization and need for continued services prior to initiating a transfer or coordination of care.
3. Refusal of transfer or coordinated services by a CMHA should be a rare occurrence. The CMHA initiating the transfer or coordinated services shall notify NSMHA when another CMHA refuses the request.

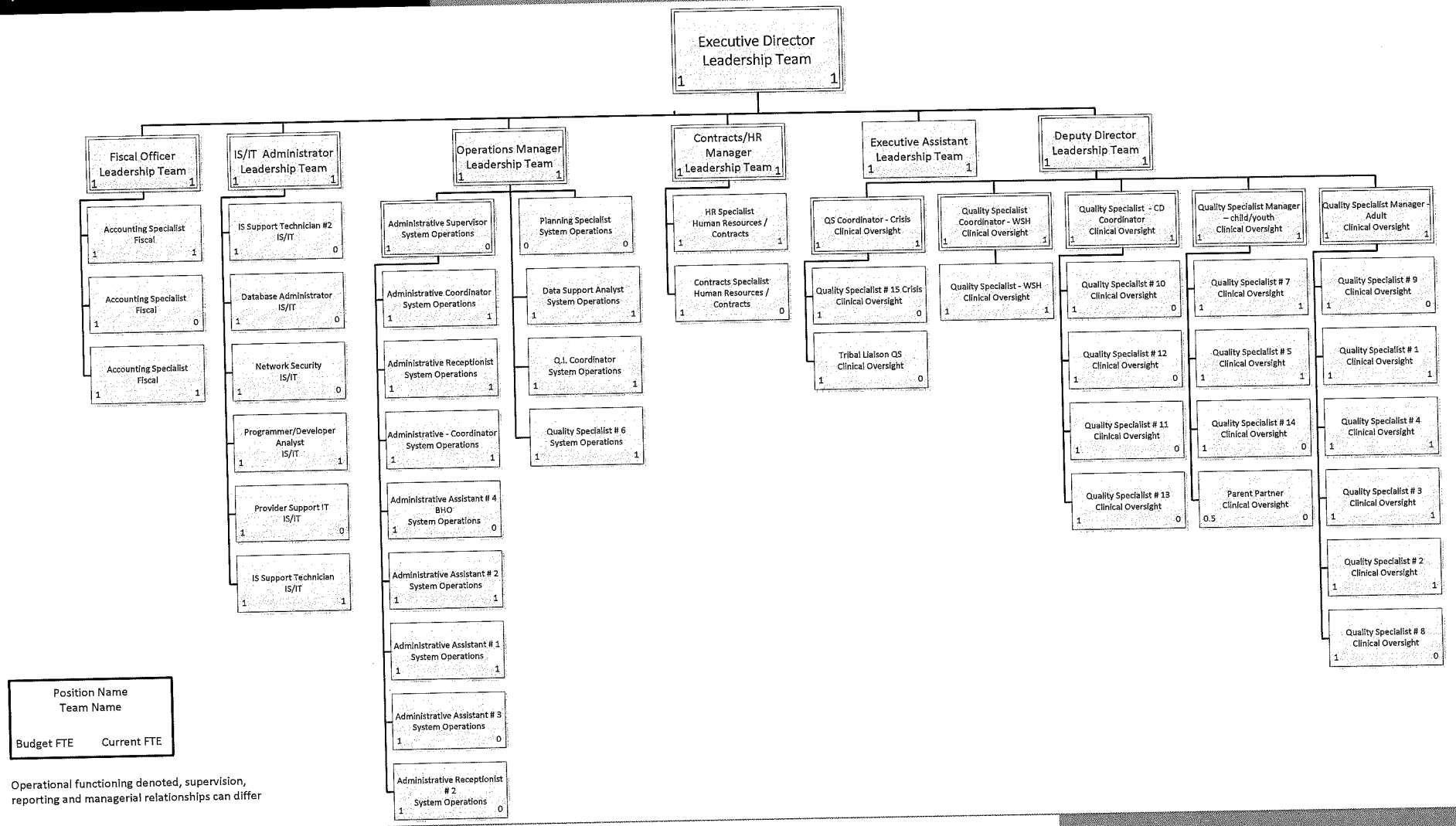
B. Transfers and coordination of care shall otherwise follow NSMHA Policy 1510.

ATTACHMENTS

None

September 28, 2015

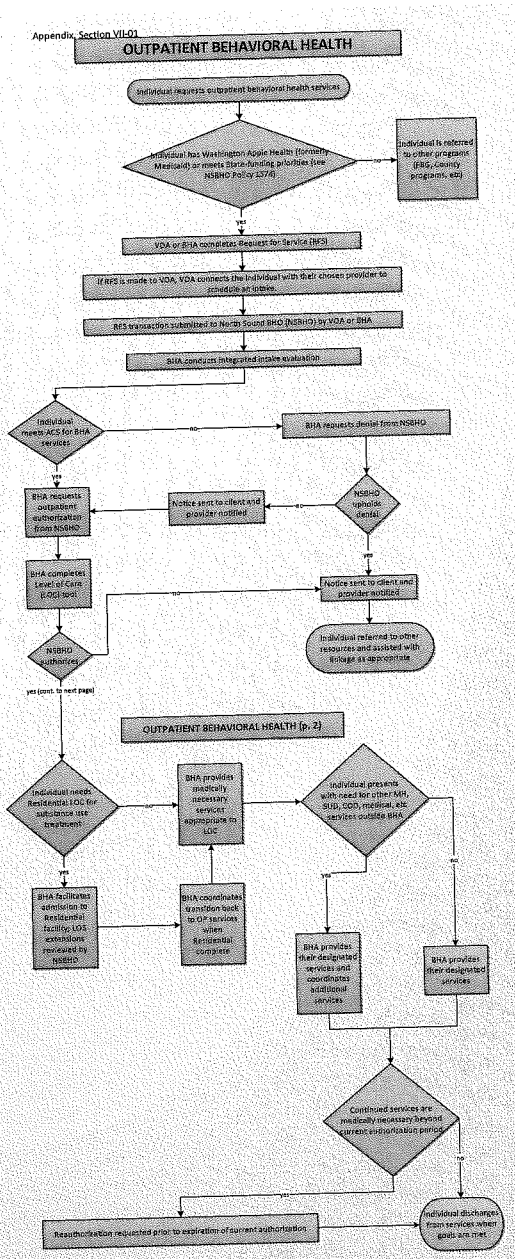
North Sound BHO Organization Chart



Position Name
Team Name

Budget FTE Current FTE

Operational functioning denoted, supervision, reporting and managerial relationships can differ


OUTPATIENT BEHAVIORAL HEALTH
Individual requests outpatient behavioral health services
Individual has Washington Apple Health (formerly Medicaid) or meets State-funding priorities (see NSBHO Policy 1374)
no
Individual is referred to other programs (FBG, county programs, etc)
yes
YDA or BHA completes Request for Service (RFS)
If RFS is made to YDA, YDA connects the individual with their chosen provider to schedule an intake.
RFS transaction submitted to North Sound BHO (NSBHO) by YDA or BHA
BHA conducts integrated intake evaluation
Individual meets ACS for BHA services
no
BHA requests denial from NSBHO
yes
BHA requests outpatient authorization from NSBHO
Notice sent to client and provider notified
no
NSBHO upholds denial
yes
BHA completes Level of Care (LOC) tool
Notice sent to client and provider notified
no
NSBHO authorizes
Individual referred to other resources and assisted with linkage as appropriate
yes (cont. to next page)
OUTPATIENT BEHAVIORAL HEALTH (p. 2)
Individual needs Residential LOC for substance use treatment
no
BHA provides medically necessary services appropriate to LOC
Individual presents with need for other MH, SUD, COD, medical, etc services outside BHA
yes
no
yes
BHA facilitates admission to Residential facility; LOS extensions reviewed by NSBHO
BHA coordinates transition back to OP services when residential complete
BHA provides their designated services and coordinates additional services
BHA provides their designated services
Continued services are medically necessary beyond current authorization period
no
yes
Reauthorization requested prior to expiration of current authorization
Individual discharges from services when goals are met

North Sound BHO

ASAM Levels of Care

LEVEL	LEVEL OF CARE PLACEMENT	DBHR SERVICE NAME
Level 0.5	Early Intervention	Early Intervention
Level 1	Outpatient Services	Outpatient Treatment
		Brief Outpatient Treatment
		Opiate Substitution Treatment
		Case Management
Level 2.1	Intensive Outpatient Services	Intensive Outpatient Treatment
		Case Management
Level 3.1	Clinically Managed Low Intensity Residential Services	Recovery House Residential Treatment
Level 3.2WM	Clinically Managed Residential Withdrawal Management	Sub-Acute Detoxification
Level 3.3	Clinically Managed Population Specific, High Intensity Residential Services	Long Term Care Residential Treatment
Level 3.5	Clinically Managed Medium Intensity Residential Services	Intensive Inpatient Residential Treatment
Level 3.7WM	Medically Monitored Residential Withdrawal Management	Acute Detoxification

NORTH SOUND
MENTAL HEALTH ADMINISTRATION

AGREEMENT
FOR THE
PROVISION OF
MEDICAID COVERED
MENTAL HEALTH SERVICES

WITH

COMPASS HEALTH

CONTRACT #NSMHA-COMPASS HEALTH-MEDICAID-13-15

OCTOBER 1, 2013 TO SEPTEMBER 30, 2015

TABLE OF CONTENTS

A. DEFINITIONS 6

B. COVERED LIVES AND BENEFITS PACKAGE

1. Enrollment 16
2. Benefit Package – Available to all Citizens in the North Sound Region 16
3. Inpatient Transition Care Services 22
4. Provision of Mental Health Services Pursuant to this Agreement 24

C. PERFORMANCE STANDARDS

1. General Operating Standards 25
2. Outpatient Initial Authorization and Continued Service Authorization 27
3. Outpatient Services and Medication Management 27
4. Specialized Outpatient/Residential Approval and Authorization 27
5. Intensive Outpatient Treatment – Adult 28
6. Medical Necessity and Second Opinion 28
7. Quality Clinical Care, Timely Access, Intake Evaluations and Individualized Resiliency Recovery Service Plans 28
8. Transition Age Youth 31
9. LOCUS/CALOCUS Level of Care Utilization System 32
10. EPSDT Requirements 32
11. Mental Health Care Providers (MHCP) 32
12. Allied System Coordination 33
13. Primary Care Coordination 33
14. Crisis Services Coordination and Cooperation 34
15. Complaint, Grievance, Appeal and Fair Hearing Processes 34
16. Local Responsiveness and Communications 34
17. Critical Incidents 35
18. Psychiatric Inpatient Services 35
19. Confidentiality 37
20. Performance Improvement and Regional Measures 38
21. Outcome Measures 38
22. Evidence-Based Practices 38
23. Trauma-Informed Care 39
24. Quality Management/Strategy 39
25. Coordination of Care Among Outpatient Providers 40
26. Coordination with Tribal Authorities 40

D. CONTRACTOR RESPONSIBILITIES

1. Community Mental Health Agency (CMHA) 41
2. Capacity 41
3. Access Standards 42

4. Distance Standards 43
5. Rural Access 43
6. Staff Competency and Training 43
7. Peer Employment 44
8. Residential Services 44
9. Resource and Utilization Management Activities 44
10. Management Information System 45
11. Medicaid Eligibility 45
12. NSMHA and DBHR Review Activities 45
13. Deliverables, Plans and Reports 45
14. Business Associates Agreement 45

E. FINANCIAL TERMS AND CONDITIONS 46
1. General Fiscal Assurances 46
2. Financial Accounting Requirements 46
3. Financial Reporting 46
4. County Funding 47
5. Rules Compliance 47
6. Liability for Payment and the Pursuit of Third Party Revenue 48
7. Financial Provisions - Reimbursement Requirements 48
8. Fraud and Abuse 50

F. OVERSIGHT, REMEDIES AND TERMINATION 50
1. Oversight Authority 50
2. Remedial Action 52
3. Additional Financial Penalties – DBHR Imposed Sanctions 52
4. Termination Due to Change in Funding 52
5. Termination Due to Change in 1915(B) Mental Health Services Waiver 52
6. Termination for Convenience 53
7. Termination for Default 53
8. Termination Procedure 54
9. Notice Requirements 56

G. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR 56
1. Background 56
2. Mutual Commitments 56
3. Assignment 56
4. Authority 56
5. Compliance with Applicable Laws, Regulations and Operational Policies 58
6. Compliance with NSMHA Operational Policies 59
7. Confidentiality of Personal Information 60
8. Contract Performance/Enforcement 60
9. Cooperation 61
10. Debarment Certification 61

11. Excluded Parties 61
12. Declaration that Clients Under the Medicaid and Other Mental Health Programs are not Third-Party Beneficiaries Under this Contract 62
13. Execution, Amendment and Waiver 62
14. Headings and Captions 62
15. Indemnification 63
16. Independent Contractor for NSMHA 63
17. Insurance 63
18. Integration 63
19. Maintenance of Records 64
20. No Waiver of Rights 64
21. Ongoing Services 64
22. Order of Precedence 64
23. Overpayments 65
24. Ownership of Materials 65
25. Performance 65
26. Resolution of Disputes 65
27. Severability and Conformity 66
28. Single Audit Act 66
29. Subcontracts 67
30. Survivability 67
31. Treatment Of Client Property 68
32. Warranties 68
33. Contract Administration 69

EXHIBITS AND ATTACHMENTS

Exhibit A – Access to Care Standards

Exhibit C – Data Security Requirements

Exhibit D – Mission Statement

Exhibit E – Program Integrity

Exhibit F – DSHS Admin Policy No. 7.21

Exhibit G – DSHS Admin Policy No. 7.01

Exhibit H – DSHS Admin Policy No. 7.20

Attachment I – Core Values and Principles

Attachment II – Contract Document links

Attachment III – DBHR-Contract link

Attachment IV – Deliverables

Attachment V – Business Associate Agreement

Attachment VI – Revenue and Expenditure Certification Report

Attachment VII – Ombuds Services

Attachment VIII – Budget

Attachment IX – SAMHSA'S 10 Components of Recovery

Attachment X – WA State Children's Mental Health System Principles and Core Practice Model

Attachment XI – Disclosure of or Change in Ownership and Control Interest Form

Attachment XII – Management Information System

AGREEMENT FOR THE PROVISION
OF
MEDICAID COVERED
MENTAL HEALTH SERVICES

THIS MENTAL HEALTH SERVICES AGREEMENT (the "Agreement"), pursuant to Chapter 71.24 RCW and all relevant and associated statutes, as amended, is made and entered into by and between the NORTH SOUND REGIONAL SUPPORT NETWORK, dba THE NORTH SOUND MENTAL HEALTH ADMINISTRATION ("NSMHA"), 117 N. 1st Street, Suite 8, Mount Vernon, Washington 98273, and COMPASS HEALTH ("Contractor") PO Box 3810, Everett, WA 98513-8810.

This Agreement incorporates the Exhibits and Attachments to the Agreement and other documents incorporated by reference.

The effective date of this Agreement is October 1, 2013, through September 30, 2015.

A. DEFINITIONS

7.01 Plan is NSMHA's Board approved plan, which outlines NSMHA's commitment to planning and service delivery for American Indian governments and communities.

Abuse means a provider's practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Access refers to the initial request for services and initial screening and the related response-time requirements.

Access to Care Standards (ACS) means the Division of Behavioral Health and Recovery (DBHR) minimum eligibility requirements for Medicaid adults & Medicaid older adults guidelines reflect the most restrictive eligibility criteria that can be applied. NSMHA may expand coverage based on availability of local resources.

Accessibility means the extent to which an eligible recipient can obtain available services. Accessibility includes both the ability to contact the organization and the availability of providers and services.

Accountability means responsibility of Contractor for achieving defined outcomes, goals, and contract obligations.

Act means the Social Security Act.

Action means in the case of a Prepaid Inpatient Health Plan (PIHP) service:

1. 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. Reduction, suspension, or termination of a previously authorized service;
3. Enrollee disagreement with a treatment plan (WAC 388-865-425 & 388-877-0620)
4. Denial in whole or in part, of payment for a service;
5. Failure to provide services in a timely manner, as defined by the state;
6. Failure of a PIHP to act within the timeframes provided in section 42 CFR 438(b).

Administrative Costs means costs for the general operation of the public mental health system. These activities cannot be identified with specific direct services or direct services support function as defined in the Budget, Accounting and Reporting System (BARS) supplemental instructions.

Advance Directive means a written document in which a principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both, and that is consistent with the provisions of Washington's Mental Health Advance Directive statute.

Agreement means this document, the General Terms and Conditions and Special Terms and Conditions, including any Exhibits and other documents attached or incorporated by reference.

Allied Systems means state or local services which provide individuals with assistance to reduce the impact of disabilities, functional impairments, or skill deficits, and which promote stable community living.

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

Appeal means a request for review of an action as "action" is defined above.

Appropriate means the extent to which a particular procedure, treatment, or service is clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to the needs of the recipient.

Arbitration means the process by which the parties to a dispute submit their differences to the judgment of an impartial person or group appointed by mutual consent or statutory provision.

Assessment means a process which provides sufficient information to determine medical necessity for mental health services covered under this Agreement.

Capitation Payment means a payment the Department of Social and Health Services (DSHS) makes monthly to a PIHP on behalf of each recipient enrolled under a contract for the provision of mental health services under the State Medicaid Plan. DBHR makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

Case Management means assistance to a recipient and family (or significant other) to obtain, maintain, or develop appropriate resources.

Center for Medicare and Medicaid Services (CMS) the US federal agency which administers Medicare, Medicaid and the Children's Health Insurance Program.

Children's Long-Term Inpatient Program (CLIP) means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from state-funded beds in CLIP.

Child Study and Treatment Center (CSTD) is DSHS's child psychiatric hospital.

Code of Federal Regulations (CFR) means all references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

Community Mental Health Agency (CMHA) means CMHA that is licensed by the State of Washington to provide mental health services and subcontracted to provide mental health services covered under this Agreement.

Community Support Services is all community-based, outpatient services. As defined in RCW 71.24.025(8) and WAC 388-865 and 388-877.

Complaint means a verbal or written statement by an enrollee that expresses dissatisfaction with some aspect of services covered under this Agreement.

Confidential Information means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential information includes, but is not limited to, personal information.

Consumer means an individual who has applied for, is eligible for, or who has received mental health services. For a child, under the age of 13, or for a child age 13 or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

Coordinated Quality Improvement Program (CQIP) the purpose of CQIP is to improve the quality of health care services by identifying and preventing health care malpractice under RCW 43.70.510.

Corrective Action/Compliance Review is when findings from a NSMHA/DBHR review or other monitoring efforts or audits show that there are apparent violations of this Agreement, Contractor shall implement corrective action within specified timeframes determined by NSMHA/DBHR/Department's other auditors.

Corrective Action Plan (CAP) is a written plan specifying what Contractor is required to do to be in compliance. This includes required improvements and a time line for such action(s) to be accomplished.

Crisis may be self-defined or a situation where an individual is acutely mentally ill, or experiencing serious disruption in cognitive, volitional, psychosocial, and/or neurophysiologic functioning.

Crisis Plan is a blueprint for action in the case of an individual (or child/family) who is experiencing imminent or substantial risk of harm to self/others or who is at risk of decompensating that could lead to future use of psychiatric inpatient services. Plans are developed in collaboration with the individual and natural supports.

Crisis Stabilization Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis.

Crisis Services means a face-to-face evaluation and treatment of mental health emergencies and crises to non-enrolled, as well as, enrolled individuals experiencing a crisis as defined by the WAC. Crisis services shall be available on a 24-hour basis with the goal of stabilizing the person in crisis and providing immediate or short-term treatment and support in the least restrictive environment available. Crisis services may be provided prior to an intake evaluation/assessment.

Cross-System Team meetings and consultations is participation and involvement with systems beyond the mental health system, which are also providing services to a mental health consumer, to assure communication and integrated, coordinated treatment planning and provision.

Cultural Competence means a set of congruent behaviors, attitudes and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

Day for the purposes of this Agreement means calendar days unless otherwise indicated in the Agreement.

Debarment means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

Deliverable means any written information required for submission to NSMHA to satisfy the work requirements of this Agreement and that are due by a particular date or on a regularly occurring schedule.

Denial is the decision by the PIHP, or formal designee, not to authorize a covered Medicaid mental health service that has been requested by a provider on behalf of an eligible Medicaid enrollee. It is also a denial if an intake is not provided upon request by a Medicaid enrollee.

Discharge Planning (Services) is the process of developing a care regimen and community integration plan for a mental health recipient leaving clinical care including appropriate residential treatment/housing supports, utilizing natural supports and community support services prior to the recipient leaving outpatient care.

Discharge Planning (Hospital) is the processes of developing a care regimen for an individual leaving inpatient care, including appropriate timing and follow-up appointments and treatment.

Discharge is (1) related to the end of an inpatient psychiatric hospital stay; (2) occurs when an eligible individual has completed an episode of care (or active service) and is no longer receiving services (i.e., closed).

Diversion means to redirect an individual from being placed in a restrictive setting (i.e., Jail, inpatient services) to clinically appropriate less restrictive alternative(s).

Early Periodic Screening Diagnosis and Treatment (EPSDT) is the program under Title XIX of the Social Security Act as amended for children/youth who have not reached their 21st birthday.

Emergent Care means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

Emerging Best-Practice or Promising-Practice means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice and is effective for the population.

Enrollee means a Medicaid recipient who is currently enrolled in a PIHP.

Evaluation and Treatment (E&T) Facility means a facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care and timely and appropriate inpatient care to persons suffering from a mental disorder and which is certified as such by DSHS.

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

Fair Hearing means a grievance hearing before Washington State Office of Administrative Hearings.

Family means

1. For adults, those the individual defines as family (i.e., guardians, siblings, caregivers and significant others)
2. For children, a child's biological parents, adoptive parents, foster parents, guardians, legal custodians authorized pursuant to Title 26 RCW; a relative with whom a child has been placed by DSHS or Tribe.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Full-Time Equivalent (FTE) is the term used to define number of full-time staff. One FTE shall be defined as 40 hours' work per week.

Geographic Area is NSMHA's Service Area consisting of the following geographic areas:

1. Island County
2. San Juan County
3. Skagit County
4. Snohomish County
5. Whatcom County

Grievance means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).

Health Insurance Portability and Accountability Act (HIPAA) of 1996 is codified in 42 USC §1320(d) et.seq. and CFR Parts 160, 162 and 164.

Individual Choice means the individual/child/families are guaranteed an opportunity to choose freely among treatment options and support services (based on identified needs) and to be full partners in the treatment process. "Choice" supports the notion that to the degree possible, individuals/children/families need to play a key role in designing their own service/support "packages", including involvement of natural supports and culturally specific services.

Involuntary Treatment Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05, 71.24.300 and 71.34.

Large Rural Area means areas with a population density of less than 20 people per square mile.

Local Funds Eligible for Match means sources of revenue that are eligible to be used as federal match are broad based taxes at the county or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Funds used for federal match under this Agreement may not be used as match for any other federal program. It can be local funds that have not been previously matched with federal funds at any point. Local funds do not include donations.

Medicaid Funds means funds provided by CMS Authority under Title XIX program of the Social Security Act.

Medicaid Waiver is a waiver granted by the Secretary of DSHS to requirements of 42 USC 1396a for the purpose of permitting DSHS/DBHR to operate a capitated managed care system to provide services to enrolled recipients of the Medicaid program. Under 42 USC 1396n, the Secretary is authorized to grant such waivers to the extent he/she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient and consistent with objectives of the Medicaid program.

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

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment/s and corresponding need/s must be the result of a mental illness. The interventions deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

Mental Disorder as defined in RCW 71.34.020(12) for children and RCW 71.05.020(2) for adults.

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

Office of Management and Budget (OMB) Circular A-133 means audits of States, Local Governments and Non-Profit Organizations.

Outcome means the results of a service period of treatment. The extents to which services are provided to individuals experiencing emotional and behavioral disorders have a positive or negative effect on their well-being, circumstances and capacity for self-management and recovery.

Outreach means a mental health service where individuals with severe and persistent mental illness or serious emotional disturbance are contacted in their place of residence or in non-traditional settings for the purpose of:

1. Improving their mental health, health, or social functioning; or
2. Increasing their utilization of human services and resources.

There are two basic approaches to outreach:

1. Mobile (going to an individual/family); and
2. Peer/Drop-in centers (i.e., shelters, clubhouses, kitchens, clothing banks).

Regardless of the approach, the outreach process has five (5) important components:

1. Locating individuals in need of services;
2. Engaging individuals into service;
3. Assessing their needs;
4. Linking individuals to an appropriate level of support services; and
5. Providing follow-up services.

Personal Information means information identifiable to any person including, but not limited to, information that relates to a person's name, health, finances, education , business , use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers and any financial identifiers.

Prepaid Inpatient Health Plan (PIHP) means an entity that provides or arranges for:

1. Mental health services to enrollees under contract with the state on the basis of prepaid capitation payments, or other payment arrangements that don't use state plan payment rates;
2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; or
3. Does not have a comprehensive risk contract.

Publish means an officially sanctioned document provided by NSMHA/DSHS Internet or Intranet websites for downloading, reading, or printing. Contractor shall be notified in writing or by e-mail when a document meets these criteria.

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

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

Quality Strategy means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.

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

Reduction means the decision by a PIHP to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. The clinical decision by a CMHA to decrease or change a covered service in an Individualized Service Plan (ISP) is not a reduction.

Rehabilitation means to restore to customary activity through education, skill building and therapy. Increase independence and ability to participate in life meaning activities.

Request for Service means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an enrollee or the person authorized to consent to treatment for that enrollee.

Reserve Accounts means an allocation of fund balance at the RSN set aside for a specific purpose by the RSN governing board or local legislative authority.

1. Operating Reserve – Funds designated from mental health revenue sources that are set aside into an operating reserve account by official action of the RSN's governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.
2. Inpatient-Risk Reserve – Funds designated from mental health revenue sources to pay for future inpatient hospital claims and funds designated from mental health revenue sources that are set aside into a risk reserve account by official action of the RSN's governing body. Risk reserve funds may only be set aside for use in the event costs of providing service exceed the revenue the RSN receives.

Residential Services are defined in WAC 388-865 and/or 388-877-0430, NSMHA Standards of Care and Clinical Eligibility Manual and NSMHA Policies and Procedures.

Resilience means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.

Risk means the possibility that Contractor may incur a loss because the cost of providing services may exceed the premium payments made by NSMHA to Contractor for services covered under this Agreement (42 CFR 434.2).

Routine Services means non-emergent and non-urgent services are offered within 14 calendar days to individuals authorized to receive services as defined in the access to care standards. Routine services are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health.

Subcontract means a separate agreement between Contractor and an individual or entity ("subcontractor") to perform all or a portion of the duties and obligations that Contractor shall perform pursuant to this Agreement.

Suspension means the decision by a PIHP or formal designee, to temporarily stop previously authorized Medicaid covered mental health services described in their Level of Care Guidelines. The clinical decision of a CMHA to temporarily stop or change a covered service in the Individualized Resiliency/Recovery Plan (IRP) is not a suspension.

Termination means the decision by a PIHP or their formal designee, to stop previously authorized covered by Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a CMHA to stop or change a covered service in the ISP is not a termination.

Title 42 is the CFR Public Health Service.

Title XIX is grants with states for Medical Assistance Program.

Title XIX Eligible Month means a calendar month in which an individual is eligible for the Title XIX program for any part of the month.

Title XXI is the State Children's Health Insurance Program.

Transition Youth means anyone age 16-21.

Underserved means persons who are minorities, children, elderly, disabled and low-income. See WAC 388-865-0150.

Urban Area means areas that have a population density of at least 500 people per square mile.

Urgent Care means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

Utilization Management Services means to provide independent utilization management process that monitors provider network to ensure services provided are sufficient, but not excessive, which are predicated on the individual needs of the recipient with respect to that person's age, culture, language and abilities.

Youth means anyone age 13-17 (13-20 if Medicaid).

B. COVERED LIVES AND BENEFITS PACKAGE

Contractor shall provide or purchase age, linguistic and culturally competent community mental health services for enrollees for whom services are medically necessary and clinically appropriate in accordance with the standards established herein.

1. ENROLLMENT

The following enrollees who reside within Contractor's service area are eligible for medically necessary mental health services provided under this contract.

Enrollees of all ages who reside within Contractor's service area who are enrolled in any of the programs included in the Federal 1915(b) Mental Health Waiver are covered by this Agreement, incorporated herein by reference.

a. Children and related poverty level populations (TANF/AFDC);
b. Adults and related poverty level populations, including pregnant women (TANF/AFDC) *except for those women who have a pregnancy-only Medicaid benefit;*
c. Blind/disabled children or adults and related populations (who qualify for SSI);
d. Aged and related populations;
e. Children in foster care;
f. Title XXI SCHIP children, targeted low income children who are eligible to participate in Medicaid;
g. Individuals with serious and persistent mental illness; and
h. Enrolled children with "D" coupons or other evidence of placement by DSHS, who currently reside in Contractor's service area without regard to the child's original residence.

2. BENEFIT PACKAGE – Available to all citizens in the North Sound Region

From the time mental health services are authorized, Contractor is responsible for providing uninterrupted linkage through a range of activities identified in the Medicaid State Plan that move an enrollee toward Resiliency and Recovery.

Contractor shall use the Mental Health Benefits Booklet published by DBHR as a mechanism by which enrollees are notified of their benefits, rights and responsibilities.

Contractor shall inform every enrollee at the time of an intake evaluation that the Mental Health Benefits Booklet published by DBHR shall be provided upon request. The booklet can be downloaded from: http://www.dshs.wa.gov/pdf/Publications/22-661.pdf.

Enrollees have access to the following benefits based on the Medicaid State Plan Services prior to an intake evaluation:

a. Crisis Services.
b. Freestanding Evaluation and Treatment.
c. Stabilization.
d. Rehabilitation Case Management as defined in the Medicaid State Plan.

All Medicaid enrollees with a mental health benefit requesting covered mental health services, who do not require urgent or emergent mental health services, must be offered an intake evaluation as defined in the Medicaid State Plan within 10 business days of the request for service. Authorization for further services will be performed in accordance with NSMHA policies and procedures.

A request for mental health services is defined as the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an enrolled individual or the person authorized to consent to treatment for that enrollee. For purposes of this Contract, an EPSDT referral is only a Request for Service when the enrollee or the person authorized to consent to treatment for that enrollee has confirmed that they are requesting services. Services must be provided based on the definitions provided below and in the Medicaid State Plan and the 1915(b) Waiver, or any successor. In addition to the services available prior to an intake evaluation, the following modalities must be provided if medical necessity and ACS are met:

a. Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long-term treatment to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused, or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's ISP must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self-care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional (MHP).
b. Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of an MHP.
c. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (i.e., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of

skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to individual ratio is no more than 1:20 and is provided by or under the supervision of an MHP in a location easily accessible to the client (i.e., CMHA, community centers). This service is available 5 hours per day, 5 days per week

d. Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid-enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and his/her family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in his/her ISP. This service is provided by or under the supervision of an MHP.

e. Group Treatment: Services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the ISP. Goals of Group Treatment may include: developing self-care and/or life skills enhancing interpersonal skills; mitigating the symptoms of mental illness and lessening the results of traumatic experiences; learning from the perspective and experiences of others and counseling/psychotherapy to establish and/or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of an MHP to two or more Medicaid-enrolled individuals at the same time. Staff to individual ratio is no more than 1:12. Maximum group size is 24.

f. High Intensity Treatment (HIT): Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individuals' needs. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for HIT include the reinforcement of safety, the promotion of stability and independence of the individual in the community and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, MHCP, under the supervision of an MHP, and other relevant persons as determined by the individual (i.e., family, guardian, friends and neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members' work together to provide intensive coordinated and integrated treatment as described in the ISP. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning shall be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the ISP or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to individual ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the MHP, MHCP and peer counselors.

*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

g. Individual Treatment Services: A set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her ISP. These services shall be congruent with the age, strengths and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of an MHP.

h. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within 10 working days of the request for services, establish the medical necessity for treatment and be completed within 30 working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by an MHP.

i. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists and/or case managers, but includes only minimal psychotherapy.

j. Medication Monitoring: Face-to-face, one-on-one cueing, observing and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to

facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of an MHP. Time spent with the enrollee is the only direct service billable component of this modality.

k. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non-hospital/non-IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than HIT. The MHCP is sited at the residential location (i.e., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care and medical services and differs for other services in the terms of location and duration.

l. Peer Support: Services provided by peer counselors to Medicaid-enrolled individuals under the consultation, facilitation, or supervision of an MHP who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills. Individuals actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, peer/drop-in centers and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where individuals are known to gather (i.e., churches, parks, community centers, etc.). Peer centers are required to maintain a log documenting identification of the individual including Medicaid eligibility.

Services provided by peer counselors to the individual are noted in the ISP which delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the ISP, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available to each enrollee for no more than four (4) hours per day. The ratio for this service is no more than 1:20.

m. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

n. Rehabilitation Case Management: A range of activities by the outpatient CMHA liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, maximize the benefits of the placement, minimize the risk of unplanned re-admission, and to increase the community tenure for the individual. Services are provided by or under the supervision of an MHP.

o. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

p. Stabilization Services: Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the MHP. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by an MHP to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

q. Therapeutic Psycho-education: Informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (i.e., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increase knowledge of mental illnesses and

understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the ISP.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the individual, by or under the supervision of an MHP. Classroom style teaching, family treatment and individual treatment are not billable components of this service.

3. INPATIENT TRANSITION CARE SERVICES

Contractor shall provide the staffing and resources to ensure individuals with Medicaid discharging from inpatient facilities, voluntary or involuntary, are provided a qualifying service within seven (7) calendar days of discharge. A list of qualifying services will be provided to Contractor on a monthly basis as part of the fee for service reconciliation.

Contractor and its subcontractor shall ensure staff is oriented to the philosophy and expectation of the transition care services. Staff shall have training regarding the recovery model and person-centered care, motivational interviewing, behavioral activation technique and co-occurring disorder.

Contractor shall provide transition care services and develop Memorandum of Understanding (MOU) with the following identified facilities:

a. Children's Hospital, Seattle, WA
b. Swedish Hospital, Edmonds, WA
c. Fairfax Hospital, Kirkland, WA
d. Mukilteo Evaluation and Treatment Center, Mukilteo, WA
e. Skagit Valley Hospital, Mt. Vernon, WA
f. St. Joseph's Hospital, Bellingham, WA

Outreach and marketing with the inpatient facilities shall be ongoing throughout the project's duration. Contractor shall engage the appropriate parties at the inpatient facilities to educate inpatient staff on the purpose and projected outcomes of the intervention strategies. Contractor will attend NSMHA inpatient meetings regularly and provide assistance to the facilities to ensure individuals being discharged have a qualifying service within seven (7)

calendar days. Contractor shall also be available to assist NSMHA and inpatient facilities on a case-by-case basis with facilitating the engagement of individuals who have a history of high utilization of inpatient and crisis services.

Contractor shall develop an MOU with the inpatient facilities listed above; primary components of the MOU shall be as follows:

a. Inpatient facility shall allow Contractor or its subcontractor access to individuals referred by NSMHA or its designee for the purpose of engagement;
b. Inpatient facility shall coordinate discharge planning with Contractor or its subcontractor program staff, within limits of applicable laws and regulations;
c. Inpatient facility shall inform Contractor or its subcontractor programs staff of any discharges identified by NSMHA or its designee as eligible for services;
d. Inpatient facility shall assist Contractor or its subcontractor staff in identifying the formal and natural supports currently involved, including providing contact information when available;
e. Inpatient facility shall identify individuals who might qualify for this intervention and work with NSMHA to provide referrals to Contractor or its subcontractor;
f. Inpatient facility shall retain all responsibility for comprehensive and appropriate discharge planning for the individual;
g. Inpatient facility shall orient Contractor or its subcontractor to the facility, explaining the process for access and discharge planning;
h. Contractor shall receive referrals from NSMHA or its designee of eligible individuals and will make contact with the inpatient facility to begin engagement efforts;
i. Contractor and its subcontractor will support the discharge planning process and assist in identifying resources and supports that may aid in the transition from the inpatient facility to a community setting;
j. Contractor and its subcontractor shall keep records of their interactions and efforts;
k. Contractor and its subcontractor shall provide its staff with tools and resources necessary to carry out assigned engagement tasks;

Contractor shall utilize certified peer counselors and/or individuals in the process of becoming certified as active, fully integrated team members. Peers will be cross-trained in all aspects of the program to include resource and referral, engagement activities, evidence-based clinical interventions and marketing.

Contractor shall begin engagement with individuals at the facility prior to discharge. Engagement shall be a process in which the transition team meets face-to-face with the individual to provide recovery support, education and available treatment options.

Contractor shall coordinate with all network providers to ensure a qualifying service takes place within seven (7) days with the agency the individual is enrolled or has chosen. If an individual is not currently enrolled with a network provider and is eligible for services, Contractor shall facilitate access to mental health services.

Contractor shall collaborate with the inpatient facility discharge planners to ensure the individual discharging has an appropriate plan that addresses their needs and provides the appropriate linkage to services upon discharge. Team member/s will support the individual at discharge to assure a face-to-face appointment takes place within seven (7) days.

Building relationships with the inpatient facilities is crucial to the support and effectiveness of the transition care service. Contractor shall make a good faith effort to build and maintain the relationships to effectively improve the outcomes of individuals being discharged from inpatient care.

Outcomes measures identified for this population are as follows:

a. A qualifying service occurs within seven (7) days of an inpatient discharge;
b. No psychiatric hospitalizations within 30 days of discharge from psychiatric inpatient; and
c. Engagement in ongoing mental health services.

The only outcome measure Contractor shall be accountable for during the pilot phase of this service is (a) a qualifying service within seven (7) days of inpatient discharge. All other outcomes will be monitored by NSMHA for improvement without incentive or penalty to Contractor.

4. PROVISION OF MENTAL HEALTH SERVICES PURSUANT to this AGREEMENT

Contractor shall provide the following service(s) as required in the provision of this Agreement in compliance with Attachment VIII and NSMHA Policy and Procedures.

a. Adult Outpatient and Medication Management;
b. Adult Intensive Outpatient;
c. Children's Outpatient and Medication Management;
d. Inpatient Care Transition;
e. Residential Services.

Contractor guarantees that NSMHA enrollees will have access to mental health and/or residential services provided throughout the term of the contract and/or within allowable resources.

C. PERFORMANCE STANDARDS

Contractor must ensure the provision or the purchase of medically necessary mental health services for all enrollees in accordance with Contractor's obligations under this Agreement. Implementation of changes in the Medicaid State Plan must be completed no later than 30 days following CMS approval of the State Plan.

1. GENERAL OPERATING STANDARDS

a. Contractor must provide medically necessary mental health services as defined in Outpatient Service Modalities outlined in section B.2 of this Agreement, the Medicaid State Plan and as defined in the 1915(b) Waiver, or its successor. If Contractor is unable to provide the services covered under this Agreement, the services must be purchased in a timely manner. Contractor must continue to pay for medically necessary mental health services outside the Service Area until Contractor is able to provide them within the Service Area.

b. Contractor must ensure that enrollees and enrollees' families participate in planning activities and participate in the implementation and evaluation of Contractor's clinical functions. Contractor must be able to demonstrate how this requirement is implemented.

c. Contractor will submit to an annual External Quality Review Organization (EQRO) monitoring review and work with the EQRO Contractor set forth by DSHS to schedule a time for the monitoring review that works best for both parties. In the event Contractor or any of Contractor's subcontractors do not provide ready access to any information or facilities for the EQRO monitoring review during the scheduled time, Contractor shall incur any costs for re-scheduling the EQRO Contractor to return and finish its review.

d. Contractor must ensure Healthy Options enrollees are not referred to a Healthy Options managed care plan if the enrollee is determined to be eligible for services based on medical necessity and the ACS.

e. Contractor must maintain a written Advance Directive policy and procedure that respects enrollees' advance directives for psychiatric care.

f. Contractor must ensure plans or reports required by this Agreement, including those outlined in Attachment IV, Deliverables, are provided to NSMHA in compliance with the timelines/formats indicated.

g. Contractor must participate in NSMHA/DBHR offered training when requested, including training on the implementation of Evidence-Based Practices, Emerging and Promising Practices.

h. Contractor shall encourage and promote Dignity and Respect throughout the system of care.

i. Contractor must ensure staff is familiar with SAMHSA's 10 Components of Recovery as outlined in Attachment IX.

j. Contractor shall incorporate Washington State Mental Health System Principles and Core Practice Model as guidelines for providing care to children, youth and their families as referenced in Attachment X.

k. Contractor shall provide customer service that is customer-friendly, flexible, proactive and responsive to individuals, families and stakeholders. Contractor shall provide a toll free number. A local telephone number may also be provided for those individuals within the local calling area

l. Contractor shall consult with NSMHA on the review of a minimum of two practice guidelines during the contract period and shall adopt and implement the practice guidelines, including training impacted staff on the use of the guidelines. In addition, Contractor participating in the implementation of a consistent Child and Family Team (CFT) protocol under the timelines and guidance published by DSHS.

m. Contractor shall make best efforts to provide written or oral notification within 15 working days of termination of a MHCP to enrollees currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.

n. Contractor must ensure benefits are provided in accordance with NSMHA's policies.

o. Contractor shall collaborate with NSMHA on development and implementation of Performance Improvement Projects (PIP) and Performance Measures during the term of this Agreement.

p. Contractor shall monitor enrollees discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320. Contractor shall offer covered mental health services to assist with compliance to the LRA conditions for individuals who meet medical necessity and access to care standards.

q. Contractor shall respond to requests for participation, implementation and monitoring of enrollees on Conditional Releases (CR) consistent under RCW 71.05.340 and 10.77.150. Contractor shall provide covered mental health services for individuals who meet medical necessity and ACS.

r. Contractor shall notify individuals in writing of changes in service, MHCP denials and/or changes, or termination in services in accordance with NSMHA policies and procedures.

s. Contractor shall ensure representative payee services are available for those who need them. When Contractor performs representative payee services, it shall charge no more than the maximum fee allowed by Social Security regulation and shall ensure that payee functions are independent from and do not have conflicts of interest with clinical service functions. Contractor shall maintain a list of the names and addresses of all known payee services available in the North Sound region, and shall ensure that before initiation of payee services, Contractor will provide the individual with a list. The form used by Contractor to enroll the individual in payee services shall require the individual to acknowledge receipt of the list.

t. Contractor shall collaboratively participate in NSMHA's regional coordination meetings, which currently include NSMHA's Ad Hoc Regional Integrated Provider, NSMHA's Quality Management Oversight Committee (QMOC), Regional ICRS Committee, subcommittees and work groups of these committees as necessary.

u. Contractor shall obtain written consent from the individual/family, in the event a picture or personal story will be used.

2. OUTPATIENT INITIAL AUTHORIZATION and CONTINUED SERVICE AUTHORIZATION

In accordance with NSMHA's operating policies, Contractor shall:

a. Implement operational policies, procedures and protocols that are consistent with NSMHA's operating policies and assure that they are consistently implemented.
b. When an individual meets the ACS, Exhibit A, they are authorized for outpatient services by NSMHA.
c. NSMHA shall notify Contractor in writing or through the Consumer Information System (CIS) of those authorized to receive Contractor services and will provide a contact person(s) for purposes of NSMHA service authorization. Contractor shall appoint a contact person to receive authorization notification.
d. If an expedited assessment is needed, it will be provided as rapidly as is medically necessary in accordance with NSMHA's Authorization and Assessments for Ongoing Services Policy and Procedure.
e. If Contractor believes medical necessity and ACS are not met, Contractor will send NSMHA clinical information necessary to allow NSMHA to make a determination of clinical eligibility.
f. If an individual is determined by NSMHA to not meet clinical eligibility requirements, NSMHA shall notify the individual of the decision with a Notice of Determination and/or Notice of Action and his/her rights to file a grievance.

3. OUTPATIENT SERVICES and MEDICATION MANAGEMENT

In accordance with NSMHA's operating policies, Contractor shall:

a. Provide the full range of outpatient mental health services described in section B.2. Outpatient Service Modalities, services must be available and provided based on the ACS, the individual's needs and medical necessity, per the policies and procedures.
b. Utilize Flex Funding in the amount specified in Attachment VIII and in accordance to NSMHA Policy and Procedure.
c. Submit a utilization plan for the use of flex funds; said plan shall be submitted on or before November 1, 2013.

4. SPECIALIZED OUTPATIENT/RESIDENTIAL APPROVAL AND AUTHORIZATION

In accordance with NSMHA's operating policies:

a. Authorization for Program for Assertive Community Treatment (PACT) shall be the responsibility of the Team Leader and NSMHA, any dispute will be mediated by NSMHA's Medical Director;
b. Authorization for specialty out-of-network services will be authorized and paid for by the Contractor. NSMHA shall authorize and pay for specialty out of network services outside the State of Washington and in other limited situations authorized by NSMHA. The arrangement and monitoring of all said services will be the responsibility of the Contractor. Contractor shall coordinate and provide updates to NSMHA upon request.

5. **INTENSIVE OUTPATIENT TREATMENT – ADULT**
Contractor shall comply with NSMHA's policies on Adult Intensive Outpatient Services.

Contractor shall ensure an individual requiring Intensive Outpatient services receive said services when medically necessary and when LOCUS/CALOCUS determine individual level of need.

Contractor shall demonstrate its performance of this function by the maintenance of written records that show routine review and discussion of service intensity.

6. **MEDICAL NECESSITY AND SECOND OPINION**
Contractor shall make the determination of medical necessity. Contractor shall ensure enrolled individuals have the right to a second opinion in accordance with NSMHA's Policy and Procedure. Contractor shall develop specific written procedures consistent with NSMHA's Second Opinion policy and notify NSMHA of any individual seeking a second opinion. Contractor shall be responsible for arranging and monitoring all second opinion services under this agreement.

7. **QUALITY CLINICAL CARE, TIMELY ACCESS, INTAKE EVALUATIONS AND INDIVIDUALIZED RESILIENCY RECOVERY SERVICE PLANS**
In addition to requirements listed elsewhere in the contract and in NSMHA Policy and Procedures, Contractor shall:

   a. Provide Medicaid individuals access to services upon request and ensure they are not placed on waiting lists nor refused any authorized services provided under this agreement.
   b. Not discriminate against enrolled individuals who are considered difficult to serve. Examples include: a refusal to treat an individual because the individual is deemed too dangerous, because housing is not available in the community, or that a particular type of residential placement is not currently available.
   c. If Contractor is unable to provide the services covered under this Agreement, the services must be purchased within 28 days for an enrolled individual with an identified need. Contractor must continue to pay for medically necessary mental health services outside the service area until Contractor is able to provide them within its service area, with the exception of specialized out-of-network services identified in section B.4 and NSMHA Policy and Procedure.
   d. Ensure medically necessary services are not contingent upon full completion of an intake evaluation.
   e. Not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.
   f. Ensure:

      i. A face-to-face Intake Assessment by an MHP is offered within 10 working days of the completed request for services.

ii. Maintain the ability to provide an intake evaluation in the individual's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to individuals being discharged from a state hospital or evaluation and treatment facilities to such placements when the individual requires an on-site service due to medical needs or lack of transportation.
iii. Co-Occurring Screening and Assessment initiated and completed in compliance with NSMHA's Co-occurring Screening and Assessment policy and procedure.
iv. Routine mental health services are offered to occur within 14 calendar days of a determination of medical necessity. The time from request for services to first routine appointment must not exceed 28 calendar days unless the CMHA documents a reason for the delay.
v. Emergent care occurs within two (2) hours.
vi. Urgent care occurs within 24 hours from the request for services.
vii. When services occur in the CMHA's office, wait time does not exceed one (1) hour beyond the time of the scheduled appointment.
viii. An appointment is offered to each individual for a face-to-face contact within seven (7) days of discharge from community inpatient care.
ix. Data/reports will be available to substantiate compliance with the above requirements as requested by NSMHA.

g. Ensure that each Medicaid individual (including parents/foster parents, assigned/appointed guardians of children and youth) is able to choose a participating CMHA and MHCP to comply with WAC 388-865-0345, or any successor, and in accordance with the approved Medicaid waiver or any successor. If the individual does not make a choice Volunteers of America (VOA) shall assign Contractor and Contractor shall assign the MHCP no later than 14 working days following the request for mental health services. Contractor shall allow a service recipient to change MHCP in the first 90 days of enrollment and once during a 12-month period for any reason. Any additional change of MHCP during the 12-month period may be made at the enrollee's request with justification that is documented by Contractor.
h. Ensure that children/foster children receive continuity of care (i.e., same case manager and/or therapist) including transition planning when changes in residential placements occur (i.e., in and out of home care, community placements including outside of Service Area) as requested by and negotiated with a Children's Administration social worker. In situations where the individual has been placed outside of the Service Area, Contractor is not required to take services to the new community and any necessary transportation of the individual is not the responsibility of Contractor. Transportation and service delivery may be negotiated with the Children's Administration social worker.
i. Ensure that services are available to eligible individuals within seven (7) days of receiving a copy of a Preadmission Screening and Annual Resident Review (PASARR) evaluation, which indicates a need for mental health services.
j. Ensure emergency requirements are met in accordance with 42 CFR.
k. Ensure prior authorization is not required for emergency services.

l. Access Services – In accordance with WAC 388-865-0415 and 388-877-0420, Contractor must document and otherwise ensure that eligible individuals have access to age and culturally competent services when and where those services are needed. They must:

i. Identify and reduce barriers to people getting the services where and when they need them.
ii. Comply with the Americans with Disabilities Act and Washington State Anti-discrimination Act, chapter 49.60 RCW.
iii. Ensure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the individual.
iv. Provide alternative service delivery models to make services available to underserved persons as defined in WAC 388-865-0150 and 388-877-420.
v. Provide access to telecommunication devices or services and certified interpreters for deaf or hearing-impaired individuals and limited English proficient individuals. Contractor shall maintain a log of interpreter and written translation requests.
vi. Bring services to the individual or locate services at sites where transportation is available to individuals.
vii. Ensure compliance with all state and federal nondiscrimination laws, rules and plans.

m. IRP – In accordance with WAC 388-865-0425, 388-877-620 and NSMHA policies, Contractor must provide individuals with a plan herein referenced IRP that meets the individual's unique needs. Individualized and tailored care is a planning process that may be used to develop a person -centered, and strength-based plan. The IRP must:

i. Be developed collaboratively with the individual and other people identified by the individual within 30 days of starting community support services. The IRP should be in language and terminology that is understandable to the individual and their family and include goals that are measurable.
ii. Individuals shall be actively involved in the development of their plans, advance directives for psychiatric care and crisis plans
iii. At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record, as part of the 180 day progress review, describing how the individual sees their progress. Contractor must be able to demonstrate how this requirement is implemented and monitored.
iv. The IRP identifies medical concerns and plans to address them.
v. Address age, cultural, or disability issues of the individual.
vi. Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, involving other systems when appropriate.

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

viii. Demonstrate that the provider has worked with the individual and others at the individual's request to determine his/her needs in the following life domains:

a) Housing;
b) Food;
c) Income;
d) Health and dental care;
e) Transportation;
f) Work, school or other daily activities;
g) Social life; and
h) Referral services and assistance in obtaining supportive services appropriate to treatment, such as substance abuse treatment.

n. Document review by the person developing the IRP and the individual. If the person developing the IRP is not an MHP, the plan must also document review by an MHP. If the person developing the plan is not a mental health specialist (MHS) required per WAC 388-865-405(5) and 388-877-0620 and is not supervised by an MHS then there must be documentation of a consultation with the appropriate MHS.

o. Document review and update at least every 180 days or more often at the request of the individual.

p. In the case of children:

i. The IRP must be integrated with the individual education plan from the education system whenever possible. When not possible, documentation must demonstrate attempts of integration and communication with the education system.

ii. If the child is under three, the plan must be integrated with the individualized family service plan (IFSP) if this exists, consistent with Title 20, Section 1436.

8. TRANSITION AGE YOUTH

Contractor shall maintain a process for addressing the needs of transition age youth (ages 16-21). The process must contain or address:

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

b. Individual mental health needs in the context of a transition age youth, which include supported transition to meaningful employment, post-secondary

education, technical training, housing, community supports, natural supports and cross-system coordination with other system providers.

c. For youth who require continued services in the adult mental health system, Contractor must identify transitional services that allow for consistent and coordinated services and supports for young people and their parents.
d. Developmentally and culturally appropriate adult services that are relevant to the individual or population.

9. LOCUS/CALOCUS LEVEL OF CARE UTILIZATION SYSTEM

Contractor shall comply with NSMHA's policy and procedure on LOCUS/CALOCUS Level of Care Utilization System.

Contractor shall ensure all children-adolescent and adult individuals eligible for services are given a complete clinical assessment using the LOCUS/CALOCUS tool.

Contractor shall comply with their NSMHA approved LOCUS/CALOCUS Training Plan and the strategies identified in efforts toward Inter-rater reliability. Data on Inter-rater reliability shall be submitted to NSMHA on a biannual basis. Contractor shall participate on efforts toward regional Inter-rater reliability standards, when requested

Contractor shall complete a LOCUS/CALOCUS on individuals at levels 1 and 2 annually and for levels 3 and above every six (6) months and/or when there is a significant life change.

10. EPSDT REQUIREMENTS

Contractor shall comply with NSMHA policy and Exhibit A on EPSDT requirements.

Contractor shall ensure children with multiple service needs who meet the requirements of EPSDT shall receive services that comply with NSMHA EPSDT policy and procedure.

Contractor must respond to referrals from primary medical care providers in accordance with NSMHA Policy and Procedure.

Contractor shall contact the enrollee within 10 working days of all EPSDT referrals to confirm whether services are being requested by the enrollee or the person authorized to consent to treatment for that enrollee. Contractor shall maintain documentation of its efforts to confirm whether the enrollee or the person authorized to consent to treatment for that enrollee requests, declines, or does not respond to efforts within 10 working days to confirm whether these services are being requested.

11. MENTAL HEALTH CARE PROVIDERS (MHCP)

Contractor shall ensure that MHP's and MHCP's have an effective method of communication with enrollees who have sensory impairments.

Contractor shall ensure that MHP's and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to:

a. Individual's mental health status.
b. Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally competent manner.
c. Any information the enrollee needs in order to decide among all relevant mental health treatment options.
d. Risks, benefits and consequences of mental health treatment (including the option of no mental health treatment).
e. Individual's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.
f. Individual's right to be treated with respect and with due consideration for his or her dignity and privacy.
g. Individual's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
h. Individual's right to request and receive a copy of his or her medical/clinical records and to request that they be amended or corrected, as specified in 45 CFR part 8 and WAC 388-877-650.
i. Individual's right to be free to exercise his/her rights and to ensure that to do so does not adversely affect the way NSMHA, Contractor, or MHCP treats the individual.

12. ALLIED SYSTEM COORDINATION

Contractor must comply with and at the request of NSMHA participate in the identification and development of Allied System Coordination plans. NSMHA's coordination plans with allied systems, includes, but is not limited to, Western State Hospital (WSH), Children's Administration (CA), Aging and Disability Services Administration (ADSA), Department of Alcohol and Substance Abuse (DASA), Criminal Justice System (CJS), Educational Service District (ESD), Federally Qualified Health Centers (FQHC), Juvenile Rehabilitation Administration (JRA), Community Integration Assistance Program (CIAP), Healthy Options Plans, Community Health Centers, and Department of Vocational Rehabilitation (DVR). The coordination plans are intended to enable coordination of services and appropriate management of care for individuals.

Contractor shall comply with published directives from DBHR when NSMHA, Contractor, or its subcontractors are unable to resolve local disputes with other service systems (Healthy Options, other DSHS administrations as provided by DBHR) regarding service or cost responsibilities.

13. PRIMARY CARE COORDINATION

Contractor must ensure that individuals with complex medical needs, who have no assigned Primary Care Provider (PCP), are assisted in obtaining a PCP. For individuals who already have

a PCP, Contractor must coordinate care as needed. Contractor must also ensure that coordination for those with complex medical needs is tracked through the treatment plan and progress notes

14. CRISIS SERVICES COORDINATION AND COOPERATION

Contractor shall coordinate and cooperate with providers in NSMHA's crisis service network to ensure the continuity of care.

Contractor shall develop protocols in collaboration with regional crisis service providers and NSMHA to utilize the Wraparound Team in the prevention and intervention with children/adolescents and families being served by a Wraparound team.

15. COMPLAINT, GRIEVANCE, APPEAL AND FAIR HEARING PROCESSES

Contractor must implement complaint, grievance, appeal and fair hearing processes that are in conformance with NSMHA policies and procedures.

Contractor and its subcontractors shall abide by NSMHA complaint, grievance, appeal and fair hearing determinations. Contractor shall be responsible for paying 100% of all Medical Director and/or Attorney fees incurred by NSMHA when an individual goes directly to a fair hearing without utilizing NSMHA's grievance processes and when the ruling favors the individual, in accordance with NSMHA policies and procedures.

In addition Contractor shall:

a. Implement a Grievance process that complies with 42 CFR §438.400, WAC 388-865 and 388-877 or any successors;
b. Coordinate with NSMHA grievance process and Ombuds Services;
c. Provide assistance to clients filing a grievance;
d. Provide access to interpreter services and toll free numbers with adequate TTY/TTD and interpreter capability;
e. Incorporate concerns from grievances into CMHA services without identifying individual clients.

16. LOCAL RESPONSIVENESS AND COMMUNICATIONS

Contractor shall cooperate with NSMHA and the Counties in the service area to provide a locally responsive delivery system.

Contractor shall provide enrollees with referral sources information and education about the referral process, service availability, service population, common symptoms of mental illness and shall post and make known consumer rights and responsibilities including complaint, grievance, appeal and fair hearing procedures and the availability of Ombuds services in a conspicuous manner with accessible placement.

Contractor will maintain written policies and procedures in accordance with NSMHA policies on enrollee communications and ensure that the provision of enrollee information complies with all requirements of 42 CFR §438.100, §438.6(i)(30) or any successors and is provided in the following prevalent languages: Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. Information on how to access the translated information must be provided prior to conducting the intake evaluation.

Contractor shall be able to demonstrate that its notification mechanisms are effective.

Contractor shall post, in a conspicuous place, a translated copy of the consumer rights as listed in the Mental Health Benefits Booklet in each of the DSHS prevalent languages. Access to translated copies may be downloaded at http://www.dshs.wa.gov/dbhr/pubs.shtml#dbhr.

Contractor will post the DBHR Benefits Booklet for Medicaid enrollees and will distribute copies at first request for services. Contractor will ensure that enrollees are informed of their right to request oral interpretation in any language and will provide oral interpretation in any language when requested by an enrollee.

Additionally, Contractor will provide:

a. General rights to the enrollee as specified in WAC 388-865-0410, 388-877-0600 and 42 CFR §438.100 or their successors.
b. Information about benefits and authorization requirements.
c. Information to enrollees, which clearly explains how the enrollee can request and be provided written materials in alternate formats. Information explaining to the enrollee how to access these materials must be provided prior to an intake evaluation.
d. Upon an enrollee's request:

    i. Identification of individual MHCP who are not accepting new enrollees.
    ii. CMHA licensure, certification and accreditation status.
    iii. Information that includes, but is not limited to: education, licensure and Board certification and/or re-certification of MHP's and MHCPs.

17. CRITICAL INCIDENTS

Contractor and its subcontractors shall comply with NSMHA's Critical Incident Reporting Policy and Procedure and any successor regarding critical incidents.

18. PSYCHIATRIC INPATIENT SERVICES

a. COMMUNITY HOSPITALS AND EVALUATION AND TREATMENT CENTERS (E&T)

Contractor shall adhere to the requirements set forth in NSMHA clinical policies and procedures and Community Psychiatric Inpatient Process, or any successors and:

i. Ensure when Contractor is notified of the hospitalization of an enrollee that contact with the community hospital or E&T staff occurs within three (3)

working days of an enrollee's admission to a community hospital or E&T. If Contractor is not notified of admission at the time the individual is admitted, they should attempt to make contact as soon as they are notified, in accordance with NSMHA's Clinical Eligibility and Care Standards and/or NSMHA clinical policies and procedures.

ii. Upon notification of the admission, the designated Contractor shall offer a non-crisis service to eligible individuals within five (5) business days/seven (7) calendar days post-discharge. The designated Contractor participates in treatment and discharge planning with the community hospital or E&T inpatient treatment team. If there is a dispute regarding the intake location, it will be brought by NSMHA Inpatient Certification designee to NSMHA for review and resolution.

iii. Contractor shall monitor enrolled individuals who meet medical necessity and ACS who are discharged from inpatient hospitalizations on an LRA under RCW 71.05.320. Contractor shall offer mental health services to assist with compliance with LRA requirements.

iv. Contractor shall respond to requests for participation, implementation and monitoring of enrolled individuals who meet medical necessity and ACS on CR's consistent with RCW 71.05.340. Contractor shall provide mental health services to assist with compliance with CR requirements.

v. Contractor shall ensure the provision of mental health services to enrolled individuals who meet medical necessity and ACS on a CR under RCW 10.77.150.

vi. Contractor shall use best efforts to secure an appointment, within 30 days of release from the facility, for medication, evaluation and prescription re-fills for enrolled individuals discharged from inpatient care, to ensure there is no lapse in prescribed medication. This may be arranged with providers other than Contractor.

vii. Contractor shall use best efforts to offer covered mental health services for follow-up and after-care as needed when Contractor is aware that an enrolled individual has been treated in an emergency room for a psychiatric condition. These services shall be offered in order to maintain the stability gained by the provision of emergency room services.

b. STATE HOSPITALS AND CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP)
Contractor shall:

i. Respond to state hospital census alert notifications by:

a) Demonstrating best efforts to divert state psychiatric hospital admissions.

b) Expediting individual discharges from the state psychiatric hospital using alternative community resources and mental health services. WSH Liaison will continue to consider resources on a region-wide basis when expediting discharges.

ii. Actively work with NSMHA's WSH liaisons and implement mechanisms that promote rapid and successful reintegration of individuals to the community from state psychiatric hospitals and CLIP programs.
iii. Comply with NSMHA WSH policies and procedures including those implementing NSMHA-WSH Working Agreement.
iv. Ensure a provision of an admission packet to the state hospital at the time of admission or at the time of transfer from community hospitals and/or evaluation and treatment facilities. Information provided as part of involuntary detention services need not be duplicated. Contractor must provide all available information related to payment resources and coverage.
v. For enrollees served through the CLIP facility Contractor shall:

a) Implement mechanisms that promote rapid and successful reintegration of enrollees back into the community from state psychiatric hospitals and CLIP placements.
b) Designate a MHCP, which has primary responsibility for coordination of the mental health aftercare services that are provided to the enrollee based on medical necessity. Services must be provided in collaboration with the state hospital treatment teams and in accordance with the ACS.
c) Contractor shall use best efforts to utilize community resources and covered mental health services to minimize State Hospital admissions.
d) Comply with NSMHA CLIP Policy and Procedure.

19. CONFIDENTIALITY

Contractor shall not use, publish, transfer, sell, or otherwise disclose any confidential information gained by reason of this Agreement for any purpose that is not directly connected with the performance of the services contemplated there under, except:

a. As provided in NSMHA policy and procedure; or
b. As provided by law;
c. In the case of personal information, as provided by law or with the prior written consent of the individual or personal representative of the person who is the subject of the personal information.
d. Contractor shall protect and maintain all confidential information gained by reason of this Agreement against unauthorized use, access, disclosure, modification or loss. This duty requires the parties to employ reasonable security measures, which include restricting access to the confidential information by:

i. Allowing access only to staff that have an authorized business requirement to view the confidential information.
ii. Physically securing any computers, documents, or other media containing the confidential information.

To the extent allowed by law, at the end of the Agreement term, or when no longer needed, the parties shall return Confidential Information or certify in writing the destruction of confidential information upon written request by the other party.

Paper documents with confidential information may be recycled through a contracted firm, provided the contract with the recycler specifies that the confidentiality of information will be protected, and the information destroyed through the recycling process. Paper documents containing confidential information requiring special handling (i.e., Protected Health Information) must be destroyed through shredding, pulping, or incineration.

The compromise or potential compromise of confidential information must be reported to NSMHA's Deputy Director within 5 business days of discovery for breaches of less than 500 persons' protected data, and 3 business days of discovery for breaches of over 500 persons' protected data. The parties must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law

20. PERFORMANCE IMPROVEMENT AND REGIONAL MEASURES

It is NSMHA's expectation that we will meet or exceed all appropriate statewide performance improvement projects and regional performance measures. Each of the performance indicators will be addressed in the 2012-15 NSMHA's Quality Management (QM)/Strategy Plan. In addition, Contractor shall develop a plan and submit it to NSMHA for approval within 90 days following the execution of this Agreement that addresses the action steps to be taken by Contractor that will assist in achieving the goals of the performance improvement projects and regional performance measures identified by NSMHA's QMOC and addressed in the Regional QM/Strategy plan. Upon request, Contractor shall submit relevant data/reports to NSMHA in the development and management of the identified performance projects and measures.

21. OUTCOME MEASURES

Contractor shall collaborate with NSMHA on identifying and incorporating outcome measurement tools used to measure an individual or group of individual's recovery and improved wellness.

Contractor shall participate in committees and/or workgroups to determine the target population and the measurement tool or tools to be implemented in the region during this contract cycle.

22. EVIDENCE-BASED PRACTICES

Contractor will participate with NSMHA/DSHS to increase the use of research and evidence-based practices, with a particular focus on increasing these practices for children and youth as identified through legislative mandates. This includes:

a. Participation in state-sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TFCBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence-based practices including

those for which state subsidy of training costs is not available. Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice.

b. Participation in state-sponsored efforts to ensure that the sites offering the TF-CBT/CBT+ evidence-based practice are operated as trauma-informed systems of care.
c. Participation in regional efforts to identify and promote evidence-based practices for adults.

23. TRAUMA-INFORMED CARE

A majority of the individuals in mental health services have experienced some form of trauma in their history. NSMHA, in collaboration with regional Contractors, shall create a trauma-informed system of care.

Contractor and NSMHA shall address the following over the course of this Agreement:

a. Develop/implement an organizational assessment tool;
b. Develop/implement a trauma screening tool;
c. Provide and participate in trauma-informed trainings.

24. QUALITY MANAGEMENT/STRATEGY

Contractor shall participate with NSMHA in the implementation, updates and evaluation of DBHR Quality Strategy located on DBHR website that is hereby incorporated by reference.

Contractor shall comply with NSMHA QM/Strategy Plan, or any successor, incorporated herein as Attachment II.

Contractor shall ensure its QM activities comply with all applicable law and standards including, but not limited to: WAC 388-865-0280-0425, 388-877-400,410 and NSMHA's QM Plan, NSMHA policies and procedures; or their successors. In addition:

a. Contractor shall maintain an ongoing, planned, systematic, organization wide QM process to design, measure, analyze and improve its performance, including identification of innovations or best practice.
b. Contractor QM plan and process, which shall be reviewed and updated by provider as needed but, at a minimum, every six (6)months, will be audited by NSMHA.
c. Contractor shall ensure Quality Assurance and Quality Improvement data is analyzed, reported and acted upon. This shall be demonstrated by written records maintained by Contractor.

Contractor shall present to NSMHA every six (6) months (March 31st and September 30th), a QM report integrating all quality improvement activities including NSMHA's performance projects and measures and data, in order to facilitate NSMHA's determination of the effectiveness of the overall regional system of care. This report shall be in a mutually agreed format and document the results of Contractor's QM plan activities and:

a. Identify areas of efficiency and effectiveness of system operations and the quality of care for individuals and/or families.
b. Identify areas of deficiency with plans to achieve expected improvement.
c. Status of implementation of all NSMHA approved corrective action plans.

25. COORDINATION OF CARE AMONG OUTPATIENT PROVIDERS

Contractor shall comply with NSMHA policy on care coordination. Contractor shall procure and maintain written Memorandums of Understanding (MOU), when necessary, with outpatient provider(s) to ensure an individual receives medically necessary services.

At a minimum, MOU must state the primary agency and methods of communiqué between agencies to ensure the individual is receiving coordinated care and monitoring.

MOU will clarify that if Contractor and the provider disagree about the medical necessity of the outpatient modality, the matter will be brought to NSMHA for resolution and NSMHA will make the final decision.

26. COORDINATION WITH TRIBAL AUTHORITIES

If an enrollee is a Tribal Member of a Washington Tribe and is referred to or presents for non-crisis services and the enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or NSMHA to assist in treatment planning and service provision for the enrollee. If the enrollee chooses to be served only by the Tribal Mental Health Service, Contractor will ensure the enrollee is referred to the appropriate Tribal Mental Health service provider.

D. CONTRACTOR RESPONSIBILITIES

Contractor shall have responsibility for the performance and responsibilities under this Agreement. Contractor shall include community and county input into planning and access to services. Contractor shall be held fully responsible for the contractual obligations and performance of its subcontractors. In the performance of these functions, Contractor shall maintain written documentation that verifies that each specific responsibility under this Agreement has been performed.

1. COMMUNITY MENTAL HEALTH AGENCY (CMHA)

a. Contractor meets the licensing requirements of WAC 388-865, 388-877; 388-877A and licensure has not been denied, revoked and/or suspended.

b. Contractor ensures it is an effective, efficient, adequate and accessible CMHA that is licensed/certified, monitored and capable of providing contracted services and able to demonstrate its ability to carry out the functions required by this Agreement.

c. Contractor shall cooperate with NSMHA's strategic plan and efforts to ensure a sufficient number, mix and geographic distribution of community mental health services, including MHCPs to meet the needs of the anticipated number of enrollees in the Service Area and provide:

   i. Access to an intake evaluation by an MHP.
   ii. An age-appropriate range of medically necessary mental health services as identified in the Medicaid state plan and 1915(b) Medicaid Waiver.
   iii. A geographic distribution and mix that allows for the access and travel standards, described below, to be met.

2. CAPACITY

a. Contractor must notify NSMHA in writing of any proposed change in capacity. NSMHA must approve any change that results in reduced capacity.

   i. A reduction in capacity is defined as the point in time when Contractor is not able to meet all the access standards as defined in this Agreement. Events that may affect capacity include: closing of a facility in any geographic area, a decrease in the state plan services currently available, decrease in the number or frequency of services, employee strike or other work stoppage related to union activities, or any change that may result in Contractor being unable to provide services for those enrollees who are covered by this Agreement.
   ii. Submit a report to NSMHA by November 1, 2013, with current capacity and submission biannually thereafter. Contractor shall notify NSMHA 30 days prior to implementation and/or public notice when Contractor adds, changes locations, or closes a facility and when the number of staff type/specialty changes at any CMHA facility by 5 staff or more. The report shall identify each Contractor facility location/address and the number and FTE of individuals providing direct services that are employed or contracted at each location by

type/WAC specialty and staff with specialized training/expertise in NSMHA identified treatments.

iii. The termination or addition of a subcontract that provides mental health services is considered a significant change. Contractor must notify NSMHA 30 days in advance of public written notice to enrollees before Contractor terminates any of its subcontracts with entities that provide direct service.

iv. Contractor must ensure the provision of written notification within 15 days to enrollees receiving services from the subcontractor upon written notification of termination by either party.

v. If either party must terminate a subcontract in less than 30 days, Contractor must notify NSMHA as soon as there is a determination to terminate the subcontract and in advance of public notice.

vi. If an event identified in section C.2 occurs, Contractor must submit a plan to NSMHA for enrollees and services that includes at least the following:

a) Notification to Ombuds services;
b) Crisis services plan;
c) Client notification plan;
d) Plan for provision of uninterrupted services;
e) Any information released to the media.

Contractor shall demonstrate its performance of this function by the maintenance of written records that show routine review and discussion of capacity issues by Contractor staff.

3. ACCESS STANDARDS

Ensure enrollees can access medically necessary mental health services upon request that do not exceed the access standards below.

a. A request for mental health services is defined as a point in time in which mental health services are sought or applied for through a telephone call, walk-in, or written request for mental health services.

b. Urgent and emergent medically necessary mental health services (i.e., crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment process. Contractor must ensure:

i. Urgent care occurs within 24 hours of the request for mental health services from any source.

ii. Emergent mental health care occurs within two (2) hours of the request for mental health services from any source.

c. Contractor shall demonstrate its performance of this function by the maintenance of written records that show routine review and discussion of access standard issues by Contractor staff.

4. DISTANCE STANDARDS

Ensure that when enrollees must travel to service sites, the sites are accessible per the following standards:

a. The drive time to the closest CMHA provider from the primary residence of the enrollee.
b. Travel standard does not apply: a) when the enrollee chooses to use service sites that require travel beyond the distance standards; b) when the service provided is at a level not available at the closest CMHA provider, such as crisis stabilization, services provided by PACT, or psychiatric inpatient services including E&T; c) under exceptional circumstances (i.e., inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, or delayed ferry service).

5. RURAL ACCESS

Contractor shall collaborate with NSMHA on increasing access to services in underserved areas of the region. Contractor will identify partnerships and collaborations in the rural communities to promote integration and expand service availability

Contractor shall provide the address of service for each encounter submitted through NSMHA's Consumer Information System (CIS).

6. STAFF COMPETENCY AND TRAINING

Contractor and its subcontractors shall comply with NSMHA credentialing policies and procedures and shall ensure that all staff is qualified for the position they hold and have at a minimum, the education, experience and skills to perform their job requirements, per WAC 388-865, 388-877-500-530 including any required licenses or certifications.

Contractor shall require a criminal history background check pursuant to RCW 43.43.830; 832; 834 and 43.20A.710 and WAC 388-877-0500 be completed for all current employees, volunteers and subcontractors and that a criminal history background check shall be initiated for all prospective employees, volunteers and subcontractors who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

Contractor shall collaborate with NSMHA to implement, maintain and revise the Regional Training Plan or any successor, incorporated as Attachment II.

Contractor must participate in training when requested by NSMHA/DBHR. Requests for NSMHA/DBHR to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to appropriate Contractor/subcontractor staff.

7. PEER EMPLOYMENT

NSMHA is promoting the increase of peer counselor employment throughout the North Sound Region. Peer Counselors with lived experience have the ability to provide a unique perspective and holistic approach to recovery. Their experience in managing symptoms and expertise in recovery strategies will provide individuals an opportunity to benefit from their experience.

As part of the regional strategy of increasing peer support throughout the region, Contractor shall work in partnership with NSMHA in the development of a peer workforce. NSMHA shall sponsor ongoing Peer Counselor training and continued education opportunities for certified peers. Contractor shall work with NSMHA to identify needs within the workforce and to identify individuals that are work ready and interested in becoming a Certified Peer Counselor. Contractor shall actively promote peer counselor training in coordination with NSMHA. Contractor shall offer pre-employment opportunities, such as volunteering, internships, on site observation and informal/formal introductory meetings with prospective peer counselors.

Contractor shall work with NSMHA to increase regional peer service encounters by 2% over the term of this Agreement.

8. RESIDENTIAL SERVICES

In accordance with NSMHA Policies and Procedures, Contractor shall ensure the following:

a. Provide timely access to Mental Health Outpatient Services or Intensive Outpatient Treatment when it is determined to be medically necessary to meet individual needs. Mental health outpatient services are provided principally under this agreement and/or with state funding, if resources allow.
b. Actively promote access and choice in safe and affordable independent housing.
c. Collaborate with NSMHA to develop additional capacity when resource and utilization processes indicate.
d. Demonstrate its performance of this function by the maintenance of written records that show routine review and discussion of residential service capacity issues by Contractor staff.

9. RESOURCE AND UTILIZATION MANAGEMENT ACTIVITIES

Contractor shall conduct resource and utilization management activities as requested by NSMHA to support NSMHA's resource and utilization management programs, after review and discussion between Contractor and NSMHA to ensure that such activities are reasonable and cost-effective. Such activities will include planning and reporting in a manner that will allow NSMHA to ensure that its resource and over and under-utilization management obligations are met.

10. MANAGEMENT INFORMATION SYSTEM

Contractor shall ensure the existence and operation of an electronic health record (EHR) that is compatible with NSMHA's CIS and has the capability to transmit data timely and accurately. Contractor shall develop and maintain an information system in comport with Exhibit C and Attachment XII, incorporated herein.

NSMHA will require Contractor to provide a Business Continuity and Disaster Recovery Plan (BCDRP) that insures timely reinstitution of the consumer information system following total loss of the primary system or a substantial loss of functionality Contractor must submit to NSMHA the most recent version of the BCDRP within 30 calendar days of execution of this agreement and within 30 calendar days of Contractor updating their BCDRP.

11. MEDICAID ELIGIBILITY

Contractor shall verify an individual's Medicaid eligibility at each appointment. For individuals not currently enrolled in Medicaid, Contractor shall refer individuals to the designated in-person assistor agency in their catchment area. Contractor shall act in accordance with NSMHA policy on Eligibility Verification herein incorporated by reference.

12. NSMHA AND DBHR REVIEW ACTIVITIES

Contractor shall ensure that remedial actions required as a result of NSMHA/DBHR review activities, as discussed in the Oversight, Remedies and Termination section, are reported and acted upon. This shall be demonstrated by written records maintained by Contractor.

13. DELIVERABLES, PLANS AND REPORTS

Contractor must ensure plans or reports required by this Agreement, including those outlined in Attachment IV, Deliverables, are provided to NSMHA in compliance with the timelines/formats indicated.

If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties Contractor may provide one report or deliverable that contains the information required by both Agreements.

14. BUSINESS ASSOCIATES AGREEMENT

Contractor shall abide by the provisions of NSMHA's and Contractor's Business Associates Agreement, Attachment V.

E. FINANCIAL TERMS AND CONDITIONS

1. GENERAL FISCAL ASSURANCES

Contractor shall comply with all applicable laws and standards, including Generally Accepted Accounting Principles and maintain, at a minimum, a financial management system that is a viable, single, integrated system with sufficient sophistication and capability to effectively and efficiently process, track and manage all fiscal matters and transactions.

2. FINANCIAL ACCOUNTING REQUIREMENTS

Contractor shall:

a. Establish and maintain operating reserves at prudent levels sufficient to ensure that Contractor has the ability to pay for all expenses incurred during this Agreement period, including those whose disposition occurs after the Agreement has been terminated and to cover the risk of financial loss resulting in the event that the cost of providing services pursuant to this Agreement exceeds the revenues derived there from.

b. Ensure that all NSMHA funds, including interest earned provided pursuant to this Agreement are used to support the public mental health system within the Service Area.

c. Contractor shall ensure that under no circumstances are individuals charged for any covered services, including those out-of-network services purchased on their behalf.

d. Contractor shall produce annual audited financial statements upon completion and make such reports available to NSMHA upon request.

3. FINANCIAL REPORTING

Contractor shall provide the following reports to NSMHA:

a. Report Contractor and subcontract revenue and expenditure information to NSMHA on a biannual basis. Reports must comply with the provisions in the BARS Supplemental Instructions for Mental Health Services promulgated by the Washington State Auditor's Office. Reports are due within 30 days of the quarter end (quarters ending in December and June of each year).

b. Contractor shall participate in NSMHA/DBHR Unit Cost Surveys and actuarial studies, when required by NSMHA/DBHR.

4. COUNTY FUNDING

Funds received by Contractor from any one or more of the Service Area's counties may not be used to provide Medicaid covered services to Medicaid enrollees.

5. RULES COMPLIANCE

Contractor shall:

a. Ensure that Medicaid enrollees are not held liable for any of the following:

i. Insolvent community psychiatric hospitals with which PIHP has directly contracted. PIHPs are specifically exempt from the requirements of 42 CFR §438 regarding solvency.

ii. Covered mental health services, including those purchased on behalf of the enrollee.

iii. Covered mental health services provided to the enrollee for which:

a) State does not pay Contractor.

b) Contractor does not pay MHCP or CMHA that furnishes the services under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the enrollee would owe if Contractor provided the services directly.

b. Submit the amount spent throughout the Service Area on specific items at the request of NSMHA, CMS, the legislature, or DSHS in the timeframe specified.

c. Account for public mental health expenditures under this Agreement in accordance with federal circular A-133, A-122, A-87 and state requirements in accordance with BARS Manual and BARS Supplemental Instructions or any successor.

d. Limit administration costs incurred by Contractor and all subcontractors to no more than 15% of the consideration provided under this contract in any state fiscal year. Administration costs must be measured on a state fiscal year basis according to the reported information submitted by Contractor in its Revenue Certification Report (Attachment VI) and reviewed by NSMHA.

6. LIABILITY FOR PAYMENT AND THE PURSUIT OF THIRD PARTY REVENUE

Contractor shall be responsible for developing financial processes that enable them to reasonably ensure that all third-party resources available to enrollees are identified and pursued in accordance with the reasonable collection practices, which Contractor applies to all other payers for services covered under this Agreement. Ensure a process is in place to demonstrate that all third-party resources are identified and pursued in accordance with Medicaid being the payer of last resort. NSMHA shall actively provide Contractor support in the pursuit of third-party payments for all services including crisis services.

Contractor shall maintain necessary records to document that all third-party resources and report to NSMHA on a biennial basis or upon the request of NSMHA, the amount of such third-party resources collected for all service recipients during the quarter, by source of payment.

7. FINANCIAL PROVISIONS - REIMBURSEMENT REQUIREMENTS

The consideration to be paid by NSMHA for the work to be provided by Contractor pursuant to this Agreement shall consist of the available amount from primary funding sources as described in Attachment VIII of this Agreement.

a. Contractor shall submit an invoice for capacity funded/cost reimbursement portions of this agreement on a monthly basis.
b. Contractor shall submit an invoice to NSMHA 15 days after the end of the month.
    i. Contractor shall submit encounter data per the MIS section on the fee for service portion of this agreement.
    ii. Contractor shall be paid on a daily rate for the following residential services:
        1. Aurora House individual daily rate of $136.22;
        2. Green House individual daily rate of $112.76; and
        3. Haven House individual daily rate of $87.31.
    iii. The payment will be adjusted to the encounters submitted;
    iv. The adjustment will calculated by a daily rate per individual per day during that month.

The consideration by NSMHA to Contractor pursuant to this Agreement shall be paid monthly within 15 working days of NSMHA's receipt of payment by DSHS/DBHR.

Funds for July 1, 2015, through September 30, 2015, following the end of the annual State legislative session, NSMHA shall offer an Amendment with the proposed funds for the next fiscal year. If for any reason Contractor does not agree to continue to provide services using the proposed funds, Contractor must provide the appropriate notice to NSMHA under the termination requirements of Section F.

8. FRAUD AND ABUSE

Contractor shall develop and implement administrative and management policy and procedures that are designed to guard against fraud and abuse including:

a. Comporting with Exhibit E of this Agreement
b. Mandatory compliance plan.
c. Designation of a compliance officer or compliance committee that is accountable to Contractor.
d. Effective ongoing training and education for compliance officer and Contractor staff.
e. Effective lines of communication between compliance officer, employees and subcontractors.
f. Enforcement of standards through well-publicized disciplinary guidelines.
g. Provision of internal monitoring and auditing.
h. Provision for prompt response to detected offenses and for development of corrective action initiatives.

i. Participation by Contractor and any subcontractors in Medicaid fraud and abuse training conducted by Washington State Attorney General's Medicaid Fraud Unit.
j. Written policies, procedures and standards of conduct that articulates Contractor's commitment to comply with all applicable Federal and State standards.

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

Complaints and reports should be directed to the contact listed below.

Compliance Officer
117 N First St., Ste. 8
Mt. Vernon, WA 98273
360.416.7013
1.800.684.3555
Compliance_officer@nsmha.org

F. OVERSIGHT, REMEDIES AND TERMINATION

1. OVERSIGHT AUTHORITY

NSMHA, DSHS, Office of the State Auditor, the Department of Health and Human Services (DHHS), CMS, the Comptroller General, or any of their duly-authorized representatives (i.e., EQRO) have the authority to conduct announced and unannounced: a) surveys, b) audits, c) reviews of compliance with licensing and certification requirements and compliance with this Agreement, d) audits regarding the quality, appropriateness and timeliness of mental health services of Contractor and subcontractors and e) audits and inspections of financial records of Contractor and subcontractors.

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

In addition, NSMHA will conduct reviews in accordance with its oversight of resource, utilization and quality management, as well as, ensure that Contractor has the clinical, administrative and fiscal structures to enable them to perform in accordance with the terms of the contract. Such reviews may include, but are not limited to, encounter data validation, utilization reviews, clinical record reviews, program integrity, administrative structures reviews, fiscal management and contract compliance. Reviews may include desk reviews, requiring Contractor to submit requested information. NSMHA will also review any activities delegated under this contract to Contractor.

Contractor shall cooperate with and allow access to North Sound Regional Ombuds in order to conduct surveys and review activities in accordance with the terms of this contract and in accordance with Attachment VII. Contractor shall cooperate with Community Action of Skagit County in resolving any disputes that arise in the provision of North Sound Regional Ombuds services.

Findings as a result of NSMHA conducted reviews may result in remedial action as outlined below. Federal and State agencies may impose remedial action or financial penalties either directly upon Contractor or through NSMHA. Contractor shall comply with the terms of such remedial action and be responsible for the payment of financial penalties.

2. REMEDIAL ACTION

NSMHA may require Contractor to plan and execute corrective action. Corrective action plans (CAP) developed by Contractor must be submitted for approval to NSMHA within 30 calendar days of notification. CAP must be provided in a format acceptable to NSMHA. NSMHA may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by NSMHA.

a. CAP must include:

   i. A brief description of the finding; and
   ii. Specific actions to be taken, a timetable, a description of the monitoring to be performed, the steps taken and responsible individuals that will reflect the resolution of the situation.

b. CAP may:

   Require modification of any policies or procedures by Contractor relating to the fulfillment of its obligations pursuant to this Agreement.

c. CAP are subject to approval by NSMHA, which may:

   i. Accept the plan as submitted;
   ii. Accept the plan with specified modifications;
   iii. Request a modified plan; or
   iv. Reject the plan.

d. Contractor agrees that NSMHA may initiate remedial action as outlined in subsection (e) below if NSMHA determines any of the following situations exist and except for instances described in subsection (d) (i), if corrective actions have not been completed within the timetable acceptable to NSMHA:

   i. If a problem exists that poses a threat to the health or safety of any person or poses a threat of property damage/an incident has occurred that resulted in injury or death to any person/resulted in damage to property.
   ii. Contractor has failed to perform any of the mental health services required in this Agreement, which includes the failure to maintain the required capacity as specified by NSMHA to ensure that enrolled individuals receive medically necessary services, including delegated functions; *except*, that no remedial action pursuant to subsection (e) hereof shall be taken if such failure to maintain required capacity is due to any interruption in, or depletion of, the available amount of money to Contractor as described in Attachment VIII of this contract for purposes of performing services to enrollees as described in Section B of this contract; however, in such an instance, NSMHA may terminate all or part of this contract on as little as 30 days written notice.
   iii. Contractor has failed to develop, produce and/or deliver to NSMHA any of the statements, reports, data, data corrections, accountings, claims and/or documentation described herein, in compliance with all the provisions of this Agreement.
   iv. Contractor has failed to perform any administrative function required under this Agreement, including delegated functions. For the purposes of this

section, "administrative function" is defined as any obligation other than the actual provision of mental health services.

v. Contractor has failed to implement corrective action required by the state and within NSMHA prescribed timeframes.

e. NSMHA may impose any of the following remedial actions in response to findings of situations as outlined above.

i. Withhold one percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. NSMHA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

ii. Compound withholdings identified above by an additional one-half of one percent for each successive month during which the remedial situation has not been resolved.

iii. Revoke delegation of any function delegated under this contract.

iv. Deny any incentive payment to which Contractor might otherwise have been entitled under this Agreement or any other arrangement by which DBHR provides incentives.

v. Termination for Default, as outlined in this Agreement.

3. ADDITIONAL FINANCIAL PENALTIES – DBHR IMPOSED SANCTIONS

Financial penalties imposed by DBHR or other regulatory agency due to the action or inaction of a Contractor may be paid by NSMHA on behalf of Contractor and the amount will be withheld from NSMHA's payments to Contractor.

4. TERMINATION DUE TO CHANGE IN FUNDING

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to its normal completion, either party may terminate this Agreement subject to re-negotiations.

5. TERMINATION DUE TO CHANGE IN 1915(B) MENTAL HEALTH SERVICES WAIVER

In the event that changes to the terms of 1915(b) (Medicaid) Mental Health Services Waiver render this Agreement invalid in any way after the effective date of this Agreement and prior to its normal completion, either party may terminate this Agreement subject to re-negotiation, if applicable, under those new special terms and conditions.

6. TERMINATION FOR CONVENIENCE

Except, as otherwise provided in this Agreement, NSMHA may terminate this Agreement in whole or in part for convenience by giving Contractor at least 30 calendar days' written notice. Contractor may terminate this Agreement for convenience by giving NSMHA at least 30 calendar days' written notice addressed to NSMHA's Program Administrator (or his/her successor) listed on the last page of this Agreement.

7. TERMINATION FOR DEFAULT

NSMHA's Program Administrator may terminate this Agreement for default, in whole or in part, by written notice to Contractor if NSMHA or DSHS has a reasonable basis to believe that Contractor has:

a. Failed to meet or maintain any requirement for contracting with NSMHA;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement; or
d. Otherwise breached any provision or condition of this Agreement.

Before the Program Administrator may terminate this Agreement for default, NSMHA shall provide Contractor with written notice of Contractor's noncompliance with this Agreement and provide Contractor a reasonable opportunity to correct noncompliance. If Contractor does not correct the noncompliance within the period of time specified in the written notice of noncompliance, the Program Administrator may then terminate this Agreement. The Program Administrator may terminate this Agreement for default without such written notice and without opportunity for correction if NSMHA has a reasonable basis to believe that a client's health or safety is in jeopardy, and/or:

a. Contractor has violated any law, regulation, rule, or ordinance applicable to services provided under this agreement.
b. Continuance of this Agreement with Contractor poses a material risk of injury or harm to any person.

Contractor may terminate this Agreement in whole or in part, by written notice to NSMHA in accordance with Section 7 above, if Contractor has a reasonable basis to believe that NSMHA has:

a. Failed to meet or maintain any requirement for contracting with Contractor;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to work performed under this Agreement; or
d. Otherwise breached any provision or condition of this Agreement.

8. TERMINATION PROCEDURE

The following provisions shall survive and be binding on the parties in the event this Agreement is terminated:

a. Contractor and any applicable subcontractors shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services. Each party shall be responsible only for its performance in accordance with the terms

of this Agreement rendered prior to the effective date of termination. Contractor and any applicable subcontractors shall assist in the orderly transfer/transition of the individuals served under this Agreement. Contractor and any applicable subcontractors shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

b. Contractor and any applicable subcontractors shall immediately deliver to NSMHA's Program Administrator or his/her successor, all DSHS and NSMHA assets (property) in Contractor and any applicable subcontractor's possession and any property produced under this Agreement. Contractor and any applicable subcontractors grants NSMHA/DSHS the right to enter upon Contractor and any applicable subcontractors premises for the sole purpose of recovering any NSMHA/DSHS property that Contractor and any applicable subcontractors fails to return within 10 working days of termination of this Agreement. Upon failure to return NSMHA/DSHS property within 10 working days of the termination of this Agreement, Contractor and any applicable subcontractors shall be charged with all reasonable costs of recovery, including transportation and attorney's fees. Contractor and any applicable subcontractors shall protect and preserve any property of NSMHA/DSHS that is in the possession of Contractor and any applicable subcontractors pending return to NSMHA/DSHS.

c. NSMHA shall be liable for and shall pay for only those services authorized and provided through the date of termination. NSMHA may pay an amount agreed to by the parties for partially completed work and services, if work products are useful to or usable by NSMHA.

d. If the Program Administrator terminates this Agreement for default, NSMHA may withhold a sum from the final payment to Contractor that NSMHA determines is necessary to protect NSMHA against loss or additional liability occasioned by the alleged default. NSMHA shall be entitled to all remedies available at law, in equity, or under this Agreement. If it is later determined that Contractor was not in default, or if Contractor terminated this Agreement for default, Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement.

e. Should the contract be terminated by either party, NSMHA will require the spend-down of all remaining reserves and fund balances within the termination period. Funds will be deducted from the final months' payments until reserves and fund balances are spent. Should the contract be terminated by either party, Contractor shall be responsible to provide all mental health services through the end of the month for which they have received payment.

9. NOTICE REQUIREMENTS

Either party to this Agreement must provide 180 days' notice of any issue that may cause the party to voluntarily terminate, refuse to renew, or refuse to sign a mandatory amendment to this Agreement.

a. If Contractor at any time decides it shall no longer be a Contractor with NSMHA for any reason, Contractor must provide NSMHA Program Administrator, or his/her successor, listed on the last page of this Agreement with written notice at least 90 days prior to

the effective date of termination and work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services. The transition plan shall address all issues leading to the transition of individuals in service and of all items/requirements of Contractor that extend beyond the termination of services.

b. NSMHA must provide Contractor's Program Administrator, or his/her successor, listed on the last page of this Agreement with written notice at least 90 days prior if NSMHA decides to voluntarily terminate, refuses to renew, or refuses to sign a mandatory amendment to this Agreement. Contractor shall work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services.

If Contractor terminates this Agreement or will not be entering into any subsequent Agreements, NSMHA shall require at least 90 days' written notice prior to the end of the contract if a decision is made not to enter into a subsequent agreement. Any funds not spent for the provision of services under this Agreement shall be returned to NSMHA within 60 days of the last day this Agreement is in effect.

G. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR

1. BACKGROUND

NSMHA is an entity formed by inter-local agreement between Island, San Juan, Skagit, Snohomish and Whatcom Counties, each county authority is recognized by the Secretary of DSHS ("Secretary"). These counties entered into an inter-local agreement to allow NSMHA to contract with the Secretary pursuant to RCW 71.24.025(13), to operate a single managed system of services for persons with mental illness living in the service area covered by Island, San Juan, Skagit, Snohomish and Whatcom Counties ("Service Area"). NSMHA is party to an interagency agreement with the Secretary, pursuant to which NSMHA has agreed to provide integrated community support, crisis response and inpatient management services to people needing such services in its Service Area. NSMHA, through this Agreement, is subcontracting with Contractor for the provision of specific mental health services as required by the agreement with the Secretary. Contractor, by signing this Agreement, attests that it is willing and able to provide such services in the Service Area.

2. MUTUAL COMMITMENTS

The parties to this Agreement are mutually committed to the development of an efficient, cost effective, integrated, person-centered, age specific recovery and resilience model approach to the delivery of quality community mental health services. To that end, the parties are mutually committed to maximizing the availability of resources to provide needed mental health services in the Service Area, maximizing the portion of those resources used for the provision of direct services and minimizing duplication of effort.

3. ASSIGNMENT

Except as otherwise provided within this Agreement, this Agreement may not be assigned, delegated, or transferred by Contractor without the express written consent of NSMHA, and any attempt to transfer or assign this Agreement without such consent shall be void. The terms "assigned", "delegated", or "transferred" shall include change of business structure to a limited liability company of any Contractor Member or Affiliate Agency.

4. AUTHORITY

Concurrent with the execution of this Agreement, Contractor shall furnish NSMHA with a copy of the explicit written authorization of its governing body to enter into this Agreement and accept the financial risk and responsibility to carry out all terms of this Agreement including the ability to pay for all expenses incurred during the contract period. Likewise, concurrent with the execution of this Agreement, NSMHA shall furnish Contractor with a written copy of the motion, resolution, or ordinance passed by NSMHA's Board authorizing NSMHA to execute this Agreement.

5. COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND OPERATIONAL POLICIES

Contractor and its subcontractors shall comply with all applicable federal and state statutes, regulations, and operational policies whether or not a specific citation is identified in various sections of this Agreement and all amendments thereto that are in effect when the

Agreement is signed, or that come into effect during the term of the Agreement, which may include, but are not limited to, the following ("Federal/State Law"):

a. Title XIX and Title XXI of the Social Security Act and Title 42 CFR.
b. All applicable Office of the Insurance Commissioner (OIC) statutes and regulations.
c. All local, State and Federal professional and facility licensing and certification requirements/standards that apply to services performed under the terms of this Agreement.
d. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738 and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS and the EPA.
e. Any applicable mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act.
f. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
g. Those specified in Title 18 RCW for professional licensing.
h. Reporting of abuse as required by RCW 26.44.030.
i. Industrial insurance coverage as required by Title 51 RCW.
j. RCW 38.52, 70.02, 71.05, 71.24, and 71.34.
k. WAC 388-865 and 388-877 and 388-877A.
l. Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not Contract with any subcontractor operating such a plan.
m. State of Washington Medicaid State Plan and 1915(b) Medicaid Mental Health Waiver or their successors, which documents are incorporated by reference.
n. DBHR Quality Strategy.
o. State of Washington mental health system mission statement, value statement and guiding principles for the system, attached hereto as Exhibit D.
p. State Medicaid Manual (SMM), OMB Circulars, BARS Manual and BARS Supplemental Mental Health Instructions.
q. Any applicable federal and state laws that pertain to Medicaid enrollee or consumer rights. Contractor shall ensure that its staff takes those rights into account when furnishing services to individuals.
r. DSHS Administrative policies, to the extent that they are applicable to this contract, which are attached as Exhibits F, G and H.
s. 42 USC 1320a-7 and 1320a-7b (Section 1128 and 1128(b) of the Social Security Act), which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit mental health services provided to individuals.
t. Any policies and procedures developed by DSHS/Health Care Authority which governs the spend-down of client assets.

u. Contractor and any subcontractors must comply with 42-USC 1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of Contractor, CMHA or subcontractor's equity, or an employee, Contractor, or consultant who is significant or material to the provision of services under this Agreement, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency.
v. Federal and State non-discrimination laws and regulations.
w. HIPAA (45 CFR parts 160-164).
x. DBHR-CIS Data Dictionary and its successors.
y. Federal funds must not be used for any lobbying activities.

If Contractor is in violation of a federal law or regulation, and Federal Financial Participation is recouped from NSMHA, Contractor shall reimburse the federal amount to NSMHA within 20 days of such recoupment.

Upon notification from DSHS, NSMHA shall notify Contractor in writing of changes/modifications in CMS policies and DSHS/DBHR contract requirement (Attachment III) changes.

6. COMPLIANCE WITH NSMHA OPERATIONAL POLICIES

Contractor shall comply with all NSMHA operational policies that pertain to the delivery of services under this Agreement that are in effect when the Agreement is signed or that come into effect during the term of the Agreement. NSMHA policies shall not exceed that required to implement federal and state requirements or to implement continuous quality improvement efforts determined by the Integrated QM Process as approved by NSMHA's Board. All proposed new policies shall specifically reference the federal or state requirements they implement and shall be limited to such requirements. NSMHA shall notify Contractor of any proposed change in federal or state requirements affecting this agreement immediately upon NSMHA receiving knowledge of such change. Such policies shall include, but not limited to:

a. NSMHA Core Values and Principles, attached hereto as Attachment I, provide a framework of principles for the regional system and Contractor shall take these principles into account when providing services under this Agreement.
b. Contractor and its subcontractors must recognize the unique social/legal status of Indian nations as required by both the Supremacy and Indian Commerce Clauses of the United States Constitution; federal treaties; executive orders; Indian Citizens Act of 1924 statutes; and state and federal court decisions; or any Memorandum of Agreement or MOU signed by State of Washington and a federally recognized tribe of recognized organization; shall maintain compliance with Exhibit G, DSHS Admin. Policy No. 7.01 American Indian Policy or any successor pursuant to the Centennial Accord between Washington State government and Washington Tribes; and maintain compliance with NSMHA 7.01 Plan, or any successor, incorporated as Attachment II.
c. NSMHA's Strategic Plan.

d. NSMHA's clinical policies and procedures, including crisis services policies.
e. NSMHA's medical records documentation and data reporting policies and procedures.
f. NSMHA's quality management/strategy plan.
g. NSMHA's consumer rights policies and procedures, including complaint, grievance, appeal and fair hearing policies.
h. Any other policies designated by NSMHA as applicable to Contractor.

Along with all NSMHA stakeholders, Contractor will be included in the process for developing relevant operational policies and procedures. NSMHA's policies and procedures are posted on NSMHA's website as indicated on Attachment II. NSMHA shall notify Contractor of new and revised policies through its Numbered Memoranda. Training will be provided on policies that impact providers, upon request.

In the event there is disagreement between NSMHA and Contractor in an operational committee regarding a proposed new policy or modification to a current policy, the following process will apply. NSMHA will provide a summary of the regulatory requirement or other rationale for the proposed policy or policy modification. Contractor will provide an analysis of its objection to the proposed policy or policy modification within 30 days from the receipt of NSMHA's summary. If the objection is primarily due to increased cost, Contractor will provide substantiation of the additional costs and, if possible, an alternative to achieving the policy goal in a less costly manner. The proposed policy or policy modification will be discussed at the next Regional Management Council. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next QMOC meeting. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next NSMHA's Board meeting.

NSMHA will make best efforts to maintain currency of policies with applicable Federal or State laws, regulations, or policies. In the event of a conflict, Federal or State Laws or policies supersede NSMHA policies and procedures and requirements of this contract.

7. CONFIDENTIALITY OF PERSONAL INFORMATION

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

a. Establishing eligibility;
b. Determining the amount of medical assistance;
c. Providing services for recipients;

d. Conducting or assisting in investigation, prosecution, or civil or criminal proceeding related to the administration of the plan;
e. Assuring compliance with Federal and State laws, regulations and with terms and requirements of this Agreement; and/or
f. Improving quality.

Contractor shall comply with all confidentiality requirements of HIPAA (45 CFR 160 and 164).

Contractor shall have a process in place to ensure that all components of its CMHA and system understand and comply with confidentiality requirements for publicly funded mental health services.

Contractor shall ensure that access to the information is restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of NSMHA and DSHS.

The parties acknowledge that coordination, planning, screening and referral require the sharing of information among the various treatment providers. Disclosure of information to verify eligibility, determine the amount of assistance and provide medically necessary mental health services are all "purposes directly connected with the administration of the Agreement", and are all appropriate justifications for sharing information.

Contractor shall assure that all staff and subcontractors providing services under this Agreement receive annual training on confidentiality policies and procedures. In addition, Contractor shall ensure that all staff and subcontractors providing services under this Agreement sign an annual Oath of Confidentiality statement. Signed copies of the Oath of Confidentiality shall be kept in Contractor's personnel files.

8. CONTRACT PERFORMANCE/ENFORCEMENT

NSMHA shall be vested with the rights of a third party beneficiary, including the "cut through" right to enforce performance should Contractor be unwilling or unable to enforce action on the part of its subcontractor(s). In the event that Contractor dissolves or otherwise discontinues operations, NSMHA may, at its sole option, assume the right to enforce the terms and conditions of this Agreement directly with subcontractors; provided NSMHA keeps Contractor reasonably informed concerning such enforcement. Contractor shall include this clause in its contracts with its subcontractors. In the event of the dissolution of Contractor, NSMHA's rights in indemnification shall survive.

9. COOPERATION

The parties to this Agreement shall cooperate in good faith to effectuate the terms and conditions of this Agreement.

10. DEBARMENT CERTIFICATION

Contractor certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any federal or state department or agency. If requested by DSHS or NSMHA, Contractor shall complete a certification regarding debarment, suspension, ineligibility, or voluntary exclusion. Any certification regarding debarment, suspension, ineligibility, or voluntary exclusion pertaining to this Agreement shall be incorporated into this Agreement by reference.

11. EXCLUDED PARTIES

Contractor is prohibited from paying with funds received under this Contract for goods and services furnished, ordered, or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 455.106, and 1001.1901(b)). Contractor shall:

a. Monitor for excluded individuals and entities as outlined in Exhibit E and by:
b. Screening Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract.
c. Screening monthly newly added Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.
d. Screening monthly Contractor and subcontractor's employees and individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

Report to NSMHA:

a. Any excluded individuals and entities discovered in the screening within 10 business days.
b. Any payments made by Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.
c. Any actions taken by Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.
d. Any Contractor and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 with 10 business days of Contractor becoming aware of the conviction.
e. Any subcontractor terminated for cause within 10 business days of the effective date of termination to include full details of the reason for termination.
f. Any Contractor and subcontractor's individuals and entities with an ownership or control interest.

Contractor must provide a list with details of ownership and control no later than 30 days from the date of ratification in comport with Attachment XI herein incorporated by reference. Contractor shall keep the list up-to-date thereafter.

Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

Contractor will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

Civil monetary penalties may be imposed against Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2)).

An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of five (5) percent or more, or are a managing employee (i.e., a general manager, business manager, administrator, or director) who exercises operational or managerial control or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR 455.104(a), and 1001.1001(a)(1)).

In addition, if NSMHA/DSHS notifies Contractor that an individual or entity is excluded from participation by DSHS in RSN's, Contractor shall terminate all beneficial, employment, contractual and control relationships with the excluded individual or entity immediately (WAC 388-502-0030 and 388-877-0500).

The list of excluded individuals will be found at: http://exclusions.oig.hhs.gov/

SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

12. DECLARATION THAT CLIENTS UNDER THE MEDICAID AND OTHER MENTAL HEALTH PROGRAMS ARE NOT THIRD-PARTY BENEFICIARIES UNDER THIS CONTRACT

Although NSMHA, Contractor and subcontractors mutually recognize that services under this Agreement may be provided by Contractor and subcontractors to clients under the Medicaid program, RCW 71.05 and 71.34 and the Community Mental Health Services Act, RCW 71.24, it is not the intention of either NSMHA or Contractor, that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement. Such third parties shall have no right to enforce this agreement.

13. EXECUTION, AMENDMENT AND WAIVER

This Agreement shall be binding on all parties only upon signature by authorized representatives of each party. This Agreement or any provision may be amended during the contract period, if circumstances warrant, by a written amendment executed by all parties. Only NSMHA's Program Administrator or designee has authority to waive any provision of this Agreement on behalf of NSMHA.

14. HEADINGS AND CAPTIONS

The headings and captions used in this Agreement are for reference and convenience only and in no way define, limit, or decide the scope or intent of any provisions or sections of this Agreement.

15. INDEMNIFICATION

Contractor shall be responsible for and shall indemnify and hold NSMHA harmless (including all costs and attorney fees) from all claims for personal injury, property damage and/or disclosure of confidential information and/or from the imposition of governmental fines or penalties resulting from the acts or omissions of Contractor and its subcontractors related to the performance of this contract. NSMHA shall be responsible and shall indemnify and hold Contractor harmless (including all costs and attorney fees) from all claims for personal injury, property damage and disclosure of confidential information and from the imposition of governmental fines or penalties resulting from the acts or omissions of NSMHA. For the purposes of these indemnifications, the Parties specifically and expressly waive any immunity granted under the Washington Industrial Insurance Act, Title 51 RCW. This waiver has been mutually negotiated and agreed to by the Parties. The provision of this section shall survive the expiration or termination of the Agreement.

16. INDEPENDENT CONTRACTOR FOR NSMHA

The parties intend that an independent contractor relationship be created by this contract. Contractor acknowledges that Contractor, its employees, or subcontractors are not officers, employees, or agents of NSMHA. Contractor shall not hold Contractor, Contractor's employees and subcontractors out as, nor claim status as, officers, employees, or agents of NSMHA. Contractor shall not claim for Contractor, Contractor's employees, or subcontractors any rights, privileges, or benefits which would accrue to an employee of NSMHA. Contractor shall indemnify and hold NSMHA harmless from all obligations to pay or withhold Federal or State taxes or contributions on behalf of Contractor, Contractor's employees and subcontractors unless specified in this Agreement.

17. INSURANCE

NSMHA certifies it is a member of Washington Governmental Entity Pool for all exposure to tort liability, general liability, property damage liability and vehicle liability, if applicable, as provided by RCW 43.19.

Contractor shall maintain Commercial General Liability Insurance (CGL). If Contractor is not a member of a risk pool, Contractor shall carry CGL to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000; shall include liability arising out of premises, operations, independent contractors, personal injury, advertising injury, and liability assumed under an insured contract. Contractor shall provide evidence of such insurance to NSMHA within 15 days of execution of this Agreement and 15 days post renewal date thereafter. All non-risk pool policies shall name NSMHA as a covered entity under said policy(s).

18. INTEGRATION

This Agreement, including Exhibits and Attachments contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

19. MAINTENANCE OF RECORDS

During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records set forth below is started before expiration of the six (6) year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the six (6) year period, whichever is later. Contractor shall maintain records sufficient to:

a. Maintain the content of all Medical Records in a manner consistent with utilization control requirements of 42 CFR 456, 434.34 (a), 456.111, and 456.211.
b. Document performance of all acts required by law, regulation, or this Agreement.
c. Substantiate Contractor statement of its organizations' structures, tax status, capabilities, and performance.
d. Demonstrate accounting procedures, practices, and records, which sufficiently and properly document Contractor invoices to NSMHA and all expenditures made by Contractor to perform as required by this Agreement.
e. Contractor and its subcontractors shall cooperate in all reviews including, but not limited to, surveys and research conducted by NSMHA, DSHS, or other Washington State Departments.
f. Evaluations shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services performed under this Agreement and to determine whether Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable state and federal regulations as existing or hereafter amended.

20. NO WAIVER OF RIGHTS

A failure by either party to exercise its rights under this Agreement shall not preclude that party from subsequent exercise of such rights and shall not constitute a waiver of any other rights under this Agreement unless stated to be such in writing signed by an authorized representative of the party and attached to the original Agreement.

Waiver of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent breach and shall not be construed to be a modification of the terms and conditions of this Agreement.

21. ONGOING SERVICES

Contractor and its subcontractors shall ensure that in the event of labor disputes or job actions, including work slowdowns, such as "sick outs", or other activities within its service CMHA network, uninterrupted services shall be available as required by the terms of this Agreement.

22. ORDER OF PRECEDENCE

In the event of an inconsistency in the terms of this Agreement or any inconsistency between the terms of this Agreement and any applicable statute, rule, or contract, unless otherwise provided herein, the conflict shall be resolved by giving precedence in the following order, to:

a. The applicable Medicaid 1915(b) Waiver, Provisions of Title XIX of the Social Security Act and Federal regulations concerning the operations of Prepaid Inpatient Health Plans.
b. State statutes and regulations concerning the operation of the community mental health programs.
c. Federal and State Law.
d. NSMHA-DSHS agreement or its successors, that covers the provision of the mental health services covered under this Agreement, which shall include any exhibit, document, or material incorporated by reference. NSMHA shall promptly notify Contractor of any amendment to NSMHA-DSHS agreement which affects any term or condition herein.
e. This Agreement.

23. OVERPAYMENTS

In the event Contractor fails to comply with any of the terms and conditions of this Agreement and that failure results in an overpayment, NSMHA may recover the amount due DSHS, CMS, or other federal or state agency subject to dispute resolution as set forth in the contract. In the case of overpayment, Contractor shall cooperate in the recoupment process and return to NSMHA the amount due upon demand.

24. OWNERSHIP OF MATERIALS

Materials created by Contractor and its subcontractors and paid for by NSMHA as a part of this Agreement shall be owned by NSMHA and shall be, "works for hire" as defined by the U.S. Copyright Act of 1976. This material includes, but is not limited to: books, computer programs, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes and/or training materials. Material which Contractor and its subcontractors use to perform this Agreement but which is not created for or paid for by NSMHA is owned by Contractor or relevant subcontractors; however, NSMHA and DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

25. PERFORMANCE

Contractor shall furnish the necessary personnel, materials/mental health services and otherwise do all things for, or incidental to, the performance of the work set forth here and as attached. Unless specifically stated, Contractor is responsible for performing or ensuring all fiscal and program responsibilities required in this contract. No subcontract will terminate the legal responsibility of Contractor to perform the terms of this Agreement.

26. RESOLUTION OF DISPUTES

The parties wish to provide for prompt, efficient, final, and binding resolution of disputes and controversies that may arise under this Agreement; therefore establish this dispute resolution procedure. All claims, disputes and other matters in question between the parties arising out of, or relating to, this Agreement shall be resolved exclusively by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

a. The parties shall use their best efforts to resolve issues prior to giving written Notice of Dispute.
b. Within 10 working days of receipt of the written Notice of Dispute, the parties (or a designated representative) shall together or, if both parties agree, with a mediator meet, confer, and attempt to resolve the claim within 5 working days.
c. The terms of the resolution of all claims concluded in meetings shall be memorialized in writing and signed by each party.

Arbitration: If the claim is not resolved within 30 days, the parties shall proceed to arbitration as follows:

a. Demand for arbitration shall be made in writing to the other party. The parties shall select one person as arbitrator.
b. If there is a delay of more than 10 days in the naming of the arbitrator, either party can ask the presiding judge of Skagit County to name the arbitrator.
c. The prevailing party shall be entitled to recover from the other party all costs and expenses, including reasonable attorney fees. The arbitrator shall determine which party, if any, is the prevailing party.
d. The parties agree that the arbitrator's decision shall be binding, final and enforceable subject to timely appeal to Skagit County Superior Court only as provided in Chapter 7.04A RCW.
e. Unless the parties agree in writing otherwise, the unresolved claims in each notice of dispute shall be considered at an arbitration session which shall occur in Skagit County no later than 30 days after the close of the meeting described in paragraph (b) above.
f. The Provisions of this section shall, with respect to any controversy or claim, survive the termination or expiration of this Agreement.
g. Nothing contained in this Agreement shall be deemed to give the arbitrator the power to change any of the terms and conditions of this Agreement in any way.
h. The prevailing party in any action to compel arbitration or to enforce an arbitration award shall be awarded its costs, including attorney fees. Venue for any such action is exclusively Skagit County Superior Court.
i. This Agreement shall be governed by laws of the State of Washington, both as to interpretation and performance.

27. SEVERABILITY AND CONFORMITY

The provisions of this Agreement are severable. If any provision of this Agreement, including any provision of any document incorporated by reference is held invalid by any court, that

invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

28. SINGLE AUDIT ACT

If Contractor or its subcontractor is a subrecipient of Federal awards as defined by OMB Circular A-133, Contractor and its subcontractors shall maintain records that identify all Federal funds received and expended. Such funds shall be identified by the appropriate OMB Catalog of Federal Domestic Assistance titles and numbers, award names and numbers, award years, if awards are for research and development, as well as names of the Federal agencies. Contractor and its subcontractors shall make Contractor and its subcontractors records available for review or audit by officials of the Federal awarding agency, the General Accounting Office, and DSHS. Contractor and its subcontractors shall incorporate OMB Circular A-133 audit requirements into all contracts between Contractor and its subcontractors who are sub recipients. Contractor and its subcontractors shall comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation.

If Contractor/subcontractors are a subrecipient and expends $500,000 or more in Federal awards from any/all sources in any fiscal year, Contractor and applicable subcontractors shall procure and pay for a single or program-specific audit for that fiscal year. Upon completion of each audit, Contractor and applicable subcontractors shall submit to NSMHA's Program Administrator the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide, if applicable and a copy of any management letters issued by the auditor.

For purposes of "subrecipient" status under the rules of OMB Circular A-133 205(i) Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part of the rule unless a State requires the fund to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.

29. SUBCONTRACTS

Contractor may subcontract services to be provided under this Agreement subject to the following requirements.

a. Contractor shall be responsible for the acts and omissions of any subcontractor.
b. Contractor must ensure that the subcontractor neither employs any person nor contracts with any person or CMHA excluded from participation in federal health care programs under either 42 USC 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions.
c. Contractor shall require subcontractors to comply with all applicable federal and state laws, regulations and operational policies as specified in this Agreement.

d. Contractor shall require subcontractors to comply with all applicable NSMHA operational policies as specified in this Agreement, including ACS, Exhibit A, distance standards and access standards.
e. Subcontracts for the provision of mental health services must require subcontractors to provide individuals access to translated information and interpreter services.
f. Contractor shall ensure a process is in place to demonstrate that all third-party resources are identified and pursued.
g. Contractor shall oversee, be accountable for and monitor all functions and responsibilities delegated to a subcontractor for conformance with any applicable statement of work in this agreement on an ongoing basis including written reviews.
h. Contractor will monitor performance of the subcontractors on an annual basis and notify NSMHA of any identified deficiencies or areas for improvement requiring corrective action by Contractor.
i. Contractor shall ensure that all subcontracts are in writing and that subcontracts specify all duties, reports and responsibilities delegated under this Agreement. Those written subcontracts shall:

    i. Require subcontractors to hold all necessary licenses, certifications/permits as required by law for the performance of the services to be performed under this Agreement.
    ii. Subcontracts must require subcontractors to notify Contractor in the event of a change in status of any required license or certification.
    iii. Include clear means to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.
    iv. Require that the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by Contractor, NSMHA/DBHR.
    v. Require best efforts to provide written or oral notification within 15 working days of termination of a MHCP to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the subcontractor.

30. SURVIVABILITY

The terms and conditions contained in this Agreement that by their sense and context are intended to survive the expiration of this Agreement shall so survive. Surviving terms include, but are not limited to: Order of Precedence, Contract Performance and Enforcement, Confidentiality of Client Information, Resolution of Disputes, Indemnification, Oversight Authority, Maintenance of Records and Ownership of Materials.

31. TREATMENT OF CLIENT PROPERTY

Unless otherwise provided in this Agreement, Contractor shall ensure that any adult individual receiving services from Contractor under this Agreement has unrestricted access to the individual's personal property. Contractor shall not interfere with any adult individual's

ownership, possession, or use of the individual's property unless clinically indicated. Contractor shall provide individuals under age 18 with reasonable access to their personal property that is appropriate to the individual's age, development and needs. Upon termination of this Agreement, Contractor shall immediately release to the individual and/or guardian or custodian all of the individual's personal property.

32. WARRANTIES

The parties' obligations are warranted and represented by each to be individually binding, for the benefit of the other party. Contractor warrants and represents that it is able to perform its obligations set forth in this Agreement and that such obligations are binding upon Contractor and other subcontractors for the benefit of NSMHA.

33. CONTRACT ADMINISTRATION

The Program Administrator for each of the parties shall be responsible for and shall be the contact person for all communications and billings regarding the performance of this Agreement.

The Program Administrator for NSMHA is:
Joe Valentine
Executive Director
North Sound Regional Support Network
117 N. 1st Street, Suite 8
Mount Vernon, WA 98273

The Program Administrator for Contractor is:
Tom Sebastian
Chief Executive Officer
PO Box 3810
Everett, WA 98213-8810

Changes shall be provided to the other party in writing within 10 working days.

THIS AGREEMENT, consisting of 70 Pages, plus Exhibits and Attachments, is executed by the persons signing below who warrant that they have the authority to execute this Agreement.

NORTH SOUND MENTAL HEALTH ADMINISTRATION	**CONTRACTOR**
Signature Date	Signature Date
Joe Valentine, Executive Director	Tom Sebastian, CEO
Name/Title	Name/Title

NORTH SOUND
MENTAL HEALTH ADMINISTRATION

STATE MENTAL HEALTH CONTRACT

WITH

COMPASS HEALTH

CONTRACT #NSMHA-COMPASS HEALTH-SMHC-13-15

OCTOBER 1, 2013 TO SEPTEMBER 30, 2015

TABLE OF CONTENTS

A. DEFINITIONS 6

B. STATE FUNDED SERVICES

1. Contracted Services 15
2. Core Services – Crisis Services 15
3. Medicaid Personal Care (MPC) 16
4. Psychiatric Inpatient Services 16
5. Expanded Community Services (ECS) 18
6. Residential Programs 19

C. SERVICES IN SUPPORT OF CORE SERVICES

1. Peer Support/Center 21
2. Inpatient Transition Care Services 23

D. PERFORMANCE STANDARDS

1. General Operating Standards 25
2. LOCUS/CALOCUS Level of Care Utilization System 26
3. Co-Occurring Disorder Screening and Assessment 26
4. Medical Necessity and Second Opinion 27
5. Outpatient Initial Authorization and Continued Service Authorization 27
7. Intensive Outpatient Treatment-Adult 27
8. Quality Clinical Care, Timely Access, Intake Evaluations and Individualized Resiliency/ Recovery Service Plans (IRSP) 28
9. Transition Age Youth 30
10. Allied Systems Coordination 31
11. Primary Care Coordination 31
12. Crisis Services Coordination and Cooperation 31
13. Disaster Response 31
14. Confidentiality 32
15. Complaint, Grievance, Appeal and Fair Hearing Processes 33
16. Local Responsiveness and Communications 33
17. Critical Incidents 33
18. Performance Improvement and Regional Measures 33
19. Outcome Measures 34
20. Evidence-Based Practices 34
21. Trauma-Informed Care 34
22. Quality Management/Strategy 34
23. Coordination of Care Among Outpatient Providers 35
24. Coordination with Tribal Authorities 35
25. DDD Enrolled Individuals 36

TABLE OF CONTENTS - cont.

E. CONTRACTOR RESPONSIBILITIES
1. Community Mental Health Agency (CMHA) 37
2. Capacity 37
3. Access Standards 38
4. Distance Standards 39
5. Rural Access 39
6. Staff Competency and Training 39
7. Peer Employment 40
8. Resource and Utilization Management Activities 40
9. Management Information System 40
10. Medicaid Eligibility 41
11. NSMHA and DBHR Review Activities 41
12. Deliverables, Plans and Reports 41
13. Business Associates Agreement 41

F. FINANCIAL TERMS AND CONDITIONS
1. General Fiscal Assurances 42
2. Financial Accounting Requirements 42
3. Financial Reporting 42
4. County Funding 43
5. Rules Compliance 43
6. Liability for Payment and the Pursuit of Third Party Revenue 43
7. Financial Provisions - Reimbursement Requirements 43
8. Fraud and Abuse 44

G. OVERSIGHT, REMEDIES AND TERMINATION
1. Oversight Authority 46
2. Remedial Action 46
3. Additional Financial Penalties – DBHR Imposed Sanctions 48
4. Termination Due to Change in Funding 48
5. Termination for Convenience 48
6. Termination for Default 48
7. Termination Procedure 49
8. Notice Requirements 50

H. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR
1. Background 51
2. Mutual Commitments 51
3. Assignment 51
4. Authority 51
5. Compliance with Applicable Laws, Regulations and Operational Policies 51
6. Compliance with NSMHA Operational Policies 53

TABLE OF CONTENTS - cont.

7. Confidentiality of Personal Information 54
8. Contract Performance/Enforcement 55
9. Cooperation 55
10. Debarment Certification 56
11. Declaration that Individuals Under the Medicaid and Other Mental Health Programs are not Third-Party Beneficiaries Under this Contract 56
12. Execution, Amendment and Waiver 56
13. Headings and Captions 56
14. Indemnification 56
15. Independent Contractor for NSMHA 57
16. Insurance 57
17. Integration 57
18. Maintenance of Records 57
19. No Waiver of Rights 58
20. Ongoing Services 58
21. Order of Precedence 58
22. Overpayments 59
23. Ownership of Materials 59
24. Performance 59
25. Resolution of Disputes 59
26. Severability and Conformity 60
27. Single Audit Act 60
28. Subcontracts 61
29. Survivability 62
30. Treatment of Individual Property 62
31. Warranties 62
32. Contract Administration 62

EXHIBITS AND ATTACHMENTS

Exhibit C – Data Security Requirements

Exhibit D – Mission Statement

Exhibit F – DSHS Admin Policy No. 7.21

Exhibit G – DSHS Admin Policy No. 07.01

Exhibit H – DSHS Admin Policy No. 07.20

Attachment I – Core Values and Principles

Attachment II – Contract Document links

Attachment III – DBHR-Contract – link

Attachment IV – Deliverables

Attachment V – Business Associate Agreement

Attachment VI – Revenue and Expenditure-Certification Report

Attachment VII – Ombuds Services

Attachment VIII – Budget

Attachment IX – SAMHSA's 10 Components of Recovery

Attachment X – ICRS Services

Attachment XI – ICRS Cooperation Agreement

Attachment XII – Management Information System

Attachment XIII – WA State Children's Mental Health System Principles and Core Practice Model

AGREEMENT FOR THE PROVISION
OF
STATE FUNDED
MENTAL HEALTH SERVICES

THIS MENTAL HEALTH SERVICES AGREEMENT (the "Agreement"), pursuant to Chapter 71.24 RCW and all relevant and associated statutes, as amended, is made and entered into by and between the NORTH SOUND REGIONAL SUPPORT NETWORK, dba THE NORTH SOUND MENTAL HEALTH ADMINISTRATION ("NSMHA"), 117 North 1st Street, Suite 8, Mount Vernon, Washington 98273, and COMPASS HEALTH ("Contractor") PO Box 3810, Everett, WA 98213-8810.

This Agreement incorporates the Exhibits and Attachments to the Agreement and other documents incorporated by reference.

The effective date of this Agreement is October 1, 2013, through September 30, 2015.

A. DEFINITIONS

7.01 Plan is NSMHA's Board approved plan, which outlines NSMHA's commitment to planning and service delivery for American Indian governments and communities.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for health care.

Access refers to the initial request for services and initial screening and related response time requirements.

Accessibility means the extent to which an eligible recipient can obtain available services. Accessibility includes both the ability to contact the organization and availability of providers and services.

Accountability means responsibility of Contractor for achieving defined outcomes, goals and contract obligations.

Administrative Costs means costs for the general operation of the public mental health system. These activities cannot be identified with specific direct services or direct services support function.

Advance Directive means a written document in which a principal makes a declaration of instructions, preferences, or appoints an agent to make decisions on behalf of the principal regarding their mental health treatment, or both and is consistent with the provisions of Washington's Mental Health Advance Directive statute.

Allied Systems means State or local services which provide individuals with assistance to reduce the impact of disabilities, functional impairments, or skill deficits and promote stable community living.

Ancillary Crisis Services means costs associated with providing medically necessary crisis services which cannot be covered under the Medicaid State Plan including, but not limited to, the cost of room and board for individuals in hospital diversion beds.

Annual Revenue means all revenue received by the Regional Support Network (RSN) pursuant to the Agreement for July of any year through June of the next year.

Arbitration means the process by which the parties to a dispute submit their differences to the judgment of an impartial person or group appointed by mutual consent or statutory provision.

Assessment means a process which provides sufficient information to determine medical necessity for mental health services covered under this Agreement.

Case Management means assistance to a recipient and family (or significant other) to obtain, maintain, or develop appropriate resources.

Census Alert means notification provided to the RSN of near-full census at the State psychiatric hospital. This may include notification of changes in hospital admission criteria.

Children's Long-Term Inpatient Program (CLIP) means the State appointed authority for policy and clinical decision-making regarding admission to and discharge from State-funded beds in CLIP (Child Study and Treatment Center, Pearl Street Center, McGraw Center, Tamarack Center and Martin Center).

Child Study and Treatment Center (CSTD) mean the Department of Social and Health Services (DSHS)/Division of Behavioral Health and Recovery (DBHR) child psychiatric hospital.

Community Mental Health Agency (CMHA) means community mental health centers that are subcontracted by the RSN and licensed to provide mental health services covered under this Agreement.

Community Support Services is all community-based, outpatient services as defined in RCW 71.24.025(8), WAC 388-865 and 388-877.

Complaint means a verbal or written statement by an individual or enrollee that expresses dissatisfaction with some aspect of services covered under this Agreement, Primary Care Provider, or Contractor.

Consultation is the review and recommendations regarding the task responsibilities, activities and decisions of administrative, clerical and clinical staff, along with contracted employees, volunteers and interns by persons with appropriate knowledge and experience in the pursuit of quality services.

Consumer means an individual who has applied for, is eligible for, or who has received mental health services. For a child, under the age of 13, or for a child age 13 or older whose parents or legal guardians are involved in the treatment plan the definition of consumer includes parents or legal guardians.

Contractor means an independent Contractor, its employees, agents and Subcontractors.

Coordinated Quality Improvement Program (CQIP) the purpose of CQIP is to improve the quality of health care services by identifying and preventing health care malpractice under RCW 43.70.15

Corrective Action/Compliance Review is when findings from NSMHA/DBHR review or other monitoring efforts or audits show there are apparent violations of this Agreement. Contractor shall implement corrective action within specified timeframes determined by NSMHA/DBHR/Departments other auditors.

Corrective Action Plan (CAP) is a written plan specifying what the Contractor is required to do to be in compliance. This includes required improvements and a timeline for such action(s) to be accomplished.

Crisis may be self-defined or a situation where an individual is acutely mentally ill, or experiencing serious disruption in cognitive, volitional, psychosocial and/or neurophysiological functioning.

Crisis Plan is a blueprint for action in the case of an individual (or child/family) who is experiencing imminent or substantial risk of harm to self/others or at risk of decompensation that could lead to future use of psychiatric inpatient services. Plans are developed in collaboration with the individual and natural supports.

Crisis Services means a face-to-face evaluation and treatment of mental health emergencies and crises to non-enrolled, as well as, enrolled individuals experiencing a crisis. Crisis services shall be available on a 24-hour basis with the goal of stabilizing the person in crisis and providing immediate or short-term treatment and support in the least restrictive environment available. Crisis services may be provided prior to an intake evaluation/assessment.

Cultural Competence means a set of congruent behaviors, attitudes and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

Day for purposes of this Agreement means calendar day unless otherwise specified.

Deliverable means any written information required for submission to NSMHA to satisfy the work requirements of this Agreement and that are due by a particular date or on a regularly occurring schedule.

Direct Care Staff means persons employed by CMHA's whose primary responsibility is providing direct treatment and support to people with mental illness or whose primary responsibility is providing direct support to such staff in areas such as scheduling, intake, reception, records-keeping and facilities maintenance.

Disaster Outreach means persons contacted in their place of residence or in non-traditional settings for the purpose of:

1. Assessing their mental health or social functioning following a disaster; or
2. Increasing their utilization of human services and resources.

There are two basic approaches to outreach:

1. Mobile (ongoing to person-to-person);
2. Community settings (i.e., temporary shelters, disaster assistance sites, disaster information forums).

Regardless of the approach, the outreach process has five (5) important components:

1. Locating persons in need of disaster relief services;
2. Assessing their needs;
3. Engaging or linking persons to an appropriate level of support or disaster relief services; and
4. Providing follow-up mental health services when clinically indicated.
5. Disaster outreach can be performed by trained volunteers, Peers and/or persons hired under a Federal Crisis Counseling Grant. These persons should be trained in disaster outreach, which is different than traditional mental health crisis intervention.

Discharge is (1) related to end of individual's inpatient psychiatric hospital stay; (2) occurs when an eligible individual has completed an episode of care (or active service) and is no longer receiving services (i.e., closed).

Discharge Planning (hospital) is the processes of developing a care regimen for an individual leaving inpatient care, including appropriate timing, follow-up appointments and treatment.

Discharge Planning (services) is the process of developing a care regimen and community integration plan for a mental health recipient leaving clinical care including appropriate residential treatment/housing supports and community support services prior to the recipient leaving outpatient care.

Diversion means to redirect an individual from being placed in a restrictive setting (i.e., jail, inpatient services) to clinically appropriate less restrictive alternative(s).

Emergent Care means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

Emerging Best Practice or Promising Practice means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

Evaluation and Treatment (E&T) Facility means a facility which can provide directly or by direct arrangement with other public or private agencies, emergency E&T, outpatient care, timely and appropriate inpatient care to persons suffering from a mental disorder and is certified as such by DSHS.

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

Fair Hearing means a hearing before Washington State Office of Administrative Hearings.

Family means:

1. For adults, those the individual defines as family (i.e., guardians, siblings, caregivers and significant others) to the individual.
2. For children, a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by DSHS or Tribe.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to self or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Full-Time Equivalent (FTE) is the term used to define number of full-time staff. One FTE shall be defined as 40 hours' work per week.

Geographic Area is NSMHA's Service Area consisting of the following geographic areas:

1. Island County
2. San Juan County
3. Skagit County
4. Snohomish County
5. Whatcom County

Grievance means an expression of dissatisfaction about any matter. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the mental health consumer's rights.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 is codified in 42 USC §1320(d) et.seq. and 45 CFR Parts 160, 162 and 164.

Individual Choice means the individual/child/families guaranteed opportunity to choose freely among treatment options and support services (based on identified needs) and to be full partners in the treatment process. "Choice" supports the notion that to the degree possible, individuals/child/families need to play a key role in designing their own service/support "packages" including involvement of natural supports and culturally specific services.

Individual Voice means indicators of ownership in and involvement with planning his/her own supports and services. In individualized plans, voice is best indicated by the use of the individual's own words and stated goals in "quotations".

In-Residence Census (IRC) means the in-residence census of all voluntary and involuntary individuals, regardless of where in the State hospital they are housed. Individuals who are committed to the State hospital under RCW 10.77 are not included in the IRC. Individuals who are committed by municipal or district court judges after failed competency restoration are considered committed under RCW 10.77 until a petition for 90 day civil commitment under RCW 71.05 has been filed in court.

Involuntary Treatment includes all services and administrative functions required for the evaluation of involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05, 71.24.300 and 71.34.

Local Funds Eligible for Match means sources of revenue that are eligible to be used as Federal match are broad based taxes at the county or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Funds used for Federal match under this Agreement may not be used as match for any other Federal program. It can be local funds that have not been previously matched with Federal funds at any point. Local funds do not include donations.

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

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

Mental Disorder as defined in RCW 71.34.020(12) for children and RCW 71.05.020(2) for adults.

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

Office of Management and Budget (OMB) Circular A-133 means audits of States, local governments and non-profit organizations.

Outcome means the results of a service period of treatment. The extents to which services are provided to individuals experiencing emotional and behavioral disorders have a positive or negative effect on their well-being, circumstances and capacity for self-management and recovery.

Outreach means a mental health service where individuals with severe and persistent mental illness or serious emotional disturbance are contacted in their place of residence or in non-traditional settings for the purpose of:

1. Improving their mental health, health, or social functioning; or
2. Increasing their utilization of human services and resources.

There are two basic approaches to outreach:

1. Mobile (going to individual/family); and
2. Peer/Drop-in centers (i.e., shelters, clubhouses, kitchens, clothing banks).

Regardless of the approach, the outreach process has five (5) important components:

1. Locating individuals in need of services;
2. Engaging individuals into service;
3. Assessing their needs;
4. Linking individuals to an appropriate level of support services; and
5. Providing follow-up services.

Personal Information means information identifiable to any person including, but not limited to, information that relates to a person's name, health, finances, education , business , use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers and any financial identifiers.

Publish means an officially sanctioned document provided by DBHR on their Internet or Intranet websites for downloading, reading, or printing.

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

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

Quality Strategy means an overarching system/process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.

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

Region is known as NSMHA or North Sound Regional Support Network (NSRSN). This region is comprised of five counties: Island, San Juan, Skagit, Snohomish and Whatcom.

Rehabilitation means to restore to customary activity through education, skill building and therapy. Increase independence and ability to participate in life meaning activities.

Reserve Accounts means an allocation of fund balance at the RSN set aside for a specific purpose by the RSN governing board or local legislative authority.

1. Operating Reserve - Funds designated from mental health revenue sources that are set aside into an operating reserve account by official action of the RSN's governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.
2. Inpatient Risk Reserve – Funds designated from mental health revenue sources to pay for future inpatient hospital claims.

Residential Services are defined in WAC 388-865 and 388-877, NSMHA Standards of Care and Clinical Eligibility Manual and NSMHA Policies and Procedures.

Resilience means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.

Risk means the possibility the Contractor may incur a loss because the cost of providing services may exceed the premium payments made by NSMHA to Contractor for services covered under this Agreement.

Subcontract means any written agreement between Contractor and subcontractor or between Contractor, subcontractor and another subcontractor to provide services or activities otherwise performed under this Agreement.

Subcontractor means an individual or entity performing all or part of the services under this Agreement under a separate contract with Contractor or its subcontractors.

Transition Youth means anyone age 17-21.

Underserved means persons who are minorities, children, elderly, disabled and low-income (See WAC 388-865-0150).

Urgent Care means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

Utilization Management Services means to provide independent utilization management process that monitors provider network to ensure services provided are sufficient, but not excessive, which are predicated on the individual needs of the recipient with respect to that person's age, culture, language and abilities.

Youth means anyone age 13-17 (13-20 if Medicaid).

B. STATE FUNDED SERVICES

Services in support of core services (Crisis Services), such as Psychiatric Hospital coordination, limited Outpatient Services, Less Restrictive Alternative (LRA) and Conditional Release (CR) monitoring are to be provided in accordance with the requirements outlined in this Agreement. In providing services in support of core services, Contractor shall mutually develop and routinely review policies and procedures that address how the availability of resources for these services is determined including how decisions are made to deny services due to insufficient resources. Other Services are to be provided in accordance with the specific requirements outlined for the service.

1. CONTRACTED SERVICES

Contractor shall provide the following Mental Health Services, within available resources, as defined in the provision of this Agreement, NSMHA Policy and in accordance with Attachment VIII:

a. Crisis Services including Involuntary Treatment Act (ITA)
b. Residential Services
c. Medicaid Personal Care
d. Inpatient Transition Care
e. Community Inpatient and State Hospital Care Coordination
f. Peer Center Services
g. Expanded Community Services
h. Adult Outpatient and Medication Management Services
i. Adult Intensive Outpatient Services

2. CORE SERVICES – CRISIS SERVICES

Contractor must provide crisis mental health services to individuals, including Tribal Members, who are within NSMHA's Service Area and are experiencing a mental health crisis. The services must be available 24-hours, 7 days a week. There must be sufficient staff available, including Designated Mental Health Professionals (DMHP), to respond to requests for crisis services. Crisis services must be provided regardless of the individual's ability to pay. Crisis services will be provided in accordance with policy and procedure and Attachments X and XI.

a. Crisis mental health services must include each of the following:

   i. Crisis Services;
   ii. Stabilization Services;
   iii. ITA Services;
   iv. Ancillary Crisis Services; and
   v. Freestanding Evaluation and Treatment;

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

i. Urgent care within 24-hours of the request received from any source for crisis mental health services.
ii. Emergent care within 2-hours of the request received from any source for crisis mental health services.

c. Contractor must provide access to all components of the Involuntary Treatment Act (ITA) to persons who have mental disorders in accordance with State law (RCW 71.05 and 71.34) and without regard to ability to pay.
d. Contractor must incorporate the statewide protocols for DMHP or its successor into the practice of DMHPs. DMHP protocols are incorporated by reference.
e. Contractor shall provide crisis services in accordance with NSMHA policies and Attachment X.
f. Contractor shall be responsible for coordinating and cooperating with other providers in NSMHA's crisis service network in accordance with Attachment XI.
g. Law enforcement or court inquiries regarding firearm permits. Contractor shall respond in a full and timely manner to law enforcement or court requests for information necessary to determine the eligibility of a person to possess a pistol or be issued a concealed pistol license under RCW 9.41.070 or to purchase a pistol under RCW 9.41.090.

3. MEDICAID PERSONAL CARE (MPC)

Contractor shall:

Identify individuals who may qualify for MPC services and request a consult from NSMHA who will determine if a referral to Home and Community Services (HCS) and/or Area Agency on Aging (AAA) are appropriate. Contractor shall adhere to NSMHA's policy and procedure on MPC and provide services in accordance with said policy.

4. PSYCHIATRIC INPATIENT SERVICES

a. COMMUNITY HOSPITALS AND EVALUATION AND TREATMENT FACILITIES (E&T)

Contractor shall:

i. Ensure when notified of the hospitalization of an individual currently enrolled in outpatient services that contact with the community hospital or E&T staff occurs within three (3) working days of an individual's admission to a community hospital or E&T. If Contractor is not notified of admission at the time the individual is admitted, they should attempt to make contact as soon as they are notified in accordance with NSMHA's Clinical Eligibility and Care Standards/NSMHA clinical policies and procedures.
ii. Upon notification of the admission, Contractor shall offer a non-crisis service to eligible individuals within five (5) business days/seven (7) calendar days post-discharge. Contractor shall participate in treatment and discharge planning with community hospital or E&T inpatient treatment team.

b. STATE HOSPITALS AND CHILDREN'S LONG TERM INPATIENT PROGRAM (CLIP)
Contractor shall:

i. Actively work with NSMHA's Western State Hospital (WSH) liaisons and implement mechanisms that promote rapid and successful reintegration of individuals to the community from State psychiatric hospitals and CLIP.
ii. Respond to State hospital census alert notifications by:

a) Demonstrating best efforts to divert State psychiatric hospital admissions.
b) Expediting individual discharges from the State psychiatric hospital using alternative community resources and mental health services. WSH liaison will continue to consider resources on a region-wide basis when expediting discharges.

iii. Comply with NSMHA WSH policies and procedures including those implementing the NSMHA-WSH Working Agreement and CLIP policy.
iv. Require that to the extent necessary and whenever possible, individuals are medically cleared prior to admission to a State psychiatric hospital.
v. Contractor must provide or require an admission packet be provided to the State psychiatric hospital within three (3) working days of admission. In the event of a transfer from community hospitals, emergency rooms, E&T centers or nursing homes an admission packet must be provided to the State psychiatric hospital on or before the admission whenever possible.
vi. Provide coordination with State hospital staff and NSMHA WSH liaison to develop appropriate community placement and treatment service plans.
vii. Contractor has the primary responsibility to coordinate with the other CMHAs and obtain a placement for the outpatient and residential services to be provided to the individual based on NSMHA policies and procedures, medical necessity and available resources. Contractor will ensure there is one point of contact for the WSH liaisons.
viii. The assigned Contractor must offer, at minimum, one follow-up service within five (5) business days from discharge.
ix. Adhere to the discharge planning process for individuals served by the State psychiatric hospitals who are also enrolled with the Division of Developmental Disabilities (DDD). This includes participation in treatment and discharge planning with State hospital staff and staff from DDD.
x. Contractor shall monitor individuals discharged from inpatient hospitalizations on a LRA under RCW 71.05.320. Contractor shall offer mental health services to assist with compliance with LRA requirements.
xi. Contractor shall respond to requests for participation, implementation and monitoring of individuals receiving service on CR consistent with RCW 71.05.340. Contractor shall provide mental health services to assist with compliance with CR requirements.

xii. Contractor shall ensure the provision of mental health services to individuals on a CR under RCW 10.77.150.

xiii. Contractor shall use best efforts to utilize community resources and covered mental health services to minimize State Hospital admissions.

5. EXPANDED COMMUNITY SERVICES (ECS)

ECS funding provided in Attachment VIII is for the provision of enhanced community support services for long-term State Hospital patients whose treatment needs constitute substantial barriers to community placement.

Contractor shall provide or maintain community residential and support services for individuals with treatment needs that constitute substantial barriers to community placement. The individual must no longer need an inpatient level of care and be determined clinically ready for discharge.

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

Prior to placement of a new ECS individual, the Contractor must convene and participate in a team of community professionals who will become familiar with the Individual and treatment plan. This includes:

a. Assessment of the individual's strengths, preferences and needs;
b. Arrangement of a safe, clinically-appropriate and stable residence; and
c. Assessment and planning for other needed medical, behavioral and social services.

Prior to placement into the community, a complete written, comprehensive transition plan must be developed. The process to develop the plan must include the participation of the individual and focus on the individual's strengths and needs.

Contractor shall utilize ECS transition guidelines developed by ECS Implementation Committee or other comparable local tools to assure transition needs of ECS individuals will be met.

Contractor must provide for face-to-face visits to the identified ECS individual during the last months of hospitalization. The purpose of the visit is to assess the individuals mental health needs and any other service needs.

Contractor shall provide a minimum of seven (7) ECS slots during this Agreement period. ECS days of service include any day an ECS resident is living outside of a State Hospital and being supported by NSMHA in community residential or other supported living settings. ECS days of service do not include days in which a patient is residing in a State Hospital, jail, or Department of Corrections facility. Contractor will monitor subcontractors receiving ECS funds to ensure compliance with meeting the required days of service and shall make available reports to demonstrate this upon request.

6. RESIDENTIAL PROGRAMS

In accordance with NSMHA policies and procedures, Contractor shall ensure the following:

The range of residential settings and programs must be available and provided based on the individual's need, medical necessity and within available resources per the policies and procedures developed as outlined at the beginning of this section.

Residential Programs are 24-hour staffed specialized living situations and services provided by NSMHA. NSMHA purchases the residential service with State Mental Health Contract funds. Mental health outpatient services are provided principally under Contractor's Medicaid contract and/or with State funding if resources allow.

There are two levels of services in residential programs funded by NSMHA, Boarding Home facility services and Residential Treatment Facility (RTF) services. These programs provide the following specific services including:

Boarding Home Services

In general, boarding homes must provide housing and assume general responsibility for the safety and well-being of each resident consistent with the resident's assessed needs and negotiated service agreement (WAC 388-78A).

a. This includes:
    i. A room with a bed;
    ii. Meals;
    iii. Nutritious snacks; and
    iv. Activities.

b. This includes space, staff support and routine supplies and equipment necessary for each resident to pursue independent or self-directed activities.
c. Group activities at least three (3) times per week may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.
    i. Housekeeping;
    ii. Laundry;
    iii. Storage of medications;
    iv. Monitoring of medication use, but not administration;
    v. Monitoring of medical conditions and issues, such as, prompting individual for glucose testing and the self-administration of insulin; and
    vi. Basic life skills coaching.

RTF

In general, the licensee must ensure residents receive housing, meals, support services including healthcare by adequate numbers of staff authorized and competent to carry out assigned responsibilities. There must be sufficient numbers of personnel present on a 24 hour per day basis to meet the healthcare needs of the residents served, managing emergency

situations, crisis intervention, implementation of healthcare plans and required monitoring activities.

Priority placement shall be given to individuals discharging from WSH.

a. Contractor shall comply with NSMHA Policy 1532, WAC 246-337, ,388-877, 388-877A and 388-865-0235 as it relates to Residential Treatment licensing and services provided under licensure;
b. An RTF is expected to meet and exceed all of the expectations of a Boarding Home.
c. An RTF has a higher level of medical capabilities than a Boarding Home. Hence, an RTF shall take individuals with more intense medical and psychiatric needs.
d. The RTF shall provide a significantly higher-level supervision and monitoring than a boarding home (a higher level of staff to individual ratio.).
e. The goal of RTF placement and treatment is to provide intensive rehabilitation and stabilization services for up to 6-18 months for the purpose of moving individuals into independent living settings/more appropriate level of care.

Contractor shall actively promote access and choice in safe and affordable independent housing.

Contractor shall provide timely access to outpatient mental health services or Intensive Outpatient Treatment (IOP) when it is determined to be medically necessary to meet individual needs.

Contractor shall collaborate with NSMHA to develop additional capacity when resource and utilization processes indicate.

Contractor shall demonstrate its performance of this function by maintenance of written records that show routine review and discussion of residential service capacity issues by Contractor staff.

Contractor shall notify NSMHA 60 days in advance of a planned date for closure of any Contractor owned RTF or the termination of a subcontract for the provision of residential services and programs. Along with the notification, Contractor shall provide NSMHA with a detailed financial analysis explaining why funds provided under this agreement are insufficient to ensure the ability to provide the required program.

Contractor shall ensure facilities operate, at a minimum, of 85% of bed day available capacity.

C. SERVICES IN SUPPORT OF CORE SERVICES

Outpatient mental health services and services listed below shall be provided based on medical necessity and within available resources per NSMHA's policy and procedures. NSMHA shall have policies and procedures that determine how the availability of resources for these services is determined including how decisions are made to authorize intake evaluations or deny provision of services due to insufficient resources.

Per policy and procedure any of the following services may be provided.

a. Provide or purchase any other clinically appropriate outpatient or residential services to a non-Medicaid individual;
b. Provide or purchase clinically appropriate outpatient services to Medicaid enrollees that are not included in the Medicaid State Plan or 1915(b) Waiver;
c. Provide assistance with transportation;
d. Provide assistance with application for entitlement programs; and/or
e. Provide assistance with meeting the requirements of the medically needy spend-down program.

1. PEER SUPPORT/CENTER

Contractor shall provide a safe, supportive and welcoming recovery oriented community where adults with mental illness can:

a. Gain confidence and learn social and vocational skills;
b. Pursue their own recovery in collaboration with Peers, advocates, staff, friends and neighbors; and
c. Educate the broader community and raise awareness about mental illness rehabilitative Peer Center settings to individuals, regardless of Medicaid eligibility.

Contractor shall ensure the Peer Center offers Peer run groups (Co-occurring groups, Wellness Recovery Action Plan (WRAP) groups, men's and women's programs, and any other that members/participants desire). Other social activities shall also be offered.

At a minimum, the following shall be available to members/participants:

a. Maintain a daily log identifying unduplicated members/participants, including number of daily visits, and submit to NSMHA as requested;
b. Provide Peer Services delivered by Certified Peer Counselors/non-Certified Peer advocates;
c. Promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills;
d. Gear services toward members or participants with severe and persistent mental illness;
e. Offer staff training quarterly on topics identified and requested by staff, including Peer Counselors and Advocates;

f. Administer quarterly survey questionnaire during peak hours of operation in order to survey as many Peer participants as possible;
g. Ensure 60% of FTE positions are Peer Counselors/Advocates;
h. Offer evening hours, unless Advisory Board and participants choose not to include evening hours in the operation; ensure documentation verifying the decision process;
i. Involve Peers in all aspects of center operation; document and verify involvement;
j. Offer employment/education groups to include, but not limited to, benefit counseling, accessing benefits and job clubs;
k. Provide computers for use by participants/members;
l. Ensure community stakeholder participation on Advisory Board, stakeholders providing in-house presentations and Peers conducting outreach to stakeholders;
m. Actively recruit community business representatives to the Advisory Board; and
n. Develop and implement a sustainable financial development plan.

Contractor shall design the Peer Center to facilitate recovery, be a supportive milieu for individuals and at the same time be attractive, adequate in size and communicate the importance of dignity and respect in daily operations.

Contractor shall establish an Advisory Committee consisting of 51% individual's with mental illness/advocates along with community stakeholders. Written minutes of Advisory Committee meetings shall be recorded and submitted to NSMHA as requested.

Individuals may stop in on a daily basis and participate as they are able. Engagement and referral services shall be offered.

Contractor shall provide Peer Support Services by Certified Peer Counselors to individuals on Medicaid and submit encounters through the Consumer Information System (CIS) when an encounter occurs at the Peer Center. The service must be documented in the Individualized Resilience/Recovery Service Plan (IRSP).

This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills. Services are geared toward members or participants with severe and persistent mental illness.

Participants shall actively participate in decision-making and the operation of programmatic supports.

Hours of operation shall include Monday through Friday, with the option of weekends or evenings depending on the need of the community and approval of the Advisory Committee.

Contractor shall ensure services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. Services shall be delivered and coordinated with Contractor's Mental Health Block Grant Agreement.

2. INPATIENT TRANSITION CARE SERVICES

Contractor shall provide the staffing and resources to ensure individuals with Medicaid discharging from inpatient facilities, voluntary or involuntary, are provided a qualifying service within seven (7) calendar days of discharge. A list of qualifying services will be provided to the Contractor on a monthly basis as part of the fee-for-service reconciliation.

Contractor and its subcontractor shall ensure staff is oriented to the philosophy and expectation of the transition care services. Staff shall have training regarding the recovery model and person-centered care, motivational interviewing, behavioral activation technique and Co-occurring Disorder.

Contractor shall provide transition care services and develop Memorandum of Understanding (MOU) with the following identified facilities:

a. Children's Hospital, Seattle, WA;
b. Swedish Hospital, Edmonds, WA;
c. Fairfax Hospital, Kirkland, WA;
d. Mukilteo Evaluation and Treatment Center, Mukilteo, WA;
e. Skagit Valley Hospital, Mt. Vernon, WA; and
f. St. Joseph's Hospital, Bellingham, WA.

Outreach and marketing with the inpatient facilities shall be ongoing throughout the project's duration. Contractor shall engage the appropriate parties at the inpatient facilities to educate inpatient staff on the purpose and projected outcomes of the intervention strategies. Contractor will attend NSMHA inpatient meetings regularly and provide assistance to the facilities to ensure individuals being discharged have a qualifying service within seven (7) calendar days. Contractor shall also be available to assist NSMHA and inpatient facilities on a case-by-case basis with facilitating the engagement of individuals who have a history of high utilization of inpatient and crisis services.

Contractor shall develop an MOU with the inpatient facilities listed above; primary components of the MOU shall be as follows:

a. Inpatient facility shall allow Contractor or its subcontractor access to individuals referred by NSMHA or its designee for the purpose of engagement;
b. Inpatient facility shall coordinate discharge planning with Contractor or its subcontractor program staff, within limits of applicable laws and regulations;
c. Inpatient facility shall inform Contractor or its subcontractor programs staff of any discharges identified by NSMHA or its designee as eligible for services;
d. Inpatient facility shall assist Contractor or its subcontractor staff in identifying the formal and natural supports currently involved, including providing contact information when available;
e. Inpatient facility shall identify individuals who might qualify for this intervention and work with NSMHA to provide referrals to Contractor or its subcontractor;
f. Inpatient facility shall retain all responsibility for comprehensive and appropriate discharge planning for the individual;

g. Inpatient facility shall orient Contractor or its subcontractor to the facility, explaining the process for access and discharge planning;
h. Contractor shall receive referrals from NSMHA or its designee of eligible individuals and will make contact with the inpatient facility to begin engagement efforts;
i. Contractor and its subcontractor will support the discharge planning process and assist in identifying resources and supports that may aid in the transition from the inpatient facility to a community setting;
j. Contractor and its subcontractor shall keep records of their interactions and efforts;
k. Contractor and its subcontractor shall provide its staff with tools and resources necessary to carry out assigned engagement tasks; and
l. Contractor and its subcontractor shall follow all applicable laws, policies and regulations.

Contractor shall utilize Certified Peer Counselors/individuals in the process of becoming certified as active, fully integrated team members. Peers will be cross-trained in all aspects of the program to include resource and referral, engagement activities, evidence-based clinical interventions and marketing.

Contractor shall begin engagement with individuals at the facility prior to discharge. Engagement shall be a process in which the transition team meets face-to-face with the individual to provide recovery support, education and available treatment options.

Contractor shall coordinate with all network providers to ensure a qualifying service takes place within seven (7) days with the agency the individual is enrolled or has chosen. If an individual is not currently enrolled with a network provider and is eligible for services, the Contractor shall facilitate access to mental health services.

Contractor shall collaborate with the inpatient facility discharge planners to ensure the individual discharging has an appropriate plan that addresses their needs and provides the appropriate linkage to services upon discharge. Team member(s) will support the individual at discharge to assure a face-to-face appointment takes place within seven (7) days.

Building relationships with the inpatient facilities is crucial to the support and effectiveness of the transition care service. Contractor shall make a good faith effort to build and maintain the relationships to effectively improve the outcomes of individuals being discharged from inpatient care.

Outcome measures identified for this population are as follows:

a. A qualifying service occurs within seven (7) days of an inpatient discharge;
b. No psychiatric hospitalizations within 30 days of discharge from psychiatric inpatient; and
c. Engagement in ongoing mental health services.

The only outcome measure the Contractor shall be accountable for during the initial phase of this service is (a) a qualifying service within seven (7) days of inpatient discharge. All other outcomes will be monitored by NSMHA for improvement without incentive or penalty to the Contractor.

D. PERFORMANCE STANDARDS

1. GENERAL OPERATING STANDARDS

a. Contractor must ensure that individuals and individuals' families participate in planning activities and participate in the implementation and evaluation of Contractor's clinical functions. Contractors must demonstrate how this requirement is implemented.

b. Contractor must maintain a written Advance Directive policy and procedure that respects enrollees' advance directives for psychiatric care. Policy and procedures must comply with NSMHA's Advance Directive policy and procedure or use NSMHA's policy.

c. Contractor must participate in NSMHA and DBHR offered training, consultation and program development when requested, including training on the implementation of Evidence-based Practices, Emerging and Promising Practices.

d. Contractor shall encourage and promote Dignity and Respect throughout the system of care.

e. Contractor shall ensure staff incorporates SAMHSA's 10 Components of Recovery, Attachment IX in service delivery.

f. Contractor shall incorporate Washington State Mental Health System Principles and Core Practice Model as guidelines for providing care to children, youth and their families as referenced in Attachment XIII.

g. Contractor shall consult with NSMHA on the review of a minimum of two practice guidelines during the contract period and shall adopt and implement the practice guidelines including training impacted staff on the use of the guidelines. In addition, Contractor shall participate in the implementation of a consistent Child and Family Team (CFT) protocol under the timelines and guidance published by DSHS.

h. Contractor shall make best efforts to provide written or oral notification within 15 working days of termination of a Mental Health Care Provider (MHCP) to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the medical record at the CMHA.

i. Contractor must ensure benefits are provided in accordance with NSMHA's policies and procedures and are not arbitrarily denied or reduced (i.e., amount, duration, or scope of a required service) based solely upon the diagnosis, type of mental illness, or the enrollee's mental health condition.

j. Contractor shall provide Customer Service that is customer-friendly, flexible, proactive and responsive to individuals, families and stakeholders. Contractor shall provide a toll free number for individuals. A local telephone number may also be provided for those individuals within the local calling area.

k. Contractor shall notify individuals in writing of changes in service, MHCP denials/changes or termination in services in accordance with NSMHA policies and procedures.

l. Contractor shall ensure representative payee services are available for those who need them. When Contractor performs representative payee services, it shall charge no more than the maximum fee allowed by Social Security regulation and shall ensure payee functions are independent from and do not have conflicts of interest with

clinical service functions. Contractor shall maintain a list of the names and addresses of all known payee services available in the North Sound region and shall ensure that before initiation of payee services, Contractor will provide individual with the list. The form used by Contractor to enroll the individual in payee services shall require the individual to acknowledge receipt of the list.

m. Contractor shall collaboratively participate in NSMHA's regional coordination meetings, which currently include NSMHA Ad Hoc Regional Integrated Provider, NSMHA Quality Management Oversight Committee (QMOC), Regional ICRS Committee and subcommittees and work groups of these committees as necessary.
n. Contractor shall obtain written consent from an individual in the event a picture or personal story will be used.

2. LOCUS/CALOCUS LEVEL OF CARE UTILIZATION SYSTEM

Contractor shall comply with NSMHA policy and procedure on LOCUS/CALOCUS.

Contractor shall ensure all children, adolescents and adults eligible for services are given a complete clinical assessment using LOCUS/CALOCUS tool.

Contractor shall comply with their NSMHA approved LOCUS/CALOCUS Training Plan and strategies identified in efforts toward Inter-rater reliability. Data on Inter-rater reliability shall be submitted to NSMHA on a biannual basis. Contractor shall participate in efforts toward regional Inter-rater reliability standards, when requested.

Contractor shall complete LOCUS/CALOCUS on individuals at levels 1 and 2 annually and for levels 3 and above every six (6) months/when there is a significant life change.

3. CO-OCCURRING DISORDER SCREENING AND ASSESSMENT

Contractor must maintain the implementation of the integrated, comprehensive screening and assessment process for chemical dependency and mental disorders as required by RCW 70.96C. Failure to maintain the screening and assessment process will result in remedial actions up to and including financial penalties as described in the Remedial Actions section of this Agreement.

DBHR provided Global Appraisal of Individual Needs – Short Screener (GAIN-SS) during:

a. All new intakes.
b. The provision of each crisis episode of care including ITA investigations services, except when:

    i. Service results in a referral for an intake assessment.
    ii. Service results in an involuntary detention under RCW 71.05 or 71.34.
    iii. Contact is by telephone only.
    iv. Professional conducting the crisis intervention or ITA investigation has information the individual completed a GAIN-SS screening within the previous 12 months?

4. MEDICAL NECESSITY AND SECOND OPINION

Contractor shall make the determination of medical necessity. Contractor shall ensure individuals have the right to a second opinion in accordance with NSMHA's policy and procedure. Contractor shall develop specific written procedures consistent with NSMHA's policy or use NSMHA's policy and notify NSMHA of any individual seeking a second opinion. Contractor shall be responsible for arranging and monitoring all second opinion services under this agreement.

5. OUTPATIENT INITIAL AUTHORIZATION and CONTINUED SERVICE AUTHORIZATION

In accordance with NSMHA's operating policies:

a. When an individual meets the criteria set out in policy and procedure and within available resources they will be authorized for limited outpatient services by NSMHA.
b. NSMHA shall notify Contractor in writing of those authorized to receive Contractor services and will provide contact person(s) for purposes of NSMHA service authorization. Contractor shall appoint a contact person to receive authorization notification.
c. If an expedited assessment is needed it will be provided as rapidly as is medically necessary, in accordance with NSMHA's Authorization and Assessments for Ongoing Services Policy and Procedure.
d. If Contractor believes criteria are not met, Contractor will send NSMHA clinical information necessary to allow NSMHA to make a determination of clinical eligibility.
e. If an individual is determined by NSMHA to not meet clinical eligibility requirements, NSMHA shall notify the individual of the decision with a Notice of Determination and his/her rights to file a grievance.

6. SPECIALIZED OUTPATIENT/RESIDENTIAL CONTINUED SERVICE APPROVAL AND CONTINUED SERVICE AUTHORIZATION

In accordance with NSMHA's operating policies:

a. Authorization for Program for Assertive Community Treatment (PACT) shall be the responsibility of the Team Leader and NSMHA; any dispute will be mediated by NSMHA's Medical Director.
b. Authorization for specialty out-of-network services will be authorized and paid for by the Contractor. NSMHA shall authorize and pay for specialty out of network services outside the State of Washington and in other limited situations authorized by NSMHA. The arrangement and monitoring of all said services will be the responsibility of the Contractor. Contractor shall coordinate and provide updates to NSMHA upon request.

7. INTENSIVE OUTPATIENT TREATMENT-ADULT

Contractor shall comply with the criteria set out in policy and procedure and within available resources for IOP services. Contractor shall ensure individual's requiring IOP services receive said services when medically necessary and LOCUS/CALOCUS determine individual level of need.

Contractor shall demonstrate its performance of this function by maintenance of written records that show routine review and discussion of service intensity.

8. QUALITY CLINICAL CARE, TIMELY ACCESS, INTAKE EVALUATIONS AND INDIVIDUALIZED RESILIENCY/RECOVERY SERVICE PLANS (IRSP)

In addition to requirements listed elsewhere in the contract, NSMHA policy and procedures and within available resources, Contractor shall:

a. Provide individuals access to services based on the individual's needs and medical necessity within available resources per NSMHA's policies and procedures.
b. Ensure medically necessary services are not contingent upon full completion of intake evaluations.
c. Ensure:

    i. A face-to-face intake assessment by an MHP is offered within 10 working days of the completed request for services.
    ii. The ability to provide an intake evaluation and provide services to individuals in their residence, including adult family homes, assisted living facilities, or skilled nursing facilities, including individuals being discharged from a State hospital or E&T facilities to such placements when the individual requires an on-site service due to medical needs or lack of transportation.
    iii. Co-Occurring screening and assessment is initiated and completed in compliance with NSMHA Co-occurring Screening and Assessment Policy and Procedure.
    iv. Routine mental health services are offered to occur within 14 calendar days of a determination of eligibility. An extension is possible on request by the individual. A total of 28 calendar days from the initial request for services until the first routine appointment is offered is the expected period of time.
    v. Emergent care occurs within two (2) hours.
    vi. Urgent care occurs within 24 hours from the request for services.
    vii. When services occur in CMHA's office, wait time does not exceed one (1) hour beyond the time of the scheduled appointment.
    viii. An appointment is offered to each individual for a face-to-face contact within seven (7) days of discharge from community inpatient care.
    ix. Data/reports will be available to substantiate compliance with the above requirements as requested by NSMHA.

d. Ensure prior authorization is not required for emergency services;
e. Access to services in accordance with WAC 388-865-0415 and 388-877-0420, Contractor must document and otherwise ensure eligible individuals have access to age and culturally competent services when and where those services are needed. They must:

i. Identify and reduce barriers to people getting the services where and when they need them;
ii. Comply with Americans with Disabilities Act (ADA) and Washington State Antidiscrimination Act, chapter 49.60 RCW;
iii. Ensure services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the individual;
iv. Provide alternative service delivery models to make services available to underserved persons as defined in WAC 388-865-0150 and 388-877-0420;
v. Provide access to telecommunication devices or services and certified interpreters for deaf or hearing impaired individuals and limited English proficient individuals;
vi. Bring services to the individual or locate services at sites where transportation is available to individuals; and
vii. Ensure compliance with all Federal and State nondiscrimination laws, rules and plans.

f. IRSP – In accordance with WAC 388-865-0425 and 388-877-620, Contractor must provide individuals with a plan, herein referenced IRSP that meets the individual's unique needs. Individualized and tailored care is a planning process that may be used to develop a person-centered, strength-based, IRSP. The IRSP must:

i. Be developed collaboratively with the individual and other people identified by the individual within 30 days of starting community support services. The IRSP should be in language and terminology that is understandable to individuals and their family and include goals that are measurable.
ii. Individuals shall be actively involved in the development of their individualized IRSP, advance directives for psychiatric care and crisis plans
iii. At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record, as part of the 180 day progress review, describing how the individual sees their progress. Contractor must be able to demonstrate how this requirement is implemented and monitored.
iv. The IRSP identifies medical concerns and plans to address them.
v. Address age, cultural, or disability issues of the individual.
vi. Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices involving other systems when appropriate.
vii. Address the overall identified needs of the individual, including those that are best met by another service delivery system, such as education, primary medical care, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections and juvenile justice as appropriate. Contractor must ensure there is coordination with the other service delivery systems responsible to meeting the identified needs.

viii. Demonstrate the provider has worked with the individual and others at the individual's request to determine needs in the following life domains:

a) Housing;
b) Food;
c) Income;
d) Health and dental care;
e) Transportation;
f) Work, school, or other daily activities;
g) Social life; and
h) Referral services and assistance in obtaining supportive services appropriate to treatment, such as substance abuse.

g. Document review by person developing the plan and the individual. If the person developing the plan is not an MHP, the plan must also document review by an MHP. If the person developing the plan is not a Mental Health Specialist (MHS) required per WAC 388-865-405(5) and 388-877-0620, there must also be documented consultation with the appropriate MHS.
h. Document review and update at least every 180 days or more often at the request of the individual.
i. In the case of children:

i. The IRSP must be integrated with individual education plan from the education system whenever possible. When not possible, documentation must demonstrate attempts of integration and communication with the education system.
ii. If the child is under three, the plan must be integrated with the Individualized Family Service Plan (IFSP) if this exists, consistent with Title 20, Section 1436.

9. TRANSITION AGE YOUTH

Contractor shall maintain a process for addressing the needs of transition age youth (ages 16-21). The process must contain or address:

a. A comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports and outcomes.
b. Individual mental health needs in the context of a transition age youth, which include supported transition to meaningful employment, post-secondary education, technical training, housing, community supports, natural supports and cross-system coordination with other system providers.
c. Youth who require continued services in the adult mental health system and must identify transitional services that allow for consistent and coordinated services and supports for young people and their parents.
d. Developmentally and culturally appropriate adult services that are relevant to the individual or population.

10. ALLIED SYSTEMS COORDINATION

Contractor must comply with and at the request of NSMHA participate in the identification and development of Allied System Coordination plans. NSMHA's coordination plans with allied systems includes, but is not limited to, Western State Hospital (WSH), Children's Administration (CA), Aging and Disabilities Services Administration (ADSA), Department of Alcohol and Substance Abuse (DASA), Criminal Justice System, Educational Service District (ESD), Federally Qualified Health Centers (FQHC), Juvenile Rehabilitation Administration (JRA), Community Integration Assistance Program (CIAP), Healthy Options Plans, Community Health Centers and Department of Vocational Rehabilitation (DVR). The coordination plans are intended to enable coordination of services and appropriate management of care for individuals.

Contractor shall comply with published directives from DBHR when NSMHA, Contractor, or its subcontractors are unable to resolve local disputes with other service systems (Healthy Options, other DSHS administrations as provided by DBHR) regarding service or cost responsibilities.

11. PRIMARY CARE COORDINATION

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

12. CRISIS SERVICES COORDINATION AND COOPERATION

Contractor shall coordinate and cooperate with providers in NSMHA's crisis service network to ensure the continuity of care.

Contractor shall develop protocols in collaboration with regional crisis service providers and NSMHA to utilize the Wraparound Team in the prevention and intervention with children/adolescents and families being served by a Wraparound team.

13. DISASTER RESPONSE

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

a. Attend DBHR sponsored training regarding the role of the public mental health system in disaster preparedness and response.
b. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
c. Provide disaster outreach as defined in Section A, Definition of Terms.
d. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.
e. Provide the name and contact information to NSMHA for person(s) coordinating Contractor's disaster/emergency preparedness and response upon request.

f. Provide information and preliminary disaster response plans to NSMHA within seven (7) days of a disaster/emergency or upon request.
g. Partner in disaster preparedness and response activities with NSMHA, DBHR and other DSHS entities, State Emergency Management Division, Federal Emergency Management Agency, American Red Cross and other volunteer organizations. This must include:

    i. Participation when requested in local and regional disaster planning and preparedness activities.
    ii. Coordination of disaster outreach activities following an event.

14. CONFIDENTIALITY

Contractor shall not use, publish, transfer, sell, or otherwise disclose any confidential information gained by reason of this Agreement for any purpose that is not directly connected with the performance of the services contemplated there under, except:

a. As provided in NSMHA policy and procedure; or
b. As provided by law;
c. In the case of personal information, as provided by law or with the prior written consent of the person or personal representative of the person who is the subject of the personal information.

Contractor shall protect and maintain all confidential information gained by reason of this Agreement against unauthorized use, access, disclosure, modification, or loss. This duty requires the parties to employ reasonable security measures, which include restricting access to the confidential information by:

a. Allowing access only to staff that have an authorized business requirement to view confidential information.
b. Physically securing any computers, documents, or other media containing confidential information.

To the extent allowed by law, at the end of the Agreement term, or when no longer needed, the parties shall return confidential information or certify in writing the destruction of confidential information upon written request by the other party.

Paper documents with confidential information may be recycled through a contracted firm, provided the contract with the recycler specifies the confidentiality of information will be protected and the information destroyed through the recycling process. Paper documents containing confidential information requiring special handling (i.e., protected health information) must be destroyed through shredding, pulping, or incineration.

The compromise or potential compromise of confidential information must be reported to NSMHA's Deputy Director within 5 business days of discovery for breaches of less than 500 persons' protected data and 3 business days of discovery for breaches of over 500 persons' protected data. The parties must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law

15. COMPLAINT, GRIEVANCE, APPEAL AND FAIR HEARING PROCESSES

Contractor must implement complaint, grievance, appeal and fair hearing processes that are in conformance with NSMHA policies and procedures.

Contractor and its subcontractors shall abide by NSMHA complaint, grievance, appeal and fair hearing determinations. Contractor shall be responsible for paying 100% of all medical director and/or attorney fees incurred by NSMHA when an individual goes directly to a fair hearing without utilizing NSMHA's grievance processes and when the ruling favors the individual, in accordance with NSMHA policies and procedures. In addition, Contractor shall:

a. Implement a grievance process that complies with WAC 388-865, 388-877, or any successors;
b. Coordinate with NSMHA grievance process and Ombuds Services;
c. Provide access to interpreter services and toll free numbers with adequate TTY/TTD and interpreter capability;
d. Provide assistance to individuals filing a grievance; and
e. Incorporate concerns from grievances into Contractor services without identifying individuals.

16. LOCAL RESPONSIVENESS AND COMMUNICATIONS

Contractor shall cooperate with NSMHA and Counties in the service area to provide a locally responsive delivery system. Contractor shall provide individuals with referral sources information and education about the referral process, service availability, service population, common symptoms of mental illness, and shall post and make known consumer rights and responsibilities including complaint, grievance, appeal and fair hearing procedures and availability of Ombuds services.

Contractor shall have written policy and procedures that comply with NSMHA's policies on consumer rights and address the following:

a. Individual mental health rights applicable to non-Medicaid individuals as defined in WAC 388-865-0410 and 388-877-0600.
b. Oral interpretation services provided free of charge to the individual.
c. Information that states written materials are available when requested in alternate formats. These materials must be available and easily understood by individuals.

Contractor shall post, in a conspicuous place, a translated copy of the consumer rights as listed in the Mental Health Benefits Booklet in each of DSHS's prevalent languages. Access to translated copies may be downloaded at: http://www.dshs.wa.gov/dbhr/pubs.shtml#dbhr

17. CRITICAL INCIDENTS

Contractor and its subcontractors shall comply with NSMHA's Critical Incident Reporting Policy and Procedure and any successor regarding critical incidents.

18. PERFORMANCE IMPROVEMENT AND REGIONAL MEASURES

It is NSMHA's expectation that we will meet or exceed all appropriate statewide Performance Improvement Projects (PIP) and regional Performance Measures (PM). Each of the performance indicators will be addressed in the 2012-15 NSMHA's Quality Management

(QM)/Strategy Plan. In addition, Contractor shall develop a plan and submit it to NSMHA for approval within 90 days following the execution of this Agreement that addresses the action steps to be taken by Contractor that will assist in achieving the goals of the PIP and PM as identified by NSMHA's QMOC and addressed in the Regional QM/Strategy Plan. Upon request, Contractor shall submit relevant data/reports to NSMHA in the development and management of the identified PIP and PM.

19. OUTCOME MEASURES

Contractor shall collaborate with NSMHA on identifying and incorporating outcome measurement tools used to measure an individual or group of individual's recovery and improved wellness.

Contractor shall participate in meetings/workgroups to determine the target population and measurement tool or tools to be used in the region during this contract cycle.

20. EVIDENCE-BASED PRACTICES

Contractor will participate with NSMHA/DSHS to increase the use of research and evidence-based practices, with a particular focus on increasing these practices for children and youth as identified through legislative mandates. This includes:

a. Participation in State-sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TFCBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence-based practices including those for which State subsidy of training costs is not available. Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice.
b. Participation in State-sponsored efforts to ensure that the sites offering the TF-CBT/CBT+ evidence-based practice are operated as trauma-informed systems of care.
c. Participation in regional efforts to identify and promote evidence-based practices for adults.

21. TRAUMA-INFORMED CARE

A majority of the individuals in mental health services have experienced some form of trauma in their history. NSMHA, in collaboration with regional Contractors, shall create a trauma-informed system of care.

Contractor and NSMHA shall address the following during the course of this Agreement:

a. Develop/implement an organizational assessment tool;
b. Develop/implement a trauma screening tool; and
c. Provide and participate in regional trauma-informed trainings.

22. QUALITY MANAGEMENT/STRATEGY

Contractor shall participate with NSMHA in the implementation, updates and evaluation of DBHR Quality Strategy located on DBHR website that is hereby incorporated by reference.

Contractor shall comply with NSMHA's QM/Strategy Plan or any successor incorporated herein as Attachment II.

Contractor shall ensure its QM activities comply with all applicable law and standards including, but not limited to: WAC 388-865-0280, -0425 and NSMHA QM Plan, NSMHA Clinical Policies and Procedures or their successors. In addition:

a. Contractor shall maintain an ongoing, planned, systematic, organization-wide quality management process to design, measure, analyze and improve its performance, including identification of innovations or best practice.
b. Contractor quality management plan and process, which shall be reviewed and updated by provider as needed but, at a minimum, every six-months, will be audited by NSMHA.
c. Contractor shall ensure Quality Assurance and Quality Improvement data is analyzed, reported and acted upon by its members and affiliates. This shall be demonstrated by written records maintained by Contractor.

Contractor shall present to NSMHA every six (6) months cycle, ending March 31st and September 30th, a QM report integrating all QM program activities and data, in order to facilitate NSMHA's determination of the effectiveness of the overall regional system of care. This report shall be in a mutually agreed format, due 35 days after the end of the six (6)month cycle, and document the results of the Contractor QM plan activities and:

a. Identify areas of efficiency and effectiveness of system operations and the quality of care for individuals;
b. Identify areas of deficiency with plans to achieve expected improvement; and
c. Status of implementation of all NSMHA approved corrective action plans.

23. COORDINATION OF CARE AMONG OUTPATIENT PROVIDERS

Contractor shall comply with NSMHA policy on care coordination. Contractor shall procure and maintain written Memorandums of Understanding (MOU), when necessary, with outpatient provider(s) to ensure an individual receives medically necessary services.

At a minimum, the MOU must State the primary agency and methods of communiqué between agencies to ensure the individual is receiving coordinated care and monitoring.

MOU will clarify if Contractor and provider disagree about the medical necessity of the outpatient modality, the matter will be brought to NSMHA for resolution and NSMHA will make the final decision.

24. COORDINATION WITH TRIBAL AUTHORITIES

If an enrollee is a Tribal Member of a Washington Tribe and is referred to or presents for non-crisis services and the enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or Recognized American Indians Organizations (RAIO) to assist in

treatment planning and service provision for the enrollee. If the enrollee chooses to be served only by Tribal Mental Health Services, Contractor will ensure the enrollee is referred to the appropriate Tribal Mental Health Service Provider

25. DDD ENROLLED INDIVIDUALS

Contractor and its subcontractors must respond to requests to provide information and staff to participate in meetings as a part of monitoring reviews for individuals enrolled with DDD, formerly hospitalized at WSH or ESH, currently living in the community.

E. CONTRACTOR RESPONSIBILITIES

Contractor shall have responsibility for the performance of this Agreement.

Contractor shall include community and county input into planning and access to services.

Contractor shall be held fully responsible for the contractual obligations and performance of its subcontractors. In the performance of these functions, Contractor shall maintain written documentation that verifies each specific responsibility under this Agreement has been performed.

1. COMMUNITY MENTAL HEALTH AGENCY (CMHA)

a. Contractor meets the licensing requirements of WAC 388-877, 388-877A and licensure has not been denied, revoked/suspended;
b. Contractor ensures it is an effective, efficient, adequate and accessible CMHA that is licensed/certified, monitored and capable of providing comprehensive services and be able to demonstrate its ability to carry out the functions required by this Agreement; and
c. Contractor shall cooperate with NSMHA's Strategic Plan and efforts to ensure a sufficient number, mix and geographic distribution of CMHAs, including MHCPs to meet the needs of the anticipated number of enrollees in the service area and provide:

   i. Access to an intake evaluation by an MHP.
   ii. An age-appropriate range of medically necessary mental health services as identified in the Medicaid State Plan and 1915(b) Medicaid Waiver.
   iii. A geographic distribution and mix that allows for the access and distance standards, described below to be met.

2. CAPACITY

Contractor must notify NSMHA in writing of any proposed change in capacity. NSMHA must approve any change that results in reduced capacity.

a. A reduction in capacity is defined as the point in time when Contractor is not able to meet all the access standards as defined in this Agreement. Events that may affect capacity include: closing of a facility in any geographic area, decrease in the State plan services currently available, decrease in the number or frequency of services, employee strike or other work stoppage related to union activities, or any change that may result in Contractor being unable to provide services for those enrollees who are covered by this Agreement.
b. Submit a report to NSMHA by November 1, 2013, or within 30 days of ratification, with current capacity and submission biannually thereafter. Contractor shall notify NSMHA 30 days prior to implementation/public notice when Contractor adds, changes location, or closes a facility and when the number of staff type/specialty changes at any CMHA facility by five (5) staff or more. The report shall identify each Contractor facility location/address, number and FTE of individuals providing direct services that are employed or contracted at each location by type/WAC specialty and staff with specialized training/expertise in NSMHA identified treatments.

c. The termination or addition of a subcontract that provides mental health services is considered a significant change in the provider network. Contractor must notify NSMHA 30 days in advance of public written notice to enrollees before Contractor terminates any of its subcontracts with entities that provide direct service.
d. Contractor must ensure the provision of written notification within 15 days to enrollees receiving services from subcontractor upon written notification of termination by either party.
e. If either party must terminate a subcontract in less than 30 days, Contractor must notify NSMHA as soon as there is a determination to terminate the subcontract and in advance of public notice.
f. If an event identified in section E.2 occurs, Contractor must submit a plan to NSMHA that includes at least the following:

    i. Notification to Ombuds services;
    ii. Crisis services plan;
    iii. Notification plan;
    iv. Plan for provision of uninterrupted services; and
    v. Any information released to the media.

g. Contractor shall demonstrate its performance of this function by maintenance of written records that show routine review and discussion of network maintenance issues by Contractor staff.

3. ACCESS STANDARDS

a. Ensure individuals can access medically necessary mental health services upon request that do not exceed the access standards specified in NSMHA policies. A request for mental health services is defined as a point in time in which mental health services are sought or applied for through a telephone call, walk-in, or written request for mental health services.
b. Urgent and emergent medically necessary mental health services (i.e., crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations/other screening and assessment processes. Contractor must ensure:

    i. Urgent care occurs within 24 hours of the request for mental health services from any source.
    ii. Emergent mental health care occurs within two (2) hours of the request for mental health services from any source.

c. Contractor shall demonstrate its performance of this function by maintenance of written records that show routine review and discussion of access standard issues by Contractor staff.

4. DISTANCE STANDARDS

Ensure when enrollees must travel to service sites, sites are accessible per the following standards:

a. The drive time to the closest CMHA provider from the primary residence of the enrollee.
b. Travel standard does not apply: a) when the enrollee chooses to use service sites that require travel beyond the distance standards; b) when the service provided is at a level not available at the closest CMHA provider, such as crisis stabilization, services provided by PACT, or psychiatric inpatient services including E&T; c) under exceptional circumstances (i.e., inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, or delayed ferry service).

5. RURAL ACCESS

Contractor shall collaborate with NSMHA on increasing access to services in underserved areas of the region. Contractor will identify partnerships and collaborations in the rural communities to promote integration and expand service availability.

Contractor shall enter the address of service for each encounter submitted through NSMHA's Consumer Information System (CIS).

6. STAFF COMPETENCY AND TRAINING

Contractor and its subcontractors shall comply with NSMHA credentialing policies and procedures and shall ensure all staff is qualified for the position they hold and have at a minimum, education, experience and skills to perform their job requirements, per WAC 388-865, 388-877 and 388-877A, including any required licenses or certifications.

Contractor shall require a criminal history background check pursuant to RCW 43.43.830; 832; 834 and 43.20A.710 and WAC 388-877-0500 be completed for all current employees, volunteers and subcontractors and a criminal history background check shall be initiated for all prospective employees, volunteers and subcontractors who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

Contractor shall collaborate with NSMHA to implement, maintain and revise the Regional Training Plan or any successor incorporated as Attachment II.

Contractor must participate in training when requested by NSMHA/DBHR. Requests for NSMHA/DBHR to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to appropriate Contractor/Subcontractor staff.

7. PEER EMPLOYMENT

NSMHA is promoting the increase of Peer counselor/parent partner employment throughout the North Sound Region. Peer Counselors with lived experience have the ability to provide a unique perspective and holistic approach to recovery. Their experience in managing symptoms and expertise in recovery strategies will provide individuals an opportunity to benefit from their experience.

As part of the regional strategy of increasing Peer support throughout the region, Contractor shall work in partnership with NSMHA in the development of a Peer workforce. NSMHA shall sponsor ongoing Peer Counselor training and continued education opportunities for Certified Peer Counselors. Contractor shall work with NSMHA to identify needs within the workforce and identify individuals that are work ready and interested in becoming a Certified Peer Counselor.

Contractor shall actively promote Peer counselor training in coordination with NSMHA. Contractor shall offer pre-employment opportunities, such as volunteering, internships, on site observation and informal/formal introductory meetings with prospective Peer Counselors.

Contractor shall work with NSMHA to increase regional Peer service encounters by 2% over the contract period.

8. RESOURCE AND UTILIZATION MANAGEMENT ACTIVITIES

Contractor shall conduct resource and utilization management activities as requested by NSMHA after discussion between Contractor and NSMHA to ensure that such activities are reasonable and cost-effective. Such activities will include planning and reporting in a manner that will allow NSMHA to ensure that its over- and under-utilization management obligations are met.

9. MANAGEMENT INFORMATION SYSTEM

Contractor shall:

Ensure the existence and operation of an electronic health record (EHR) that is compatible with NSMHA's CIS and has the capability to transmit data timely and accurately. Contractor shall develop and maintain an information system in comport with Exhibit C and Attachment XII, incorporated herein.

NSMHA will require Contractor to provide a Business Continuity and Disaster Recovery Plan (BCDRP) that ensures timely reinstitution of the CIS following total loss of the primary system or a substantial loss of functionality. Contractor must submit to NSMHA the most recent version of the BCDRP within 30 calendar days of execution of this agreement and within 30 calendar days of Contractor updating their BCDRP.

10. MEDICAID ELIGIBILITY

Contractor shall verify an individual's Medicaid eligibility at each appointment. For individuals not currently enrolled in Medicaid, Contractor shall refer individuals to the designated in-person assistor agency in their catchment area. Contractor shall act in accordance with NSMHA policy on eligibility verification herein incorporated by reference.

11. NSMHA AND DBHR REVIEW ACTIVITIES

Contractor shall ensure that remedial actions required as a result of NSMHA/DBHR review activities, as discussed in the Oversight, Remedies and Termination section, are reported and acted upon. This shall be demonstrated by written records maintained by Contractor.

12. DELIVERABLES, PLANS AND REPORTS

Contractor must ensure plans or reports required by this Agreement, including those outlined in Attachment IV, Deliverables, are provided to NSMHA in compliance with the timelines/formats indicated.

If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties, the Contractor may provide one report or deliverable that contains the information required by both Agreements.

13. BUSINESS ASSOCIATES AGREEMENT

Contractor shall abide by the provisions of NSMHA's and Contractor's Business Associates Agreement, Attachment V.

F. FINANCIAL TERMS AND CONDITIONS

1. GENERAL FISCAL ASSURANCES

Contractor shall comply with all applicable laws and standards, including Generally Accepted Accounting Principles and maintain, at a minimum, a financial management system that is a viable, single, integrated system with sufficient sophistication and capability to effectively and efficiently process, track and manage all fiscal matters and transactions.

Contractor and subcontractors shall make all possible efforts to maintain current compensation levels of "Direct Care Staff". Such efforts shall include, but not be limited to, identifying local administrative reductions at the provider level and engaging stakeholders on cost-savings ideas that maintain services and staff compensation. Upon request, Contractor shall provide information to NSMHA on efforts to comply with these statutory requirements.

2. FINANCIAL ACCOUNTING REQUIREMENTS

Contractor shall:

a. Establish and maintain operating reserves at prudent levels sufficient to ensure Contractor has the ability to pay for all expenses incurred during this Agreement period, including those whose disposition occurs after the Agreement has been terminated and to cover the risk of financial loss resulting in the event the cost of providing services pursuant to this Agreement exceeds the revenues derived therefrom;
b. Ensure all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system within the service area.
c. Reimburse within 60 calendar days subcontractors and any crisis service providers accessed by individuals while out-of-the-state.
d. Contractor shall produce annual audited financial statements upon completion and make such reports available to NSMHA upon request.

3. FINANCIAL REPORTING

Contractor shall provide the following reports to NSMHA:

a. Report Contractor and subcontract revenue and expenditure information to NSMHA on a biannual basis. Reports must comply with the provisions in the Budget, Accounting and Reporting System (BARS) Supplemental Instructions for Mental Health Services promulgated by Washington State Auditor's Office. Reports are due within 30 days of the quarter end (quarters ending in December and June of each year).
b. Contractor shall participate in NSMHA/DBHR Unit Cost Surveys and actuarial studies, when required by NSMHA/DBHR.

4. COUNTY FUNDING

Funds received by Contractor from any one or more of the service area counties specifically for the purpose of providing services to individual county programs during the term of this Agreement are not intended to reduce or supplant funds provided under this Agreement. County funds shall be used as additional funds in furnishing those additional local services for which such county funds were provided.

5. RULES COMPLIANCE

Contractor shall:

a. Contractor shall have a sliding fee scale which is posted and accessible to staff and service recipients and does not require payment from service recipients with income levels equal to or below the grant standards for the general assistance program of the State of Washington;
b. Submit the amount spent throughout the service area on specific items at the request of NSMHA, Centers for Medicare and Medicaid Services (CMS), legislature, or DSHS in the timeframe specified;
c. Account for public mental health expenditures under this Agreement in accordance with Federal circular A-133, A-122, A-87 and State requirements in accordance with BARS Manual and BARS Supplemental Instructions or any successor
d. Limit administration costs incurred by Contractor and all subcontractors to no more than 15% of the consideration provided under this contract in any State fiscal year. Administration costs must be measured on a State fiscal year basis according to the reported information submitted by Contractor in its Revenue and Expenditure reports (Attachment VI) and reviewed by NSMHA.

6. LIABILITY FOR PAYMENT AND THE PURSUIT OF THIRD PARTY REVENUE

Contractor shall be responsible for developing financial processes that enable them to reasonably ensure all third-party resources available to individuals are identified and pursued in accordance with the reasonable collection practices which Contractor's apply to all other payers for services covered under this Agreement. NSMHA shall actively provide Contractor support in the pursuit of third-party payments for all services including crisis services.

Contractor shall maintain necessary records to document all third-party resources and report to NSMHA on a biennial basis or upon the reasonable request of NSMHA, the amount of such third-party resources collected for all service recipients during the quarter by source of payment.

7. FINANCIAL PROVISIONS - REIMBURSEMENT REQUIREMENTS

The consideration to be paid by NSMHA for the work to be provided by Contractor pursuant to this Agreement shall consist of the available amount from primary funding sources as described in Attachment VIII of this Agreement.

a. Contractor shall submit an invoice for capacity funded/cost reimbursement portions of this agreement on a monthly basis.
b. Contractor shall submit requests for flex funds and interpreter services in compliance with NSMHA Flex Fund Policy and Flex Fund Form incorporated herein by reference.
c. Contractor shall submit an invoice to NSMHA 15 days after the end of the month.

    i. Contractor shall submit encounter data per the MIS section on the fee-for-service portion of this agreement.
    ii. Contractor shall be paid on a daily rate for the following residential services:

        a) Aurora House individual daily rate of $45.41;
        b) Green House individual daily rate of $37.59; and
        c) Haven House individual daily rate of $29.10.

    iii. Payment will be adjusted to the encounters submitted;
    iv. Adjustment will be calculated by a daily rate per individual per day during that month.

    The consideration by NSMHA to Contractor pursuant to this Agreement shall be paid monthly within 15 working days of NSMHA's receipt of payment by DSHS/DBHR.

d. Performance Incentive Payment
   Performance will be measured by creating a monthly list of Medicaid/non-Medicaid individuals referred by NSMHA to Contractor who have been admitted to one of the identified inpatient facilities.

Upon discharge an individual receiving a qualifying service within seven (7) calendar days will be counted as meeting the measurement. An individual not receiving a qualifying service within seven (7) calendar days of discharge will be counted as not meeting the measurement.

a. Baseline for measure is set at 46%;
b. Goal for measure is set at 75%;
c. Percent of positive change between baseline and goal will be multiplied by $20,000;
d. Reconciliation will occur every 3 months;
e. Maximum incentive is $100,000 through June 30, 2015.

Funds for July 1, 2015, through September 30, 2015, following the end of the annual State legislative session, NSMHA shall offer an Amendment with the proposed funds for the next fiscal year. If for any reason Contractor does not agree to continue to provide services using the proposed funds, Contractor must provide the appropriate notice to NSMHA under the termination requirements of Section G.

8. FRAUD AND ABUSE

Contractor shall develop and implement administrative and management procedures designed to guard against fraud and abuse including:

a. Mandatory compliance plan;
b. Designation of compliance officer or compliance committee that is accountable to Contractor;
c. Effective ongoing training and education for compliance officer and Contractor staff;
d. Effective lines of communication between compliance officer, employees and any subcontractors;
e. Enforcement of standards through well-publicized disciplinary guidelines;
f. Provision of internal monitoring and auditing;
g. Provision for prompt response to detected offenses and for development of corrective action initiatives;
h. Participation by Contractor and any subcontractors in Medicaid fraud and abuse training conducted by Washington State Attorney General's Medicaid Fraud Unit.
i. Written policies, procedures and standards of conduct that articulate Contractor's commitment to comply with all applicable Federal and State standards.

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

Complaints and reports should be directed to NSMHA contact listed below.

Compliance Officer
117 N First St., Ste. 8
Mt. Vernon, WA 98273
360.416.7013
1.800.684.3555
compliance_officer@nsmha.org

G. OVERSIGHT, REMEDIES AND TERMINATION

1. OVERSIGHT AUTHORITY

NSMHA, DSHS, Office of the State Auditor, the Department of Health and Human Services (DHHS), CMS, the Comptroller General, or any of their duly-authorized representatives (i.e., External Quality Review Organizations), have the authority to conduct announced and unannounced: a) surveys; b) audits; c) reviews of compliance with licensing and certification requirements and compliance with this Agreement; d) audits regarding the quality, appropriateness and timeliness of mental health services of Contractor and subcontractors; and e) audits and inspections of financial records of Contractor and subcontractors. Contractor shall notify NSMHA when an entity other than NSMHA performs any audit described above related to any activity contained in this Agreement.

In addition, NSMHA will conduct reviews in accordance with its oversight of resource, utilization and quality management, as well as, ensure Contractor has the clinical, administrative and fiscal structures to enable them to perform in accordance with the terms of the contract. Such reviews may include, but are not limited to, encounter data validation, utilization reviews, clinical record reviews, administrative structures reviews, fiscal management and contract compliance. Reviews may include desk reviews, requiring Contractor to submit requested information. NSMHA will also review any activities delegated under this contract to Contractor.

Contractor shall cooperate with and allow access to North Sound Regional Ombuds to review activities in accordance with the terms of this contract and in accordance with Attachment VII. Contractor shall cooperate with Community Action of Skagit County in resolving any disputes that arise in the provision of Ombuds services.

Findings as a result of NSMHA conducted reviews may result in remedial action as outlined below. Federal and State agencies may impose remedial action or financial penalties either directly upon Contractor or through NSMHA. Contractor shall comply with the terms of such remedial action and be responsible for the payment of financial penalties.

2. REMEDIAL ACTION

NSMHA may require Contractor to plan and execute corrective action. Corrective action plans (CAP) developed by Contractor must be submitted for approval to NSMHA within 30 calendar days of notification. CAP must be provided in a format acceptable to NSMHA. NSMHA may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by NSMHA.

a. CAP must include:

   i. A brief description of the finding.
   ii. Specific actions to be taken, timetable, description of the monitoring to be performed, steps taken and responsible individuals that will reflect the resolution of the situation.

b. CAP may:

Require modification of any policies or procedures by Contractor relating to the fulfillment of its obligations pursuant to this Agreement.

c. CAP are subject to approval by NSMHA, which may:

i. Accept the plan as submitted;
ii. Accept the plan with specified modifications;
iii. Request a modified plan; or
iv. Reject the plan.

d. Contractor agrees NSMHA may initiate remedial action with or without a CAP as outlined in subsection below if NSMHA determines any of the following situations exist:

i. A problem exists that poses a threat to the health or safety of any person or poses a threat of property damage/incident has occurred that resulted in injury or death to any person/resulted in damage to property;
ii. Contractor has failed to perform any of the mental health services required in this Agreement, which includes the failure to maintain the required capacity as specified by NSMHA to ensure individuals receive medically necessary services, including delegated functions; *except*, that no remedial action pursuant to subsection (e) hereof shall be taken if such failure to maintain required capacity is due to any interruption in, or depletion of, the available amount of money to Contractor as described in Attachment VIII of this contract for purposes of performing services to enrollees as described in Section B of this contract; however, in such an instance, NSMHA may terminate all or part of this contract on as little as 30 days written notice.
iii. Contractor has failed to develop, produce/deliver to NSMHA any of the statements, reports, data, data corrections, accountings, claims and/or documentation described herein in compliance with all the provisions of this Agreement;
iv. Contractor has failed to perform any administrative function required under this Agreement including delegated functions. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of mental health services;
v. Contractor has failed to implement corrective action required by the State and within NSMHA prescribed timeframes.

e. NSMHA may impose any of the following remedial actions in response to findings of situations as outlined above:

i. Withhold one percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. NSMHA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved;
ii. Compound withholdings identified above by an additional one-half of one percent for each successive month during which the remedial situation has not been resolved;
iii. Revoke delegation of any function delegated under this contract;
iv. Deny any incentive payment to which Contractor might otherwise have been entitled under this Agreement or any other arrangement by which DBHR provides incentives; or
v. Termination for Default, as outlined in this Agreement.

3. ADDITIONAL FINANCIAL PENALTIES – DBHR IMPOSED SANCTIONS

Financial penalties imposed by DBHR or other regulatory agency due to the action or inaction of Contractor may be paid by NSMHA on behalf of Contractor and the amount will be withheld from NSMHA's payments to Contractor.

4. TERMINATION DUE TO CHANGE IN FUNDING

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to its normal completion, either party may terminate this Agreement subject to re-negotiations.

5. TERMINATION FOR CONVENIENCE

Except, as otherwise provided in this Agreement, NSMHA may terminate this Agreement in whole or in part for convenience by giving Contractor at least 30 calendar days' written notice. Contractor may terminate this Agreement for convenience by giving NSMHA at least 30 calendar days' written notice addressed to NSMHA's Program Administrator or his/her successor listed on the last page of this Agreement.

6. TERMINATION FOR DEFAULT

NSMHA's Program Administrator may terminate this Agreement for default, in whole or in part, by written notice to Contractor if NSMHA or DSHS has a reasonable basis to believe that Contractor has:

a. Failed to meet or maintain any requirement for contracting with NSMHA;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement; and/or
d. Otherwise breached any provision or condition of this Agreement.

Before the Program Administrator may terminate this Agreement for default, NSMHA shall provide Contractor with written notice of non-compliance with this Agreement and provide Contractor a reasonable opportunity to correct non-compliance. If Contractor does not

correct non-compliance within the period of time specified in the written notice of non-compliance, the Program Administrator may then terminate this Agreement. The Program Administrator may terminate this Agreement for default without such written notice and without opportunity for correction if NSMHA has a reasonable basis to believe an individual's health or safety is in jeopardy and/or:

a. Contractor has violated any law, regulation, rule, or ordinance applicable to services provided under this agreement or
b. Continuance of this Agreement with Contractor poses a material risk of injury or harm to any person.

Contractor may terminate this Agreement in whole or in part, by written notice to NSMHA, if Contractor has a reasonable basis to believe NSMHA has:

a. Failed to meet or maintain any requirement for contracting with the Contractor;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to work performed under this Agreement; and/or
d. Otherwise breached any provision or condition of this Agreement.

7. TERMINATION PROCEDURE

The following provisions shall survive and be binding on the parties in the event this Agreement is terminated:

a. Contractor and any applicable subcontractors shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of individuals, distribution of property and termination of services. Each party shall be responsible only for its performance in accordance with the terms of this Agreement rendered prior to the effective date of termination. Contractor and any applicable subcontractors shall assist in the orderly transfer/transition of the individuals served under this Agreement. Contractor and any applicable subcontractors shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.
b. Contractor and any applicable subcontractors shall immediately deliver to NSMHA's Program Administrator or his/her successor, all NSMHA/DSHS assets (property) in Contractor and any applicable subcontractor's possession and any property produced under this Agreement. Contractor and any applicable subcontractors grants NSMHA/DSHS the right to enter upon Contractor and any applicable subcontractors premises for the sole purpose of recovering any NSMHA/DSHS property Contractor and any applicable subcontractors fail to return within 10 working days of termination of this Agreement. Upon failure to return NSMHA/DSHS property within 10 working days of the termination of this Agreement, Contractor and any applicable subcontractors shall be charged with all reasonable costs of recovery, including transportation and attorney's fees. Contractor and any applicable subcontractors shall

protect and preserve any property of NSMHA/DSHS that is in the possession of Contractor and any applicable subcontractors pending return to NSMHA/DSHS.

c. NSMHA shall be liable for and shall pay for only those services authorized and provided through the date of termination. NSMHA may pay an amount agreed to by the parties for partially completed work and services, if work products are useful to or usable by NSMHA.
d. If the Program Administrator terminates this Agreement for default, NSMHA may withhold a sum from the final payment to Contractor that NSMHA determines is necessary to protect NSMHA against loss or additional liability occasioned by the alleged default. NSMHA shall be entitled to all remedies available at law, in equity, or under this Agreement. If it is later determined Contractor was not in default, or if Contractor terminated this Agreement for default, Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement.
e. If Contractor terminates this Agreement, NSMHA will require the spend-down of all remaining State fund reserves and fund balance within the termination period. State funds shall be deducted from the final months' payments until reserves and fund balances are spent.

8. NOTICE REQUIREMENTS

Either party to this Agreement must provide 180 days' notice of any issue that may cause the party to voluntarily terminate, refuse to renew, or refuse to sign a mandatory amendment to this Agreement.

a. If Contractor at any time decides it shall no longer be a Contractor with NSMHA for any reason, Contractor must provide NSMHA's Program Administrator or his/her successor listed on the last page of this Agreement with written notice at least 90 days prior to the effective date of termination and work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services. The transition plan shall address all issues leading to the transition of individuals in service and all items/requirements of Contractor that extend beyond the termination of services.
b. NSMHA must provide Contractor's Program Administrator or his/her successor listed on the last page of this Agreement with written notice at least 90 days prior if NSMHA decides to voluntarily terminate, refuses to renew, or refuses to sign a mandatory amendment to this Agreement. Contractor shall work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services.

If Contractor terminates this Agreement or will not be entering into any subsequent Agreements, NSMHA shall require at least 90 days' notice prior to the end of the contract if a decision is made not to enter into a subsequent agreement. Any funds not spent for the provision of services under this Agreement shall be returned to NSMHA within 60 days of the last day this Agreement is in effect.

H. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR

1. BACKGROUND

NSMHA is an entity formed by inter-local agreement between Island, San Juan, Skagit, Snohomish and Whatcom Counties, each county authority is recognized by the Secretary of DSHS ("Secretary"). These counties entered into an inter-local agreement to allow NSMHA to contract with the Secretary pursuant to RCW 71.24.025(13), to operate a single managed system of services for persons with mental illness living in the service area covered by Island, San Juan, Skagit, Snohomish and Whatcom Counties. NSMHA is party to an inter-agency agreement with the Secretary, pursuant to which NSMHA has agreed to provide integrated community support, crisis response and inpatient management services to people needing such services in its service area. NSMHA, through this Agreement, is subcontracting with Contractor for the provision of specific mental health services as required by the agreement with the Secretary. Contractor, by signing this Agreement, attests it is willing and able to provide such services in the service area.

2. MUTUAL COMMITMENTS

The parties to this Agreement are mutually committed to the development of an efficient, cost effective, integrated, person-centered, age-specific resilience and recovery model approach to the delivery of quality community mental health services. To that end, the parties are mutually committed to maximizing the availability of resources to provide needed mental health services in the service area, maximizing the portion of those resources used for the provision of direct services and minimizing duplication of effort.

3. ASSIGNMENT

Except as otherwise provided within this Agreement, this Agreement may not be assigned, delegated, or transferred by Contractor without the express written consent of NSMHA and any attempt to transfer or assign this Agreement without such consent shall be void. The terms "assigned", "delegated", or "transferred" shall include change of business structure to a limited liability company of any Contractor Member or Affiliate Agency.

4. AUTHORITY

Concurrent with the execution of this Agreement, Contractor shall furnish NSMHA with a copy of the explicit written authorization of its governing body to enter into this Agreement and accept the financial risk and responsibility to carry out all terms of this Agreement including the ability to pay for all expenses incurred during the contract period. Likewise, concurrent with the execution of this Agreement, NSMHA shall furnish Contractor with a written copy of the motion, resolution, or ordinance passed by NSMHA's Board authorizing NSMHA to execute this Agreement.

5. COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND OPERATIONAL POLICIES

Contractor and its subcontractors shall comply with all applicable Federal and State statutes, regulations and operational policies whether or not a specific citation is identified in various sections of this Agreement and all amendments thereto that are in effect when the

Agreement is signed or come into effect during the term of the Agreement which may include, but are not limited to, the following ("Federal/State law"):

a. Title XIX and Title XXI of the Social Security Act and Title 42 CFR.
b. All applicable Office of the Insurance Commissioner (OIC) statutes and regulations.
c. All local, Federal and State professional and facility licensing and certification requirements/standards that apply to services performed under the terms of this Agreement.
d. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738 and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS and the EPA.
e. Any applicable mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.
f. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
g. Those specified in Title 18 RCW for professional licensing.
h. Reporting of abuse as required by RCW 26.44.030.
i. Industrial insurance coverage as required by Title 51 RCW.
j. RCW 38.52, 70.02, 71.05, 71.24, and 71.34.
k. WAC 388-865 and 388-877, 877A.
l. 42 CFR 438, including 438.58 (conflict of interest) and 438.106 (physician incentive plans).
m. State of Washington Medicaid State Plan and 1915(b) Medicaid Mental Health Waiver or their successors which documents are incorporated by reference.
n. DBHR Quality Strategy.
o. State of Washington mental health system mission statement, value statement and guiding principles for the system, attached hereto as Exhibit D.
p. State Medicaid Manual (SMM), OMB Circulars, BARS Manual and BARS Supplemental Mental Health Instructions.
q. Any applicable Federal and State laws that pertain to Medicaid enrollee or consumer rights. Contractor shall ensure its staff takes those rights into account when furnishing services to individuals.
r. DSHS Administrative policies, to the extent they are applicable to this contract are attached as Exhibits F, G and H.
s. 42 USC 1320a-7 and 1320a-7b (Section 1128 and 1128 (b) of the Social Security Act) which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit mental health services provided to individuals.
t. Any policies and procedures developed by DSHS/Health Care Authority which governs the spend-down of an individual's assets.
u. Contractor and any subcontractors must comply with 42-USC 1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of

more than 5% of Contractor, CMHA, or subcontractor's equity or an employee, Contractor, or consultant who is significant or material to the provision of services under this Agreement who has been or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any Federal agency.

v. Federal and State non-discrimination laws and regulations.
w. HIPAA (45 CFR parts 160-164).
x. DBHR-CIS Data Dictionary and its successors.
y. Federal funds must not be used for any lobbying activities.

If Contractor is in violation of a Federal law or regulation and Federal Financial Participation is recouped from NSMHA, Contractor shall reimburse the Federal amount to NSMHA within 20 days of such recoupment.

Upon notification from DSHS, NSMHA shall notify Contractor in writing of changes/modifications in CMS policies and DSHS/DBHR contract requirement (Attachment III) changes.

6. COMPLIANCE WITH NSMHA OPERATIONAL POLICIES

Contractor shall comply with all NSMHA operational policies that pertain to the delivery of services under this Agreement that are in effect when the Agreement is signed or come into effect during the term of the Agreement. NSMHA policies shall not exceed that required to implement Federal and State requirements or to implement continuous quality improvement efforts determined by the Integrated QM Process as approved by NSMHA's Board. All proposed new policies shall specifically reference the Federal or State requirements they implement and shall be limited to such requirements. NSMHA shall notify Contractor of any proposed change in Federal or State requirements affecting this agreement immediately upon NSMHA receiving knowledge of such change. Such policies shall include, but not limited to:

a. NSMHA Core Values and Principles attached hereto as Attachment I provide a framework of principles for the regional system and Contractor shall take these principles into account when providing services under this Agreement.
b. Contractor and its subcontractors must recognize the unique social/legal status of Indian nations as required by both the Supremacy and Indian Commerce Clauses of the United States Constitution, Federal treaties, executive orders, Indian Citizens Act of 1924 statutes and Federal and State court decisions, or any Memorandum of Agreement or MOU signed by State of Washington and Federally recognized tribe of recognized organization; shall maintain compliance with Exhibit G, DSHS Admin. Policy No. 7.01 American Indian Policy or any successor pursuant to the Centennial Accord between Washington State Government and Washington Tribes and maintain compliance with NSMHA 7.01 Plan or any successor incorporated as Attachment II.
c. NSMHA's Strategic Plan.
d. NSMHA's clinical policies and procedures including crisis services policies.
e. NSMHA's medical records documentation and data reporting policies and procedures.
f. NSMHA's QM/Strategy Plan.

g. NSMHA consumer rights policies and procedures including complaint, grievance, appeal and fair- hearing policies.
h. Any other policies designated by NSMHA as applicable to Contractor.

Along with all NSMHA stakeholders, Contractor will be included in the process for developing relevant operational policies and procedures. NSMHA's policies and procedures are posted on NSMHA's website as indicated on Attachment II. NSMHA shall notify Contractor of new and revised policies through its Numbered Memoranda. Training will be provided on policies that impact providers, upon request.

In the event there is a disagreement between NSMHA and Contractor in an operational committee regarding a proposed new policy or modification to a current policy, the following process will apply:

a. NSMHA will provide a summary of the regulatory requirement or other rationale for the proposed policy or policy modification.
b. Contractor will provide an analysis of its objection to the proposed policy or policy modification within 30 days from the receipt of NSMHA's summary. If the objection is primarily due to increased cost, Contractor will provide substantiation of the additional costs and, if possible, an alternative to achieving the policy goal in a less costly manner.
c. The proposed policy or policy modification will be discussed at the next Regional Management Council.
d. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next QMOC meeting.
e. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next NSMHA Board meeting.

NSMHA will make best efforts to maintain currency of policies with applicable Federal or State laws, regulations, or policies. In the event of a conflict, Federal or State laws or policies supersede NSMHA policies and procedures and requirements of this contract.

7. CONFIDENTIALITY OF PERSONAL INFORMATION

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

a. Establishing eligibility;
b. Determining the amount of medical assistance;
c. Providing services for recipients;
d. Conducting or assisting in investigation, prosecution, or civil/criminal proceeding related to the administration of the plan;
e. Ensuring compliance with Federal and State laws, regulations, terms and requirements of this Agreement; and/or
f. Improving quality.

Contractor shall comply with all confidentiality requirements of HIPAA (45 CFR 160 and 164).

Contractor shall have a process in place to ensure all components of its CMHA and system understand and comply with confidentiality requirements for publicly funded mental health services.

Contractor shall ensure access to the information is restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of NSMHA and DSHS.

The parties acknowledge coordination, planning, screening and referral require the sharing of information among the various treatment providers. Disclosure of information to verify eligibility, determine the amount of assistance and provide medically necessary mental health services are all "purposes directly connected with the administration of the Agreement" and are all appropriate justifications for sharing information.

Contractor shall ensure all staff and subcontractors providing services under this Agreement receive annual training on confidentiality policies and procedures. In addition, Contractor shall ensure all staff and subcontractors providing services under this Agreement sign an annual Oath of Confidentiality statement. Signed copies of the Oath of Confidentiality shall be kept in Contractor's personnel files.

8. CONTRACT PERFORMANCE/ENFORCEMENT

NSMHA shall be vested with the rights of a third party beneficiary including the "cut through" right to enforce performance should Contractor be unwilling or unable to enforce action on the part of its subcontractor(s). In the event Contractor dissolves or otherwise discontinues operations, NSMHA may, at its sole option, assume the right to enforce the terms and conditions of this Agreement directly with subcontractors; provided, NSMHA keeps Contractor reasonably informed concerning such enforcement. Contractor shall include this clause in its contracts with its subcontractors. In the event of the dissolution of Contractor, NSMHA's rights in indemnification shall survive.

9. COOPERATION

The parties to this Agreement shall cooperate in good faith to effectuate the terms and conditions of this Agreement.

10. DEBARMENT CERTIFICATION

Contractor certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal or State department or agency. If requested by DSHS or NSMHA, Contractor shall complete a certification regarding debarment, suspension, ineligibility, or voluntary exclusion. Any certification regarding debarment, suspension, ineligibility, or voluntary exclusion pertaining to this Agreement shall be incorporated into this Agreement by reference.

11. DECLARATION THAT INDIVIDUALS UNDER THE MEDICAID AND OTHER MENTAL HEALTH PROGRAMS ARE NOT THIRD-PARTY BENEFICIARIES UNDER THIS CONTRACT

Although NSMHA, Contractor and subcontractors mutually recognize services under this Agreement may be provided by Contractor and subcontractors to individuals under the Medicaid program, RCW 71.05 and 71.34 and the Community Mental Health Services Act, RCW 71.24, it is not the intention of either NSMHA or Contractor that such individuals or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement. Such third parties shall have no right to enforce this agreement.

12. EXECUTION, AMENDMENT AND WAIVER

This Agreement shall be binding on all parties only upon signature by authorized representatives of each party. This Agreement or any provision may be amended during the contract period, if circumstances warrant, by a written amendment executed by all parties. Only NSMHA's Program Administrator or designee has authority to waive any provision of this Agreement on behalf of NSMHA.

13. HEADINGS AND CAPTIONS

The headings and captions used in this Agreement are for reference and convenience only and in no way define, limit, or decide the scope or intent of any provisions or sections of this Agreement.

14. INDEMNIFICATION

Contractor shall be responsible for and shall indemnify and hold NSMHA harmless (including all costs and attorney fees) from all claims for personal injury, property damage/disclosure of confidential information/the imposition of governmental fines or penalties resulting from the acts or omissions of Contractor and its subcontractors related to the performance of this contract. NSMHA shall be responsible and shall indemnify and hold Contractor harmless (including all costs and attorney fees) from all claims for personal injury, property damage, disclosure of confidential information and the imposition of governmental fines or penalties resulting from the acts or omissions of NSMHA. For the purposes of these indemnifications, Parties specifically and expressly waive any immunity granted under Washington Industrial Insurance Act, Title 51 RCW. This waiver has been mutually negotiated and agreed to by the Parties. The provision of this section shall survive the expiration or termination of the Agreement.

15. INDEPENDENT CONTRACTOR FOR NSMHA

The parties intend that an independent contractor relationship be created by this contract. Contractor acknowledges the Contractor, its employees, or subcontractors are not officers, employees, or agents of NSMHA. Contractor shall not hold Contractor, Contractor's employees and subcontractors out as, nor claim status as, officers, employees, or agents of NSMHA. Contractor shall not claim for Contractor, Contractor's employees, or subcontractors any rights, privileges, or benefits which would accrue to an employee of NSMHA. Contractor shall indemnify and hold NSMHA harmless from all obligations to pay or withhold Federal or State taxes or contributions on behalf of Contractor, Contractor's employees and subcontractors unless specified in this Agreement.

16. INSURANCE

NSMHA certifies it is a member of Washington Governmental Entity Pool for all exposure to tort liability, general liability, property damage liability and vehicle liability, if applicable, as provided by RCW 43.19.

Contractor shall maintain Commercial General Liability Insurance (CGL). If Contractor is not a member of a risk pool, Contractor shall carry CGL to include coverage for bodily injury, property damage and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000; shall include liability arising out of premises, operations, independent contractors, personal injury, advertising injury and liability assumed under an insured contract. Contractor shall provide evidence of such insurance to NSMHA within 15 days of execution of this Agreement and 15 days post renewal date thereafter. All non-risk pool policies shall name NSMHA as a covered entity under said policy(s).

17. INTEGRATION

This Agreement, including Exhibits and Attachments, contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

18. MAINTENANCE OF RECORDS

During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records set forth below is started before expiration of the six (6) year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the six (6) year period, whichever is later. Contractor shall maintain records sufficient to:

a. Maintain the content of all Medical Records in a manner consistent with utilization control requirements of 42 CFR 456, 434.34 (a), 456.111 and 456.211.
b. Document performance of all acts required by law, regulation, or this Agreement.
c. Substantiate Contractor statement of its organizations' structures, tax status, capabilities and performance.

d. Demonstrate accounting procedures, practices and records which sufficiently and properly document Contractor invoices to NSMHA and all expenditures made by Contractor to perform as required by this Agreement.
e. Contractor and its subcontractors shall cooperate in all reviews including, but not limited to, surveys and research conducted by NSMHA, DSHS, or other Washington State Departments.
f. Evaluations shall be done by inspection or other means to measure quality, appropriateness and timeliness of services performed under this Agreement and to determine whether Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable Federal and State regulations as existing or hereafter amended.

19. NO WAIVER OF RIGHTS

A failure by either party to exercise its rights under this Agreement shall not preclude that party from subsequent exercise of such rights and shall not constitute a waiver of any other rights under this Agreement unless stated to be such in writing signed by an authorized representative of the party and attached to the original Agreement.

Waiver of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent breach and shall not be construed to be a modification of the terms and conditions of this Agreement.

20. ONGOING SERVICES

Contractor and its subcontractors shall ensure that in the event of labor disputes or job actions including work slowdowns, such as "sick outs", or other activities within its service CMHA network, uninterrupted services shall be available as required by the terms of this Agreement

21. ORDER OF PRECEDENCE

In the event of an inconsistency in the terms of this Agreement or any inconsistency between the terms of this Agreement and any applicable statute, rule, or contract, unless otherwise provided herein, the conflict shall be resolved by giving precedence in the following order to:

a. State statutes and regulations concerning the operation of the community mental health programs.
b. Federal and State law.
c. NSMHA-DSHS agreement or its successors that covers the provision of the mental health services covered under this Agreement, which shall include any exhibit, document, or material incorporated by reference. NSMHA shall promptly notify Contractor of any amendment to NSMHA-DSHS agreement which affects any term or condition herein.
d. This Agreement.

22. OVERPAYMENTS

In the event Contractor fails to comply with any of the terms and conditions of this Agreement and that failure results in an overpayment, NSMHA may recover the amount due DSHS, CMS, or other Federal or State agency subject to dispute resolution as set forth in the contract. In the case of overpayment, Contractor shall cooperate in the recoupment process and return to NSMHA the amount due upon demand.

23. OWNERSHIP OF MATERIALS

Materials created by Contractor and its subcontractors and paid for by NSMHA as a part of this Agreement shall be owned by NSMHA and shall be "works for hire" as defined by the U.S. Copyright Act of 1976. This material includes, but is not limited to: books, computer programs, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes and/or training materials. Material which Contractor and its subcontractors use to perform this Agreement but which is not created for or paid for by NSMHA is owned by Contractor or relevant subcontractors; however, NSMHA and DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

24. PERFORMANCE

Contractor shall furnish the necessary personnel, materials/mental health services and otherwise do all things for, or incidental to, the performance of the work set forth here and as attached. Unless specifically stated, Contractor is responsible for performing or ensuring all fiscal and program responsibilities required in this contract. No subcontract will terminate the legal responsibility of Contractor to perform the terms of this Agreement.

25. RESOLUTION OF DISPUTES

The parties wish to provide for prompt, efficient, final and binding resolution of disputes and controversies that may arise under this Agreement; therefore, establish this dispute resolution procedure. All claims, disputes and other matters in question between the parties arising out of, or relating to, this Agreement shall be resolved exclusively by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

a. The parties shall use their best efforts to resolve issues prior to giving written Notice of Dispute.
b. Within 10 working days of receipt of the written Notice of Dispute, the parties (or a designated representative) shall together or, if both parties agree, with a mediator meet, confer and attempt to resolve the claim within the next five (5) working days.
c. The terms of the resolution of all claims concluded in meetings shall be memorialized in writing and signed by each party.

Arbitration: If the claim is not resolved within 30 days, the parties shall proceed to arbitration as follows:

a. Demand for arbitration shall be made in writing to the other party. The parties shall select one person as arbitrator.
b. If there is a delay of more than 10 days in the naming of the arbitrator, either party can ask the presiding judge of Skagit County to name the arbitrator.
c. The prevailing party shall be entitled to recover from the other party all costs and expenses including reasonable attorney fees. The arbitrator shall determine which party, if any, is the prevailing party.
d. The parties agree the arbitrator's decision shall be binding, final and enforceable subject to timely appeal to Skagit County Superior Court only as provided in Chapter 7.04A RCW.
e. Unless the parties agree in writing otherwise, the unresolved claims in each notice of dispute shall be considered at an arbitration session which shall occur in Skagit County no later than 30 days after the close of the meeting described in paragraph (b) above.
f. Provisions of this section shall, with respect to any controversy or claim, survive the termination or expiration of this Agreement.
g. Nothing contained in this Agreement shall be deemed to give the arbitrator the power to change any of the terms and conditions of this Agreement in any way.
h. The prevailing party in any action to compel arbitration or to enforce an arbitration award shall be awarded its costs including attorney fees. Venue for any such action is exclusively Skagit County Superior Court.
i. This Agreement shall be governed by laws of State of Washington, both as to interpretation and performance.

26. SEVERABILITY AND CONFORMITY

The provisions of this Agreement are severable. If any provision of this Agreement, including any provision of any document incorporated by reference is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

27. SINGLE AUDIT ACT

If Contractor or its subcontractor is a subrecipient of Federal awards as defined by OMB Circular A-133, Contractor and its subcontractors shall maintain records that identify all Federal funds received and expended. Such funds shall be identified by the appropriate OMB Catalog of Federal Domestic Assistance titles and numbers, award names and numbers, award years if awards are for research and development, as well as, names of the Federal agencies. Contractor and its subcontractors shall make Contractor and its subcontractors' records available for review or audit by officials of the Federal awarding agency, the General Accounting Office and DSHS. Contractor and its subcontractors shall incorporate OMB Circular A-133 audit requirements into all contracts between Contractor and its subcontractors who are subrecipients. Contractor and its subcontractors shall comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation.

If Contractor/its subcontractors are a subrecipient and expends $500,000 or more in Federal awards from any/all sources in any fiscal year, Contractor and applicable subcontractors shall procure and pay for a single or program-specific audit for that fiscal year. Upon completion of each audit, Contractor and applicable subcontractors shall submit to NSMHA's Program Administrator the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide, if applicable, and a copy of any management letters issued by the auditor.

28. SUBCONTRACTS

Contractor may subcontract services to be provided under this Agreement subject to the following requirements.

a. Contractor shall be responsible for the acts and omissions of any subcontractor.
b. Contractor must ensure the subcontractor neither employs any person nor contracts with any person or CMHA excluded from participation in Federal healthcare programs under either 42 USC 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions.
c. Contractor shall require subcontractors to comply with all applicable Federal and State laws, regulations and operational policies as specified in this Agreement.
d. Contractor shall require subcontractors to comply with all applicable NSMHA operational policies as specified in this Agreement.
e. Subcontracts for the provision of mental health services must require Subcontractors to provide individuals access to translated information and interpreter services.
f. Contractor shall ensure a process is in place to demonstrate all third-party resources are identified and pursued.
g. Contractor shall oversee, be accountable for and monitor all functions and responsibilities delegated to a subcontractor for conformance with any applicable statement of work in this agreement on an ongoing basis including written reviews.
h. Contractor will monitor performance of the subcontractors on an annual basis and notify NSMHA of any identified deficiencies or areas for improvement requiring corrective action by Contractor.
i. Contractor shall ensure all subcontracts are in writing and subcontracts specify all duties, reports and responsibilities delegated under this Agreement. Those written subcontracts shall:

    i. Require subcontractors to hold all necessary licenses, certifications and/or permits as required by law for the performance of the services to be performed under this Agreement.
    ii. Subcontracts must require subcontractors to notify Contractor in the event of a change in status of any required license or certification.
    iii. Include clear means to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.
    iv. Require the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by Contractor, NSMHA/DBHR.

v. Require best efforts to provide written or oral notification within 15 working days of termination of a MHCP to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the medical record at the subcontractor.

29. SURVIVABILITY

The terms and conditions contained in this Agreement that by their sense and context are intended to survive the expiration of this Agreement shall so survive. Surviving terms include, but are not limited to: Order of Precedence, Contract Performance and Enforcement, Confidentiality of Personal Information, Resolution of Disputes, Indemnification, Oversight Authority, Maintenance of Records and Ownership of Materials.

30. TREATMENT OF INDIVIDUAL PROPERTY

Unless otherwise provided in this Agreement, Contractor shall ensure any adult individual receiving services from Contractor under this Agreement has unrestricted access to the individual's personal property. Contractor shall not interfere with any adult individual's ownership, possession, or use of the individual's property unless clinically indicated. Contractor shall provide individuals under age 18 with reasonable access to their personal property that is appropriate to the individual's age, development and needs. Upon termination of this Agreement, Contractor shall immediately release to the individual and/or individual's guardian or custodian all of the individual's personal property.

31. WARRANTIES

The parties' obligations are warranted and represented by each to be individually binding for the benefit of the other party. Contractor warrants and represents it is able to perform its obligations set forth in this Agreement and such obligations are binding upon Contractor and other subcontractors for the benefit of NSMHA.

32. CONTRACT ADMINISTRATION

The Program Administrator for each of the parties shall be responsible for and shall be the Program Administrator for all communications and billings regarding the performance of this Agreement.

The Program Administrator for NSMHA is:
Joe Valentine, Executive Director
North Sound Regional Support Network
117 North First Street, Suite 8
Mount Vernon, WA 98273

The Program Administrator for is:
Tom Sebastian, CEO
Compass Health
PO Box 3810
Everett, WA 98213-8810

Changes shall be provided to the other party in writing within 10 working days.

THIS AGREEMENT, consisting of 63 Pages, plus Exhibits and Attachments, is executed by the persons signing below who warrant that they have the authority to execute this Agreement.

NORTH SOUND MENTAL HEALTH ADMINISTRATION	**COMPASS HEALTH**
_____	_____
Signature Date	Signature Date
Joe Valentine, Executive Director	Tom Sebastian, CEO
Name/Title	Name/Title

NORTH SOUND
MENTAL HEALTH ADMINISTRATION

INTERAGENCY AGREEMENT

WITH

SKAGIT COUNTY

CONTRACT #NSMHA-SKAGIT-ADMIN-15

JANUARY 1, 2015 TO DECEMBER 31, 2015

TABLE OF CONTENTS

A. DEFINITIONS 5
B. DELEGATED FUNCTION
1. Regional Advisory Board *(PIHP Section 16; SMHC Section 2)* 11
2. Governing Board *(PIHP Section 16; SMHC Section 2)* 11
3. Quality Management Support *(PIHP Section 9.3; SMHC Section 6.3)* 11
4. Allied System Coordination *(PIHP Section 10.4)* 12
5. Community Coordination (*SMHC Section 13*) 12
6. Housing And Recovery Through Peer Supports (HARPS) Housing Subsidies (*SMHC Exhibit G*). 13
C. CONTRACTOR RESPONSIBILITIES
1. Appointment Of County Coordinator 15
2. Resource Management Support 15
3. Local Oversight Committee 15
4. Coordinated Quality Improvement Program (CQIP) Committee 15
5. Business Associate Agreement 16
6. Performance Measures 16
D. FINANCIAL TERMS AND CONDITIONS
1. General Fiscal Assurances 17
2. Financial Accounting Requirements 17
3. Financial Reporting 17
4. Rules Compliance 17
5. Financial Provisions – Reimbursement Requirements 18
6. Working Capital Advance 18
E. OVERSIGHT, REMEDIES AND TERMINATION
1. Oversight Authority 19
2. Remedial Action 19
3. Additional Financial Penalties – DBHR Imposed Sanctions 21
4. Termination Due To Change In Funding 21
5. Termination Due To Change In 1915(B) Mental Health Services Waiver 21
6. Termination For Convenience 21
7. Termination For Default 21
8. Termination Procedure 22
F. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR
1. Background 23
2. Mutual Commitments 23
3. Assignment 23
4. Authority 23
5. Compliance With Applicable Laws, Regulations And Operational Policies 24
6. Compliance With NSMHA Operational Policies 25
7. Confidentiality Of Client Information 25
8. Contract Performance/Enforcement 26
9. Cooperation 26
10. Debarment Certification 27

Table of Contents-cont.

11. Declaration That Clients Under The Medicaid And Other Mental Health Programs Are Not Third-Party Beneficiaries Under This Contract 27
12. Execution, Amendment And Waiver 27
13. Headings And Captions 27
14. Indemnification 27
15. Independent Contractor For NSMHA 28
16. Insurance 28
17. Integration 28
18. Maintenance Of Records 28
19. No Waiver Of Rights 29
20. Ongoing Services 29
21. Order Of Precedence 29
22. Overpayments 30
23. Ownership Of Materials 30
24. Performance 30
25. Resolution Of Disputes 30
26. Severability And Conformity 31
27. Single Audit Act 31
28. Subcontracts 32
29. Survivability 33
30. Treatment Of Client Property 33
31. Warranties 33
32. Contract Administration 33

ATTACHMENTS

Attachment I – NSMHA 7.01 Policy, Provider P&P Grid and Quality Management Plan – links

Attachment II – Business Associate Agreement

Attachment III – Budget

Attachment IV – Ombuds Services

Attachment V – Deliverables

INTERAGENCY AGREEMENT

THIS INTERAGENCY AGREEMENT (the "Agreement"), pursuant to Chapter 71.24 RCW and all relevant and associated statutes, as amended, is made and entered into by and between the NORTH SOUND REGIONAL SUPPORT NETWORK, dba THE NORTH SOUND MENTAL HEALTH ADMINISTRATION (NSMHA), 117 N. 1st Street, Suite 8, Mt. Vernon, WA 98273, and SKAGIT COUNTY (Contractor), 1800 Continental Place, Suite 100, Mt. Vernon, WA 98273-3820.

This Agreement incorporates the Agreement's Attachments to the Agreement and other documents incorporated by reference.

The effective date of this Agreement is January 1, 2015, through December 31, 2015.

A. DEFINITIONS

As used anywhere within this Agreement or Attachments, the following terms have the indicated meanings:

7.01 Plan: NSMHA Board approved plan, which outlines NSMHA's commitment to planning and service delivery for American Indian governments and communities (Attachment I).

Access to Care Standards: Department of Behavior Health and Recovery's Minimum Eligibility Requirements for Medicaid Adults & Medicaid Older Adults Guidelines reflect the most restrictive eligibility criteria that can be applied. NSMHA may expand coverage based on availability of local resources.

Accountability: Responsibility of Contractor for achieving defined outcomes, goals, and contract obligations.

Act: The Social Security Act.

Administrative costs: Costs for the general operation of the public mental health system. These activities cannot be identified with a specific direct or direct services support function.

Advance Directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care (including mental health care) when the individual is incapacitated.

Aging and Long-Term Support Administration (ALTSA) means the DSHS governing public health care, mental health care and substance abuse services, and its employees and authorized agents.

Agreement: means this Agreement, including all documents attached or incorporated by reference.

Allied Systems: State or local services which provide individuals with assistance to reduce the impact of disabilities, functional impairments, or skill deficits, and which promote stable community living.

Annual revenue: All revenue received by Contractor pursuant to the contract for January of any year through December of the next year.

Arbitration: The process by which the parties to a dispute submit their differences to the judgment of an impartial person or group appointed by mutual consent or statutory provision.

Assessment: A process, which provides sufficient information to determine medical necessity for mental health services covered under this Agreement.

Benefit Period: The period of service authorization, typically a one-year period. The individual may be open (actively receiving services) or closed during this period of time.

Behavioral Health Agency (BHA) means behavioral health agencies that are subcontracted by PIHP and licensed to provide mental health/chemical dependency services.

Budget Accounting Reporting System (BARS)

Centennial Accord: An agreement dated August 4, 1989 between federally recognized Indian Tribes in Washington and the State of Washington. The Accord provides a framework for government-to-government relationship and implementation procedures to ensure execution of that relationship.

Center for Medicare and Medicaid Services (CMS)

Code of Federal Regulations (CFR): All references in the Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

Complaint: A verbal or written statement by an individual or enrollee that expresses dissatisfaction with some aspect of services covered under this Agreement, the Primary Care Provider, or Contractor.

Consumer: A person with lived experience who is now or has in the past received mental health services.

Coordinated Quality Improvement Program (CQIP) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service Contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200.

Corrective Action/Compliance Review: When findings from a NSMHA/DBHR review or other monitoring efforts or audits show that there are apparent violations of this Agreement, Contractor shall implement corrective action within specified timeframes determined by NSMHA/DBHR/Department's other auditors.

Corrective Action Plan: A written plan specifying what Contractor is required to do to be in compliance. This includes required improvements and a time line for such action(s) to be accomplished.

Crisis: Crisis may be self-defined or a situation where an individual is acutely mentally ill, or experiencing serious disruption in cognitive, volitional, psychosocial/neurophysiological functioning.

Crisis Intervention: Intervention activities of duration of less than 24 hours (with a 24-hour period) to stabilize a client in a psychiatric emergency. (HCPCS procedure codes)

Crisis Services: Face-to-face evaluation and treatment of mental health emergencies and crises to non-enrolled, as well as, enrolled individuals experiencing a crisis as defined by the WAC. Crisis services shall be available on a 24-hour basis with the goal of stabilizing the person in crisis and providing immediate or short-term treatment and support in the least restrictive environment available. Crisis services may be provided prior to an intake evaluation/assessment.

Crisis Stabilization Services: Services provided to individuals who are experiencing a mental health emergency or crisis. This service is provided through telephone/face-to-face in-vivo services.

Cross-System Team meetings and consultations: Participation and involvement with systems beyond the mental health system, who are also providing mental health services (i.e., Division of Children and Family Services (DCFS), Developmental Disabilities Administration (DDA), Juvenile Rehabilitation Administration (JRA), Department of Corrections (DOC), schools, etc.), to ensure communication, and integrated, coordinated treatment planning and provision.

Cultural Competency: A set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. (WAC 388-865-0150)

The ability to serve individuals with mental illness of all ages, of all ethnic groups (including American Indians) and who identify as a sexual minority, in a manner which is responsive to their age and unique cultural background.

Disaster Outreach: Persons contacted in their place of residence or in non-traditional settings for the purpose of:

1. Assessing their mental health, or social functioning following a disaster; or
2. Increasing their utilization of human services and resources.
3. There are two basic approaches to outreach:
4. Mobile (ongoing to person to person);
5. Community settings (e.g., temporary shelters, disaster assistance sites, disaster information forums).

Regardless of the approach, the outreach process has five important components:

1. Locating persons in need of disaster relief services;
2. Assessing their needs;
3. Engaging or linking persons to an appropriate level of support or disaster relief services; and
4. Providing follow-up mental health services when clinically indicated.

Disaster outreach can be performed by trained volunteers, peers/persons hired under a Federal Crisis Counseling Grant. These persons should be trained in disaster outreach, which is different from traditional mental health crisis intervention.

Emergent Care: Services provided for a person, that if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

Exempt American Indians: Medicaid eligible and non-eligible American Indians as defined by 25 USC 1603 that have received an exemption, which permits Medicaid, reimbursed services to be delivered by Indian health service programs or tribal clinics.

Fair Hearing: A Grievance hearing before the Washington State Office of Administrative Hearings.

Fraud: means "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person". It includes any act that constitutes fraud under applicable Federal or State law (Medicaid Managed Care Fraud and Abuse Guidelines).

Geographic Area: NSMHA Service Area consists of the following geographic areas:

1. Island
2. San Juan County
3. Skagit County
4. Snohomish County
5. Whatcom County

Gravely Disabled: As defined in RCW 71.34.020(8) for children, and 71.05.020(1) in the case of adults.

Grievance: Means an expression of dissatisfaction about any matter other than the action as "action" is defined above. The term is also used to refer to the overall process that includes grievance and appeals handled at the PHIP 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, or failure to respect the enrollee's rights.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

Indirect Costs: Costs incurred for activities other than those that qualify as direct costs. Indirect costs include, but are not limited to: activities, staff, tools, depreciation and equipment, transportation, education or training related to financial, facilities, or data management, quality management, resource management (except for direct costs incurred pursuant to RCW 71.24.025), and RSN/PHP or subcontractor administration. Indirect costs do not include capital items or unexpended reserves.

Local Funds Eligible for Match: Sources of revenue that is eligible to be used as Federal match are broad based taxes at the County or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Funds used for Federal match under this Agreement may not be used as match for any other Federal program. It can be State or local funds that have not been previously matched with Federal funds at any point. Local funds do not include donations. Although State funds (non-Medicaid) can be used for local match, these funds are intended to be used for non-Medicaid services and non-Medicaid individuals and can only be used as match once these obligations are met.

Management Information System (MIS): A computer system designed to provide management personnel with up-to-date information on an organization's performance.

Mental Health Professional (MHP): As defined in RCW 71.34.020(13) for children, and RCW 71.05.020(12) for adults. (WAC 388-865-0150)

OMB Circular A-133: Audits of States, Local Governments and Non-Profit Organizations.

Ombuds: An individual performing an Ombuds service as defined at WAC 388-865-0250 as existing or hereafter amended.

Public Funds: State, Federal, or local government funds gained by a taxing authority.

Regional Support Network (RSN): A county authority or group of county authorities recognized and certified by the Secretary of DSHS which enter into joint operating agreements to contract with the Secretary pursuant to RCW 71.24 to operate a single managed system of services for persons with mental illness living in the Service Area covered by the county or group of counties. The RSN shall assume all duties assigned to county authorities by RCW 71.24, 71.34, and 71.05.

Revised Code of Washington (RCW): All references in the Agreement to RCW chapters or sections shall include any successor, amended, or replaced statute.

Subcontract: Any written agreement between Contractor and subcontractor or between Contractor, subcontractor, and another subcontractor to provide services or activities otherwise performed under this Agreement.

Subcontractor: An individual or entity performing all or part of the services under this Agreement under a separate contract with Contractor or its subcontractors.

Title 42: The CFR Public Health Service.

Title XIX: Grants with states for Medical Assistance Program.

Title XXI: State Children's Health Insurance Program.

Transition Youth: Anyone age 17-21.

Underserved: Persons who are minorities, children, elderly, disabled, and low-income (See WAC 388-865-0150).

Washington Administrative Code (WAC): All references in the Agreement to WAC chapters or sections shall include any successor, amended, or replacement regulation.

Waiver: The document by which DSHS/DBHR, requests sections of the Social Security Act be waived in order to operate a capitated managed care system to provide services to enrolled recipients. Section 1915(b) of the Act, authorizes the Secretary to waive the requirements of sections 1902 of the Act to the extent he/she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program.

Wraparound Services: Community-based services of whatever intensity is needed to maintain stability, placement, and avoid more restrictive levels of care. This may include, but is not limited to, the use of individual treatment or crisis stabilization aides.

Youth: Anyone age 13-17.

B. DELEGATED FUNCTION

Contractor shall furnish the necessary personnel and services and do all things necessary for the performance of the delegated functions set forth herein as presently written or as may be later amended.

1. REGIONAL ADVISORY BOARD *(PIHP Section 16; SMHC Section 2)*

Contractor shall appoint individuals with lived experience/advocate representatives to the NSMHA Regional Advisory Board in accordance with the Interlocal Agreement forming NSMHA, the Prepaid Inpatient Health Plan (PIHP) and State Mental Health Contracts (SMHC) and in accordance with WAC 388-865-0222, or any successor.

Contractor shall appoint representatives that reflect the demographic character of the county which shall include, but not be limited to, representatives of individuals, families, and law enforcement from one Member County. Composition and length of terms of board members may differ between counties. Regional membership shall be comprised of at least 51% individuals with lived experience or family members as defined in WAC 388-865-0222.

2. GOVERNING BOARD *(PIHP Section 16; SMHC Section 2)*

Member Counties shall establish a Governing Body responsible for oversight of the Regional Support Network in compliance with the Interlocal Agreement and the State PIHP and SMHC Agreements. The Governing Body can be an existing executive or legislative body within a county government. Each member of the Governing Body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests. Members of the Governing Body must act within the best interests of NSMHA and the individuals and families with lived experience.

3. QUALITY MANAGEMENT SUPPORT *(PIHP Section 9.3; SMHC Section 6.3)*

Contractor shall invite enrolled and non-enrolled individuals and their families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public mental health system. Contractor must be able to demonstrate how this requirement is implemented.

Member Counties shall encourage local efforts to provide services that are integrated and coordinated with other formal/informal service delivery systems.

a. Contractor's County Coordinator shall assist NSMHA in conducting quality management programs and activities, in accordance with Attachment I. Activities include regularly participating in NSMHA's Quality Management Oversight Committee and other quality management processes as appropriate, which are designed to allow NSMHA to:

   i. Assess the degree to which mental health services and planning is driven by and incorporates individual and family voice.
   ii. Assess the degree to which mental health services are age, culturally and linguistically competent.

iii. Assess the degree to which mental health services are provided in the least restrictive environment.
iv. Assess the degree to which uninterrupted linkages occur that move the individual toward recovery and resiliency.
v. Assess the continuity in service linkages and integration with other formal/informal systems and settings.
vi. Assess the strengths and barriers of resource management mechanism, access standards, and the utilization management activities.

b. Quality management activities specified in this Quality Management Support section shall be subject to requirements of NSMHA, including requirements to maintain confidentiality of information in accordance with federal and state privacy laws and requirements applicable to NSMHA for maintaining protection of confidentiality under its coordinated quality improvement program.

4. ALLIED SYSTEM COORDINATION *(PIHP Section 10.4)*

Contractor shall coordinate with NSMHA in the following area to ensure individuals in the community are receiving continuity of care.

Contractor shall develop in collaboration with NSMHA a new or update an existing allied system coordination plan with the Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections) and Chemical Dependency and Substance Abuse service providers in their respective county at least every three years, or as requested by NSMHA, DSHS or as necessary. The allied system coordination plan must contain all of the following elements.

Contractor shall work with NSMHA to identify the need for local resources, including initiatives to address those needs. This will include a process to evaluate progress in cross-system coordination and integration of services.

Contractor shall work with NSMHA on a process for facilitation of community integration from out of home placements, Children's Long-term inpatient facilities, Juvenile Rehabilitation facilities, foster care, nursing homes, and acute inpatient settings for individuals of all ages.

Contractor shall, when requested, provide information, referral and training to the community in how to access the public mental health system.

5. COMMUNITY COORDINATION (*SMHC Section 13*)

Contractor shall coordinate and participate with NSMHA in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by NSMHA. Contractor shall work with NSMHA in the event of a disaster to ensure the following activities are implemented:

a. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration;
b. Locating persons in need of disaster relief services;
c. Engaging or linking persons to an appropriate level of support or disaster relief services;

d. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs;
e. Partner in disaster preparedness and response activities with DBHR and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations;
f. Participation when requested in local and regional disaster planning and preparedness activities;
g. Coordination of disaster outreach activities following an event.

6. HOUSING AND RECOVERY THROUGH PEER SUPPORTS (HARPS) HOUSING SUBSIDIES (*SMHC Exhibit G*)

Contractor shall provide time limited financial assistance to individuals and families who are homeless and in need of short term assistance to either acquire and/or sustain housing. This funding is part of a Division of Behavioral Health and Recovery (DBHR) grant received by NSMHA for housing support services and financial housing assistance. For the purposes of this agreement, the funding is to be used exclusively for financial assistance to individuals and families who are homeless. No administrative costs may be paid out of the HARPS housing assistance allocation.

a. The priority population for the housing assistance is as follows:

    i. Individuals who are Co-Occurring (Mental Health & Substance Abuse) who meet Access to Care Standards, or
    ii. Individuals who experience mental health issues and who meet Access to Care Standards, or
    iii. Individuals who experience substance abuse issues and who do not meet Access to Care Standards.

b. Who are released from:

    i. Psychiatric Inpatient settings, or
    ii. Substance Abuse Treatment Inpatient settings.

c. Who are Homeless/At Risk of homelessness:

    Broad definition of homeless (couch surfing included).

Allowable expenses for the subsidy funding:

a. Monthly rent and utilities, and any combination of first and last months' rent for up to three (3) months. Rent may only be paid one (1) month at a time, although rental arrears, pro-rated rent, and last month's may be included with the first month's payment.
b. Rental and/or utility arrears for up to three (3) months. Rental and/or utility arrears may

be paid if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit.

c. Security deposits and utility deposits for a household moving into a new unit.
d. HARPS rent assistance may be used for move-in costs including, but not limited to, deposits and first months' rent associated with housing, including project- or tenant-based housing.
e. Application fees, background and credit check fees for rental housing.
f. Lot rent for RV or manufactured home.
    i. Costs of parking spaces when connected to a unit.
    ii. Landlord incentives (provided there are written policies and/or procedures explaining what constitutes landlord incentives, how they are determined, and who has approval and review responsibilities).
    iii. Reasonable storage costs.
    iv. Reasonable moving costs such as truck rental and hiring a moving company.
    v. Hotel/Motel expenses for up to 30 days if unsheltered households are actively engaged in housing search and no other shelter option is available.
    vi. Temporary absences, if a household must be temporarily away from his or her unit, but is expected to return (e.g., participant violates conditions of their DOC supervision and is placed in confinement for 30 days or re-hospitalized), Contractor may pay for the households rent for up to 60 days.

The funding is flexible depending on the specific individual/family situation, with the ultimate goal of procuring placement in permanent housing. The funding may be used in a lump sum or over a period of time in increments.

The funding is not to be used for Residential Treatment Facilities, Adult Family Homes or housing that is contingent on treatment compliance.

Contractor shall accept referrals for bridge housing assistance from the HARPS team for individuals and families residing in their respective county.

Contractor shall report quarterly on housing subsidies on the Housing Subsidy template found at the following link:
http://nsmha.org/Contracts/Deliverable_Templates/Default.htm

C. CONTRACTOR RESPONSIBILITIES

Contractor shall furnish the necessary personnel and services and do all things necessary for the performance of the work set forth herein as presently written or as may be later amended.

1. APPOINTMENT OF COUNTY COORDINATOR

Contractor Program Manager will act as or appoint a County Coordinator and the County Coordinator or designee will participate in NSMHA County Coordinator meetings, provide regular reports to NSMHA Advisory Board on county specific activities, and facilitate delivery of the services required under this section. In addition to those outlined in this section, responsibilities of County Coordinators include regularly participating in ad hoc committees, advising NSMHA of county-specific areas of concern or need and participation in disaster response preparedness activities.

2. RESOURCE MANAGEMENT SUPPORT

Contractor's County Coordinator shall assist NSMHA in conducting resource management. Activities include regular participation in strategic planning and other ad hoc planning initiatives and the ongoing evaluation of service provision in the county and the provision of recommendations to NSMHA based on the results.

3. LOCAL OVERSIGHT COMMITTEE

Contractor and NSMHA shall convene this committee a minimum of twice per year with the function and purpose as outlined below:

a. This membership will be broad and include all identified stakeholder groups.
b. Will be Co-Chaired by NSMHA and the County Coordinator or their designee.
c. Meeting will be facilitated by the County Coordinator or their designee.
d. Will be scheduled by the County Coordinator, but coordinated with NSMHA.
e. Will be called on an as needed basis, but at least twice per year.
f. Will cover the following areas:

    i. Public Mental Health System complaints or concerns,
    ii. Identifying gaps in the local public mental health system, such as but not limited to outpatient, emergency, inpatient mental health services.
    iii. Designing county specific protocols, which coordinate services with other community resources, county services and alternative systems of care, and
    iv. Provide a venue for community input and cross system networking.

4. COORDINATED QUALITY IMPROVEMENT PROGRAM (CQIP) COMMITTEE

Contractor and NSMHA shall convene this committee on an as needed basis with the function and purpose as outlined below:

This is a protected CQIP meeting intended solely for the purpose of assuring Continuous Quality Improvement, and Quality Assurance by the North Sound Mental Health Administration, its providers and component Counties. The CQIP program is strictly confidential to the fullest extend allowed by RCW 43.70.510 and WAC 246.50.

a. Membership is limited to NSMHA and the county,
b. Other participants will be limited to those community stakeholders that are/or have been involved with the specific case being reviewed,
c. Will be Co-Chaired by NSMHA and the County Coordinator or their designee.
d. Meeting will be facilitated by NSMHA.
e. Will be scheduled by NSMHA as requested by the County Coordinator and NSMHA, but coordinated with NSMHA.
f. Will cover the following areas:

    i. Advise NSMHA, County Coordinator, Outpatient and Integrated Crisis Response System (ICRS) management on issues, review of critical incidents, exceptional circumstances, and integrated crisis response or outpatient needs that require correcting.
    ii. Address contract non-compliance and available remedies including, but not limited to, fiscal penalties.

5. BUSINESS ASSOCIATE AGREEMENT

Contractor shall abide by the provisions of NSMHA/Skagit County Business Associates Agreement (Attachment II).

6. PERFORMANCE MEASURES

Contractor shall provide NSMHA with a biannual report on the following measures due 7/15/15 and 1/15/16 (Attachment V).

a. Update on Delegated Functions to include Community and Allied System Coordination activities.

D. FINANCIAL TERMS AND CONDITIONS

1. GENERAL FISCAL ASSURANCES

Contractor shall comply with all applicable laws and standards, including Generally Accepted Accounting Principles, and maintain, at a minimum, a financial management system that is a viable, single, integrated system with sufficient sophistication and capability to effectively and efficiently process, track, and manage all fiscal matters and transactions.

2. FINANCIAL ACCOUNTING REQUIREMENTS

Contractor shall:

a. Establish and maintain operating reserves at prudent levels sufficient to ensure that Contractor has the ability to pay for all expenses incurred during this Agreement period, including those whose disposition occurs after the Agreement has been terminated, and to cover the risk of financial loss resulting in the event that the cost of providing services pursuant to this Agreement exceeds the revenues derived therefrom;
b. Ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system within the Service Area.
c. Contractor shall produce annual audited financial statements within 180 days of fiscal year end and make such reports available to NSMHA upon request.

3. FINANCIAL REPORTING

Contractor shall provide the following reports to NSMHA:

a. Within 15 days from the effective date of this Agreement, a program-specific budget that demonstrates to NSMHA's reasonable satisfaction, compliance with direct service and indirect cost requirements.
b. Report Contractor's revenue and expenditure information to NSMHA on a quarterly basis. Reports must comply with the provisions in the BARS Supplemental Instructions for Mental Health Services promulgated by the Washington State Auditor's Office. Reports are due within 35 days of the biennial quarter end (December and June of each year). A final report is due February 5, 2016.

4. RULES COMPLIANCE

Contractor shall:

a. Funds provided to Contractor are to be used to provide specific administrative services on behalf of NSMHA and may not be used for direct services, with the exception of Section B.6.
b. Submit the amount spent throughout the Service Area on specific items at the request of NSMHA, CMS, the legislature, or DSHS in the timeframe specified.
c. Account for public mental health expenditures under this Agreement in accordance with federal circular A-133 and A-87, and state requirements in accordance with the BARS Manual, and BARS Supplemental Instructions.

d. Ensure State or Federal funds are not used to replace local funds from any source, which were being used to finance mental health services in the constituent county/counties in the calendar year prior to January 1, 1990. Contractor shall not use State or Federal funds to replace local funds used to administer the Involuntary Treatment Program in the constituent county/counties in the calendar year prior to January 1, 1974.

5. FINANCIAL PROVISIONS – REIMBURSEMENT REQUIREMENTS

The consideration to be paid by NSMHA for the work to be provided by Contractor pursuant to this Agreement shall consist of the available amount from primary funding sources as described in Attachment III of this Agreement, for maximum consideration of $256,572.

a. The consideration by NSMHA to Contractor pursuant to this Agreement shall be paid monthly within 10 working days of NSMHA's receipt of payment by DSHS/DBHR.
b. Payment Methodology: NSMHA shall pay to Contractor all allowable and allocable costs incurred as evidenced by proper invoice of Contractor as submitted on a monthly basis to the extent that those costs do not exceed each funding source maximum as set forth in Attachment III.
c. Maximum consideration for this contract shall not exceed $256,572.

6. WORKING CAPITAL ADVANCE

Contractor maintains a working capital advance in the amount of $4,612. The purpose of the advance is to ensure that sufficient cash flow is available at the county level for services that Contractor provides on behalf of NSMHA. In the event of termination, repayment shall occur in accordance with the termination procedure specified herein.

E. OVERSIGHT, REMEDIES AND TERMINATION

1. OVERSIGHT AUTHORITY

NSMHA, DSHS, Office of the State Auditor, the Department of Health and Human Service (DHHS), Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives (e.g., External Quality Review Organizations), have the authority to conduct announced and unannounced: a) surveys; b) audits; c) reviews of compliance with licensing and certification requirements and compliance with this Agreement; d) audits regarding the quality, appropriateness, and timeliness of mental health services of Contractor and subcontractors; and e) audits and inspections of financial records of Contractor and subcontractors. Contractor shall notify NSMHA when an entity other than NSMHA performs any audit described above related to any activity contained in this Agreement.

In addition, NSMHA will conduct reviews in accordance with its oversight of resource, utilization and quality management, as well as to ensure that Contractor have the clinical, administrative and fiscal structures to enable them to perform in accordance with the terms of the contract. Such reviews may include, but are not limited to encounter data validation, utilization reviews, clinical record reviews, and reviews of administrative structures, fiscal management and contract compliance. Reviews may include desk reviews, requiring Contractor to submit requested information. NSMHA will also review activities delegated under this contract to Contractor.

Contractor shall cooperate with and allow access to NSMHA Ombuds in order to conduct surveys and review activities in accordance with the terms of this contract, in accordance with Attachment IV. Contractor shall cooperate with Skagit County Community Action Agency in resolving any disputes that arise in the provision of Ombuds services.

Findings as a result of NSMHA conducted reviews may result in remedial action as outlined below. Federal and State agencies may impose remedial action or financial penalties either directly upon Contractor or through NSMHA. Contractor shall comply with the terms of such remedial action and be responsible for the payment of financial penalties.

2. REMEDIAL ACTION

NSMHA may require Contractor to plan and execute corrective action. Corrective action plans (CAP) developed by Contractor must be submitted for approval to NSMHA within 30 calendar days of notification. Corrective action plans must be provided in a format acceptable to NSMHA. NSMHA may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by NSMHA.

a. CAPs must include:

   i. A brief description of the finding.
   ii. Specific actions to be taken, a timetable, a description of the monitoring to be performed, the steps taken and responsible individuals that will reflect the resolution of the situation.

b. CAPs may:

Require modification of any policies or procedures by Contractor relating to the fulfillment of its obligations pursuant to this Agreement.

c. CAPs are subject to approval by NSMHA, which may:

i. Accept the plan as submitted.
ii. Accept the plan with specified modifications.
iii. Request a modified plan; or,
iv. Reject the plan.

d. Contractor agrees that NSMHA may initiate remedial action with or without a CAP as outlined in subsection below if NSMHA determines any of the following situations exist:

i. A problem exists that negatively impacts enrollees.
ii. Contractor has failed to perform any of the mental health services required in this Agreement, including delegated functions, which includes the failure to maintain the required capacity as specified by NSMHA to ensure that enrollees receive medically necessary services.
iii. Contractor has failed to develop, produce/deliver to NSMHA any of the statements, reports, data, data corrections, accountings, claims/documentation described herein, in compliance with all the provisions of this Agreement.
iv. Contractor has failed to perform any administrative function required under this Agreement, including delegated functions. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of mental health services.
v. Contractor has failed to implement corrective action required by the state and within NSMHA prescribed time frames.

e. NSMHA may impose any of the following remedial actions in response to findings of situations as outlined above.
f. Withhold one percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. NSMHA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.
g. Compound withholdings identified above by an additional one-half of one percent for each successive month during which the remedial situation has not been resolved.
h. Revoke delegation of any function delegated under this contract.
i. Deny any incentive payment to which Contractor might otherwise have been entitled under this Agreement or any other arrangement by which the DBHR provides incentives; or
j. Termination for Default, as outlined in this Agreement.

3. ADDITIONAL FINANCIAL PENALTIES – DBHR IMPOSED SANCTIONS

Financial penalties imposed by DBHR or other regulatory agency due to the action or inaction of Contractor may be paid by NSMHA on behalf of Contractor and the amount will be withheld from NSMHA's payments to Contractor.

4. TERMINATION DUE TO CHANGE IN FUNDING

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to its normal completion, NSMHA may terminate this Agreement, subject to re-negotiations.

5. TERMINATION DUE TO CHANGE IN 1915(B) MENTAL HEALTH SERVICES WAIVER

In the event that changes to the terms of the 1915(b) (Medicaid) Mental Health Services Waiver render this Agreement invalid in any way after the effective date of this Agreement and prior to its normal completion, NSMHA may terminate this Agreement, subject to re-negotiation, if applicable, under those new special terms and conditions.

6. TERMINATION FOR CONVENIENCE

Except, as otherwise provided in this Agreement, a party may terminate this Agreement upon 90 days written notification by certified mail to the other party. The effective date of termination shall be the ninetieth day after receipt of written notification to the other party or the last day of the calendar month in which the ninetieth day occurs, whichever is later.

7. TERMINATION FOR DEFAULT

NSMHA's Program Manager may terminate this Agreement for default, in whole or in part, by written notice to Contractor if NSMHA or DSHS has a reasonable basis to believe that Contractor has or have:

a. Failed to meet or maintain any requirement for contracting with DSHS.
b. Failed to perform under any provision of this Agreement.
c. Violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement; and/or
d. Otherwise breached any provision or condition of this Agreement.

Before NSMHA's Program Manager may terminate this Agreement for default, in whole or in part, NSMHA shall provide Contractor with written notice of Contractor's noncompliance with this Agreement which notice shall provide Contractor a reasonable time period to correct its/their noncompliance. If Contractor does not correct the noncompliance within the period of time specified in the written notice of noncompliance, the Program Administrator may then terminate this Agreement. The Program Administrator may terminate this Agreement for default without such written notice and without opportunity for correction, if NSMHA has a reasonable basis to believe that a client's health or safety is in jeopardy, and/or:

a. Contractor has violated any law, regulation, rule or ordinance applicable to services provided under this agreement, or
b. Continuance of this Agreement with Contractor poses a material risk of injury or harm to any person.

Contractor may terminate this Agreement in whole or in part, by written notice to NSMHA, if Contractor has a reasonable basis to believe that NSMHA has:

a. Failed to meet or maintain any requirement for contracting with Contractor.
b. Failed to perform under any provision of this Agreement.
c. Violated any law, regulation, rule, or ordinance applicable to work performed under this Agreement; and/or
d. Otherwise breached any provision or condition of this Agreement.

8. TERMINATION PROCEDURE

The following provisions shall survive and be binding on the parties in the event this Agreement is terminated:

a. Contractor and any applicable subcontractors shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services. Each party shall be responsible only for its performance in accordance with the terms of this Agreement rendered prior to the effective date of termination. Contractor and any applicable subcontractors shall assist in the orderly transfer/transition of the individuals and families served under this Agreement. Contractor and any applicable subcontractors shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.
b. Contractor and any applicable subcontractors shall immediately deliver to NSMHA Program Manager or to his/her successor, all DSHS and NSMHA assets (property) in Contractor and any applicable subcontractor's possession and any property produced under this Agreement. Contractor and any applicable subcontractors grants NSMHA and DSHS the right to enter upon Contractor and any applicable subcontractors premises for the sole purpose of recovering any NSMHA or DSHS property that Contractor and any applicable subcontractors fails to return within 10 working days of termination of this Agreement. Upon failure to return NSMHA/DSHS property within 10 working days of the termination of this Agreement, Contractor and any applicable subcontractors shall be charged with all reasonable costs of recovery, including transportation and attorney's fees. Contractor and any applicable subcontractors shall protect and preserve any property of NSMHA/DSHS that is in the possession of Contractor and any applicable subcontractors pending return to NSMHA/DSHS.
c. NSMHA shall be liable for and shall pay for only those services authorized and provided through the date of termination. NSMHA may pay an amount agreed to by the parties for partially completed work and services, if work products are useful to or usable by NSMHA. Should the contract be terminated by either party, NSMHA will require the spend-down of all remaining reserves and fund balances within the termination period. Funds will be deducted from the final months' payments until reserves and fund balances are spent.

F. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR

1. BACKGROUND

NSMHA is an entity formed by inter-local agreement between Island, San Juan, Skagit, Snohomish and Whatcom Counties, each a county authority recognized by the Secretary of Department of Social and Health Services (Secretary). These counties entered into an inter-local agreement to allow NSMHA to contract with the Secretary pursuant to RCW 71.24.025(13), to operate a single managed system of services for persons with mental illness living in the service area covered by Island, San Juan, Skagit, Snohomish and Whatcom Counties (Service Area). NSMHA is party to an interagency agreement with the Secretary, pursuant to which NSMHA has agreed to provide integrated community support, crisis response, and inpatient management services to people needing such services in its Service Area. NSMHA, through this Agreement, is subcontracting with Contractor for the provision of specific mental health services as required by the agreement with the Secretary. Contractor, by signing this Agreement, attests that it is willing and able to provide such services in the Service Area.

2. MUTUAL COMMITMENTS

The parties to this Agreement are mutually committed to the development of an efficient, cost effective, integrated, person-driven, age specific recovery and resilience model approach to the delivery of quality community mental health services. To that end, the parties are mutually committed to maximizing the availability of resources to provide needed mental health services in the Service Area, maximizing the portion of those resources used for the provision of direct services and minimizing duplication of effort.

3. ASSIGNMENT

Except as otherwise provided within this Agreement, this Agreement may not be assigned, delegated, or transferred by Contractor without the express written consent of NSMHA, and any attempt to transfer or assign this Agreement without such consent shall be void. The terms "assigned", "delegated", or "transferred" shall include change of business structure to a limited liability company, of any Contractor Member or Affiliate Agency.

4. AUTHORITY

Concurrent with the execution of this Agreement, Contractor shall furnish NSMHA with a copy of the explicit written authorization of its governing body to enter into this Agreement and accept the financial risk and responsibility to carry out all terms of this Agreement including the ability to pay for all expenses incurred during the contract period. Likewise, concurrent with the execution of this Agreement, NSMHA shall furnish Contractor with a written copy of the motion, resolution, or ordinance passed by NSMHA Board of Directors (NSMHA Board) authorizing NSMHA to execute this Agreement.

5. COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND OPERATIONAL POLICIES

Contractor and its subcontractors shall comply with all applicable federal and state statutes, regulations, and operational policies, as applicable to this Agreement, whether or not a specific citation is identified in various sections of this Agreement, and all amendments thereto that are in effect when the Agreement is signed, or that come into effect during the term of the Agreement, which may include but are not limited to, the following ("Federal/State Law":

a. Title XIX and Title XXI of the Social Security Act and Title 42 of the Code of Federal Regulations.
b. All applicable Office of the Insurance Commissioner (OIC) statutes and regulations.
c. All local, State, and Federal professional and facility licensing and certification requirements/standards that apply to services performed under the terms of this Agreement.
d. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS and EPA.
e. Any applicable mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act.
f. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
g. Those specified in Title 18 RCW for professional licensing.
h. Reporting of abuse as required by RCW 26.44.030.
i. Industrial insurance coverage as required by Title 51 RCW.
j. RCW 38.52, 70.02, 71.05, 71.24, and 71.34.
k. WAC 388-865.
l. 42 CFR 438, including 42 CFR 438.58 (conflict of interest) and 42 CFR 438.106 (physician incentive plans).
m. The State of Washington Medicaid State Plan and the 1915(b) Medicaid Mental Health Waiver or their successors, which documents are incorporated by reference.
n. DBHR Quality Strategy.
o. The State Medicaid Manual (SMM), Office of Management and Budget (OMB) Circulars, the Budgeting, Accounting, and Reporting System (BARS) Manual, and BARS Supplemental Mental Health Instructions.
p. Any applicable federal and state laws that pertain to Medicaid enrollee or individual rights. Contractor shall ensure that its staff takes those rights into account when furnishing services to individuals and/or families.
q. 42 USC 1320a-7 and 1320a-7b (Section 1128 and 1128 (b) of the Social Security Act), which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit mental health services provided to individuals and/or families.

r. Any policies and procedures developed by Medical Assistance Administration for compliance with WAC 388-519-0110, which governs the spend-down of client assets.
s. Contractor and any subcontractors must comply with 42-USC 1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of Contractor, BHA or subcontractor's equity, or an employee, Contractor, or consultant who is significant or material to the provision of services under this Agreement, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency.
t. Federal and State non-discrimination laws and regulations.
u. The Health Insurance Portability and Accountability Act (HIPAA), 45 CFR parts 160-164.
v. DBHR-CIS Data Dictionary and its successors.
w. Federal funds must not be used for any lobbying activities.

If Contractor is in violation of a federal law or regulation, and Federal Financial Participation is recouped from NSMHA, Contractor shall reimburse the federal amount to NSMHA within 20 days of such recoupment.

Upon notification from DSHS, NSMHA shall notify Contractor in writing of changes/modifications in CMS policies and DSHS/DBHR contract requirement changes, if applicable to this Agreement.

6. COMPLIANCE WITH NSMHA OPERATIONAL POLICIES

Contractor shall comply with all NSMHA operational policies that pertain to the delivery of services under this Agreement that are in effect when the Agreement is signed or that come into effect during the term of the Agreement.

Along with all NSMHA stakeholders, Contractor will be included in the process for developing relevant operational policies and procedures. NSMHA's Provider Policy & Procedure Grid and successors contain a list of NSMHA's policies and their applicability to Contractor in accordance with Attachment I. The Grid and NSMHA's policies and procedures are posted on NSMHA's website. NSMHA shall notify Contractor of new and revised policies through its numbered memoranda. Training will be provided on policies that impact providers.

NSMHA will make best efforts to maintain currency of policies with applicable federal or state law, regulation or policy. In the event of a conflict, federal or state laws, regulations or policies supersede NSMHA policies and procedures.

7. CONFIDENTIALITY OF CLIENT INFORMATION

Pursuant to 42 CFR 431.301 and 431.302, information concerning applicants and recipients may be disclosed for purposes directly concerning the administration of this Agreement. Purposes include, but are not limited to:

a. Establishing eligibility.
b. Determining the amount of medical assistance.

c. Providing services for recipients.
d. Conducting or assisting in investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.
e. Assuring compliance with Federal and State laws, regulations, with terms and requirements of this Agreement.
f. Improving quality.

Contractor shall protect all information, records and data collected from unauthorized disclosure in accordance with 42 CFR 431.300 through 431.307, RCW's 70.02, 71.05, and 71.34, HIPAA, and for service recipients receiving alcohol and drug abuse services, in accordance with 42 CFR Part 2. Contractor shall have a process in place to ensure that all components of its BHA and system understand and comply with confidentiality requirements for publicly funded mental health services.

Contractor shall ensure that access to the information is restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of NSMHA and DSHS.

The parties acknowledge that coordination, planning, screening, and referral require the sharing of information among the various treatment providers. Disclosure of information to verify eligibility, determine the amount of assistance, and to provide medically necessary mental health services are all "purposes directly connected with the administration of the Agreement", and are all appropriate justifications for sharing information.

Contractor shall ensure that all staff and subcontractors providing services under this Agreement receive annual training on confidentiality policies and procedures. In addition, Contractor shall ensure that all staff and subcontractors providing services under this Agreement sign an annual Oath of Confidentiality statement. Signed copies of the Oath of Confidentiality shall be kept in Contractor's personnel files.

8. CONTRACT PERFORMANCE/ENFORCEMENT

NSMHA shall be vested with the rights of a third party beneficiary, including the "cut through" right to enforce performance should Contractor be unwilling or unable to enforce action on the part of its subcontractor(s). In the event that Contractor dissolves or otherwise discontinues operations, NSMHA may, at its sole option, assume the right to enforce the terms and conditions of this Agreement directly with Contractor's subcontractors; provided, that NSMHA shall keep Contractor reasonably informed concerning such enforcement. Contractor shall include this clause in its contracts with its subcontractors. In the event of the dissolution of Contractor, NSMHA's rights in indemnification shall survive.

9. COOPERATION

The parties to this Agreement shall cooperate in good faith to effectuate the terms and conditions of this Agreement.

10. DEBARMENT CERTIFICATION

Contractor certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any federal or state department or agency. If requested by DSHS or NSMHA, Contractor shall complete a Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion. Any Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion pertaining to this Agreement shall be incorporated into this Agreement by reference.

11. DECLARATION THAT CLIENTS UNDER THE MEDICAID AND OTHER MENTAL HEALTH PROGRAMS ARE NOT THIRD-PARTY BENEFICIARIES UNDER THIS CONTRACT

Although NSMHA, Contractor, and subcontractors mutually recognize that services under this Agreement may be provided by Contractor and subcontractors to clients under the Medicaid program, RCW 71.05 and 71.34, and the Community Mental Health Services Act, RCW 71.24, it is not the intention of either NSMHA, Contractor, that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement. Such third parties shall have no right to enforce this agreement.

12. EXECUTION, AMENDMENT AND WAIVER

This Agreement shall be binding on all parties only upon signature by authorized representatives of each party. This Agreement, or any provision, may be amended during the contract period, if circumstances warrant, by a written amendment executed by all parties. Only NSMHA Program Manager or NSMHA Program Manager's designee has authority to waive any provision of this Agreement on behalf of NSMHA.

13. HEADINGS AND CAPTIONS

The headings and captions used in this Agreement are for reference and convenience only, and in no way define, limit, or decide the scope or intent of any provisions or sections of this Agreement.

14. INDEMNIFICATION

Contractor shall be responsible for and shall indemnify and hold NSMHA harmless (including all costs and attorney fees) from all claims for personal injury, property damage/disclosure of confidential information/from the imposition of governmental fines or penalties resulting from the acts or omissions of Contractor and its subcontractors related to the performance of this contract. NSMHA shall be responsible and shall indemnify and hold Contractor harmless (including all costs and attorney fees) from all claims for personal injury, property damage and disclosure of confidential information and from the imposition of governmental fines or penalties resulting from the acts or omissions of NSMHA. For the purposes of these indemnifications, the Parties specifically and expressly waive any immunity granted under the Washington Industrial Insurance Act, Title 51 RCW. This waiver has been mutually negotiated and agreed to by the Parties. The provision of this section shall survive the expiration or termination of the Agreement.

15. INDEPENDENT CONTRACTOR FOR NSMHA

The parties intend that an independent Contractor relationship be created by this contract. Contractor acknowledges that neither Contractor nor its employees or subcontractors are not officers, employees, or agents of NSMHA. Contractor shall not hold Contractor or any of Contractor's employees and subcontractors out as, nor claim status as, officers, employees, or agents of NSMHA. Contractor shall not claim for Contractor or Contractor's employees or subcontractors any rights, privileges, or benefits which would accrue to an employee of NSMHA. Contractor shall indemnify and hold NSMHA harmless from all obligations to pay or withhold Federal or State taxes or contributions on behalf of Contractor or Contractor's employees and subcontractors unless specified in this Agreement.

16. INSURANCE

NSMHA certifies it is a member of Washington Governmental Entity Pool for all exposure to tort liability, general liability, property damage liability, and vehicle liability, if applicable, as provided by RCW 43.19.

Contractor shall maintain Commercial General Liability Insurance (CGL). If Contractor is not a member of a risk pool, Contractor shall carry CGL to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. Any risk pool shall provide coverage with the same minimum limits. Any policy (non-risk pool and risk pool) shall include liability arising out of premises, operations, independent Contractors, personal injury, advertising injury, and liability assumed under an insured contract. Contractor shall provide evidence of such insurance to NSMHA within 15 days of execution of this Agreement and 15 days post renewal date thereafter. All non-risk pool policies shall name NSMHA as a covered entity under said policy(s).

17. INTEGRATION

This Agreement, including Attachments contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

18. MAINTENANCE OF RECORDS

During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records set forth below is started before expiration of the six year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the six year period, whichever is later. Contractor shall maintain records sufficient to:

a. Maintain the content of all Medical Records in a manner consistent with utilization control requirements of 42 CFR 456, 42 CFR 434.34 (a), 42 CFR 456.111, and 42 CFR 456.211.
b. Document performance of all acts required by law, regulation, or this Agreement.
c. Substantiate Contractor statement of its organizations' structures, tax status, capabilities, and performance.

d. Demonstrate accounting procedures, practices, and records, which sufficiently and properly document Contractor invoices to NSMHA and all expenditures made by Contractor to perform as required by this Agreement.
e. Contractor and its subcontractors shall cooperate in all reviews, including but not limited to, surveys, and research conducted by NSMHA, DSHS or other Washington State Departments.
f. Evaluations shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services performed under this Agreement, and to determine whether Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable state and federal regulations as existing or hereafter amended.

19. NO WAIVER OF RIGHTS

A failure by either party to exercise its rights under this Agreement shall not preclude that party from subsequent exercise of such rights and shall not constitute a waiver of any other rights under this Agreement unless stated to be such in a writing signed by an authorized representative of the party and attached to the original Agreement.

Waiver of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent breach and shall not be construed to be a modification of the terms and conditions of this Agreement.

20. ONGOING SERVICES

Contractor and its subcontractors shall ensure that in the event of labor disputes or job actions, including work slowdowns, so called "sick outs", or other activities, within its service BHA network, uninterrupted services shall be available as required by the terms of this Agreement

21. ORDER OF PRECEDENCE

In the event of an inconsistency in the terms of this Agreement, or any inconsistency between the terms of this Agreement and any applicable statute, rule or contract, unless otherwise provided herein, the conflict shall be resolved by giving precedence in the following order, to:

a. The applicable Medicaid 1915(b) Waiver, Provisions of Title XIX of the Social Security Act and Federal regulations concerning the operations of Prepaid Inpatient Health Plans.
b. State statutes and regulations concerning the operation of the community mental health programs.
c. Federal and State Law.

d. NSMHA-DSHS agreement, or its successors, that covers the provision of the mental health services covered under this Agreement, which shall include any document or material incorporated by reference. NSMHA shall promptly notify Contractor of any amendment to NSMHA-DSHS agreement which affects any term or condition herein.
e. This Agreement.

22. OVERPAYMENTS

In the event Contractor fails to comply with any of the terms and conditions of this Agreement and that failure results in an overpayment, NSMHA may recover the amount due DSHS, CMS or other federal or state agency, subject to dispute resolution as set forth in the contract. In the case of overpayment, Contractor shall cooperate in the recoupment process and return to NSMHA the amount due upon demand.

23. OWNERSHIP OF MATERIALS

Materials created by Contractor and its subcontractors and paid for by NSMHA as a part of this Agreement shall be owned by NSMHA and shall be, "works for hire" as defined by the U.S. Copyright Act of 1976. This material includes but is not limited to: books, computer programs, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes/training materials. Material which Contractor and its subcontractors use to perform this Agreement, but which is not created for or paid for by NSMHA, is owned by Contractor or relevant subcontractors; however, NSMHA and DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS.

24. PERFORMANCE

Contractor shall furnish the necessary personnel, materials/mental health services and otherwise do all things for, or incidental to, the performance of the work set forth here and as attached. Unless specifically stated, Contractor is responsible for performing or ensuring all fiscal and program responsibilities required in this contract. No subcontract will terminate the legal responsibility of Contractor to perform the terms of this Agreement.

25. RESOLUTION OF DISPUTES

The parties wish to provide for prompt, efficient, final, and binding resolution of disputes and controversies that may arise under this Agreement and therefore establish this dispute resolution procedure. All claims, disputes, and other matters in question between the parties arising out of, or relating to, this Agreement shall be resolved exclusively by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

a. The parties shall use their best efforts to resolve issues prior to giving written Notice of Dispute.
b. Within 10 working days of receipt of the written Notice of Dispute, the parties (or a designated representative) shall together or, if both parties agree, with a mediator meet, confer, and attempt to resolve the claim.
c. The terms of the resolution of all claims concluded in meetings shall be memorialized in writing and signed by each party.

Arbitration: If the claim is not resolved within 30 days, the parties shall proceed to arbitration as follows:

a. Demand for arbitration shall be made in writing to the other party. The parties shall select one person as arbitrator.
b. If there is a delay of more than 10 days in the naming of the arbitrator, either party can ask the presiding judge of Contractor to name the arbitrator.
c. The prevailing party shall be entitled to recover from the other party all costs and expenses, including reasonable attorney fees. The arbitrators shall determine which party, if any, is the prevailing party.
d. The parties agree that the arbitrators' decision shall be binding, final and appealable to Contractor Superior Court only as provided in Chapter 7.04A RCW.
e. Unless the parties agree in writing otherwise, the unresolved claims in each notice of dispute shall be considered at an arbitration session which shall occur in Contractor no later than 30 days after the close of the meeting described in paragraph (b) above.
f. The Provisions of this section shall, with respect to any controversy or claim, survive the termination or expiration of this Agreement.
g. Nothing contained in this Agreement shall be deemed to give the arbitrator the power to change any of the terms and conditions of this Agreement in any way.
h. The prevailing party in any action to compel arbitration or to enforce an arbitration award shall be awarded its costs, including attorney fees. Venue for any such action is exclusively Contractor Superior Court.
i. This Agreement shall be governed by laws of the State of Washington, both as to interpretation and performance.

26. SEVERABILITY AND CONFORMITY

The provisions of this Agreement are severable. If any provision of this Agreement, including any provision of any document incorporated by reference, is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

27. SINGLE AUDIT ACT

If Contractor or its subcontractor is a subrecipient of Federal awards as defined by OMB Circular A-133, Contractor and its subcontractors shall maintain records that identify all Federal funds received and expended. Such funds shall be identified by the appropriate OMB Catalog of Federal Domestic Assistance titles and numbers, award names and numbers, award years, if awards are for research and development, as well as, names of the Federal agencies. Contractor and its subcontractors shall make Contractor and its subcontractors records available for review or audit by officials of the Federal awarding agency, the General Accounting Office, and DSHS. Contractor and its subcontractors shall incorporate OMB Circular A-133 audit requirements into all contracts between Contractor and its subcontractors who are sub recipients. Contractor and its subcontractors shall comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation.

If Contractor/its subcontractors are a subrecipient and expends $500,000 or more in Federal awards from any/all sources in any fiscal year, Contractor and applicable subcontractors shall procure and pay for a single or program-specific audit for that fiscal year. Upon completion of each audit, Contractor and applicable subcontractors shall submit to NSMHA Program Manager the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide, if applicable, and a copy of any management letters issued by the auditor.

For purposes of "subrecipient" status under the rules of OMB Circular A-133 205(i) Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part of the rule unless a State requires the fund to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.

28. SUBCONTRACTS

Contractor may subcontract services to be provided under this Agreement subject to the following requirements.

a. Contractor shall be responsible for the acts and omissions of any subcontractor.
b. Contractor must ensure that the subcontractor neither employs any person nor contracts with any person or BHA excluded from participation in federal health care programs under either 42 USC 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions.
c. Contractor shall require subcontractors to comply with all applicable federal and state laws, regulations, and operational policies as specified in this Agreement.
d. Contractor shall ensure a process is in place to demonstrate that all third-party resources are identified and pursued.
e. Contractor shall oversee, be accountable for, and monitor all functions and responsibilities delegated to a subcontractor for conformance with any applicable statement of work in this agreement on an ongoing basis including written reviews.
f. Contractor will monitor performance of the subcontractors on an annual basis and notify NSMHA of any identified deficiencies or areas for improvement requiring corrective action by Contractor.
g. Contractor shall ensure that all subcontracts are in writing and that subcontracts specify all duties, reports, and responsibilities delegated under this Agreement. Those written subcontracts shall:

    i. Require subcontractors to hold all necessary licenses, certifications/permits as required by law for the performance of the services to be performed under this Agreement.
    ii. Include clear means to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.

iii. Require that the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by Contractor, NSMHA/DBHR.
iv. Require best efforts to provide written or oral notification within 15 working days of termination of a Mental Health Care Provider (MHCP) to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the subcontractor.

29. SURVIVABILITY

The terms and conditions contained in this Agreement that by their sense and context are intended to survive the expiration of this Agreement shall so survive. Surviving terms include, but are not limited to: Order of Precedence, Contract Performance and Enforcement, Confidentiality of Client Information, Resolution of Disputes, Indemnification, Oversight Authority, Maintenance of Records and Ownership of Materials.

30. TREATMENT OF CLIENT PROPERTY

Unless otherwise provided in this Agreement, Contractor shall ensure that any adult individual receiving services from Contractor under this Agreement has unrestricted access to the individual's personal property. Contractor shall not interfere with any adult individual's ownership, possession, or use of the individual's property unless clinically indicated. Contractor shall provide individuals under age eighteen (18) with reasonable access to their personal property that is appropriate to the individual's age, development, and needs. Upon termination of this Agreement, Contractor shall immediately release to the individual/the individual's guardian or custodian all of the individual's personal property.

31. WARRANTIES

The parties' obligations are warranted and represented by each to be individually binding, for the benefit of the other party. Contractor warrants and represents that it is able to perform its obligations set forth in this Agreement and that such obligations are binding upon Contractor and other subcontractors for the benefit of NSMHA.

32. CONTRACT ADMINISTRATION

The Program Manager for each of the parties shall be responsible for and shall be the contact person for all communications and billings regarding the performance of this Agreement.

The Program Manager for NSMHA is:

Joe Valentine, Executive Director
North Sound Regional Support Network
117 N. 1st Street, Suite 8
Mount Vernon, WA 98273

The Program Manager for Contractor is:

Rebecca Clark, County Coordinator
Skagit County Human Services
309 S. 3rd Street
Mount Vernon, WA 98273

Changes shall be provided to the other party in writing within 10 working days.

THIS AGREEMENT, consisting of 35 Pages, plus Attachments, is executed by the persons signing below who warrant that they have the authority to execute this Agreement.

NSMHA		**SKAGIT COUNTY**	
_____		See attached Skagit County signature page	
Joe Valentine	Date	Authorized Signature	Date
Executive Director			
Approved as to Form for NSMHA		Approved as to Form for County	
Basic Form approved by Brad Furlong	10/1/01	_____	
Name & Title	Date	Name & Title	Date

NORTH SOUND
MENTAL HEALTH ADMINISTRATION

AGREEMENT
FOR THE
PROVISION OF
MEDICAID COVERED
MENTAL HEALTH SERVICES

WITH

VOLUNTEERS OF AMERICA

CONTRACT #NSMHA-VOA-MEDICAID-13-15

OCTOBER 1, 2013 TO SEPTEMBER 30, 2015

TABLE OF CONTENTS

A. DEFINITIONS 6

B. MENTAL HEALTH SUPPORT SERVICES
1. Care Crisis Program 16

C. DELEGATED FUNCTION
1. Community Psychiatric Inpatient Services Management – General Requirements 17
2. Customer Service Requirements 18
3. Access Line 18

D. PERFORMANCE STANDARDS
1. General Operating Standards 20
2. LOCUS/CALOCUS Level Of Care Utilization System 21
3. Allied System Coordination 21
4. Crisis Services Coordination and Cooperation 21
5. Complaint, Grievance, Appeal and Fair Hearing Processes 21
6. Local Responsiveness and Communications 22
7. Critical Incidents 23
8. Confidentiality 23
9. Performance Improvement and Regional Measures 24
10. Evidence-Based Practices 24
11. Trauma-Informed Care 24
12. Quality Strategy/Management 24

E. CONTRACTOR RESPONSIBILITIES
1. Capacity 26
2. Access Standards 27
3. Staff Competency and Training 27
4. Resource and Utilization Management Activities 28
5. Management Information System 28
6. NSMHA and DBHR Review Activities 28
7. Deliverables, Plans and Reports 28
8. Business Associates Agreement 28

F. FINANCIAL TERMS AND CONDITIONS
1. General Fiscal Assurances 29
2. Financial Accounting Requirements 29
3. Financial Reporting 29
4. County Funding 29
5. Rules Compliance 30
6. Financial Provisions - Reimbursement Requirements 30
7. Fraud and Abuse 31

TABLE OF CONTENTS - cont.

G. OVERSIGHT, REMEDIES AND TERMINATION

1. Oversight Authority 32
2. Remedial Action 32
3. Additional Financial Penalties – DBHR Imposed Sanctions 34
4. Termination Due to Change in Funding 34
5. Termination Due to Change in 1915(B) Mental Health Services Waiver 34
6. Termination for Convenience 34
7. Termination for Default 35
8. Termination Procedure 35
9. Notice Requirements 36

H. GENERAL TERMS AND CONDITIONS FOR Contractor

1. Background 38
2. Mutual Commitments 38
3. Assignment 38
4. Authority 38
5. Compliance with Applicable Laws, Regulations and Operational Policies 38
6. Compliance with NSMHA Operational Policies 40
7. Confidentiality of Personal Information 41
8. Contract Performance/Enforcement 42
9. Cooperation 42
10. Debarment Certification 43
11. Excluded Parties 43
12. Declaration that Clients Under the Medicaid and Other Mental Health Programs are not Third-Party Beneficiaries Under this Contract 44
13. Execution, Amendment and Waiver 44
14. Headings and Captions 45
15. Indemnification 45
16. Independent Contractor for NSMHA 45
17. Insurance 45
18. Integration 46
19. Maintenance of Records 46
20. No Waiver of Rights 46
21. Ongoing Services 46
22. Order of Precedence 47
23. Overpayments 47
24. Ownership of Materials 47
25. Performance 47
26. Resolution of Disputes 48
27. Severability and Conformity 49
28. Single Audit Act 49
29. Subcontracts 49

TABLE OF CONTENTS - cont.

30. Survivability 50
31. Treatment of Client Property 51
32. Warranties 51
33. Contract Administration 51

EXHIBITS AND ATTACHMENTS

Exhibit A – Access to Care Standards

Exhibit B – Community Psychiatric Inpatient Instructions & Requirements

Exhibit C – Data Security Requirements

Exhibit D – Mission Statement

Exhibit E – Program Integrity

Exhibit F – DSHS Admin Policy No. 7.21

Exhibit G – DSHS Admin Policy No. 7.01

Exhibit H – DSHS Admin Policy No. 7.20

Attachment I – Core Values and Principles

Attachment II – Contract Document links

Attachment III – DBHR-Contract link

Attachment IV – Deliverables

Attachment V – Business Associate Agreement

Attachment VI – Revenue and Expenditure Certification Report

Attachment VII – Ombuds Services

Attachment VIII – Budget

Attachment IX – SAMHSA's 10 Components of Recovery

Attachment X – Disclosure of or Change in Ownership and Control Interest Form

Attachment XI – Management Information System

Attachment XII – Voluntary and Involuntary Crisis Response

Attachment XIII – ICRS Cooperation Agreement

Attachment XIV – Voluntary Inpatient Certification and Involuntary Payment Authorization Number Assignment

AGREEMENT FOR THE PROVISION
OF
MEDICAID COVERED
MENTAL HEALTH SERVICES

THIS MENTAL HEALTH SERVICES AGREEMENT (the "Agreement"), pursuant to Chapter 71.24 RCW and all relevant and associated statutes, as amended, is made and entered into by and between the NORTH SOUND REGIONAL SUPPORT NETWORK, dba THE NORTH SOUND MENTAL HEALTH ADMINISTRATION ("NSMHA"), 117 N. 1st Street, Suite 8, Mount Vernon, Washington 98273, and VOLUNTEERS OF AMERICA ("Contractor") 2802 Broadway Ave, Everett, WA 98201.

This Agreement incorporates the Exhibits and Attachments to the Agreement and other documents incorporated by reference.

The effective date of this Agreement is October 1, 2013, through September 30, 2015.

A. DEFINITIONS

7.01 Plan is NSMHA's Board approved plan, which outlines NSMHA's commitment to planning and service delivery for American Indian governments and communities.

Abuse means a provider's practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Access refers to the initial request for services and initial screening and the related response-time requirements.

Access to Care Standards (ACS) means the Division of Behavioral Health and Recovery (DBHR) minimum eligibility requirements for Medicaid adults & Medicaid older adults guidelines reflect the most restrictive eligibility criteria that can be applied. NSMHA may expand coverage based on availability of local resources.

Accessibility means the extent to which an eligible recipient can obtain available services. Accessibility includes both the ability to contact the organization and the availability of providers and services.

Accountability means responsibility of Contractor for achieving defined outcomes, goals, and contract obligations.

Act means the Social Security Act.

Action means in the case of a Prepaid Inpatient Health Plan (PIHP) service:

1. 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. Reduction, suspension, or termination of a previously authorized service;
3. Enrollee disagreement with a treatment plan (WAC 388-865-425 & 388-877-0620)
4. Denial in whole or in part, of payment for a service;
5. Failure to provide services in a timely manner, as defined by the state;
6. Failure of a PIHP to act within the timeframes provided in section 42 CFR 438(b).

Administrative Costs means costs for the general operation of the public mental health system. These activities cannot be identified with specific direct services or direct services support function as defined in the Budget, Accounting and Reporting System (BARS) supplemental instructions.

Advance Directive means a written document in which a principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both, and that is consistent with the provisions of Washington's Mental Health Advance Directive statute.

Agreement means this document, the General Terms and Conditions and Special Terms and Conditions, including any Exhibits and other documents attached or incorporated by reference.

Allied Systems means state or local services which provide individuals with assistance to reduce the impact of disabilities, functional impairments, or skill deficits, and which promote stable community living.

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

Appeal means a request for review of an action as "action" is defined above.

Appropriate means the extent to which a particular procedure, treatment, or service is clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to the needs of the recipient.

Arbitration means the process by which the parties to a dispute submit their differences to the judgment of an impartial person or group appointed by mutual consent or statutory provision.

Assessment means a process which provides sufficient information to determine medical necessity for mental health services covered under this Agreement.

Capitation Payment means a payment the Department of Social and Health Services (DSHS) makes monthly to a PIHP on behalf of each recipient enrolled under a contract for the provision of mental health services under the State Medicaid Plan. DBHR makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

Case Management means assistance to a recipient and family (or significant other) to obtain, maintain, or develop appropriate resources.

Center for Medicare and Medicaid Services (CMS) the US federal agency which administers Medicare, Medicaid and the Children's Health Insurance Program.

Children's Long-Term Inpatient Program (CLIP) means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from state-funded beds in CLIP.

Child Study and Treatment Center (CSTD) is DSHS's child psychiatric hospital.

Code of Federal Regulations (CFR) means all references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

Community Mental Health Agency (CMHA) means CMHA that is licensed by the State of Washington to provide mental health services and subcontracted to provide mental health services covered under this Agreement.

Community Support Services is all community-based, outpatient services. As defined in RCW 71.24.025(8) and WAC 388-865 and 388-877.

Complaint means a verbal or written statement by an enrollee that expresses dissatisfaction with some aspect of services covered under this Agreement.

Confidential Information means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential information includes, but is not limited to, personal information.

Consumer means an individual who has applied for, is eligible for, or who has received mental health services. For a child, under the age of 13, or for a child age 13 or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

Coordinated Quality Improvement Program (CQIP) the purpose of CQIP is to improve the quality of health care services by identifying and preventing health care malpractice under RCW 43.70.510.

Corrective Action/Compliance Review is when findings from a NSMHA/DBHR review or other monitoring efforts or audits show that there are apparent violations of this Agreement, Contractor shall implement corrective action within specified timeframes determined by NSMHA/DBHR/Department's other auditors.

Corrective Action Plan (CAP) is a written plan specifying what Contractor is required to do to be in compliance. This includes required improvements and a time line for such action(s) to be accomplished.

Crisis may be self-defined or a situation where an individual is acutely mentally ill, or experiencing serious disruption in cognitive, volitional, psychosocial and/or neurophysiologic functioning.

Crisis Plan is a blueprint for action in the case of an individual (or child/family) who is experiencing imminent or substantial risk of harm to self/others or who is at risk of decompensating that could lead to future use of psychiatric inpatient services. Plans are developed in collaboration with the individual and natural supports.

Crisis Stabilization Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis.

Crisis Services means a face-to-face evaluation and treatment of mental health emergencies and crises to non-enrolled, as well as, enrolled individuals experiencing a crisis as defined by the WAC. Crisis services shall be available on a 24-hour basis with the goal of stabilizing the person in crisis and providing immediate or short-term treatment and support in the least restrictive environment available. Crisis services may be provided prior to an intake evaluation/assessment.

Cross-System Team meetings and consultations is participation and involvement with systems beyond the mental health system, which are also providing services to a mental health consumer, to assure communication and integrated, coordinated treatment planning and provision.

Cultural Competence means a set of congruent behaviors, attitudes and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

Day for the purposes of this Agreement means calendar days unless otherwise indicated in the Agreement.

Debarment means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

Deliverable means any written information required for submission to NSMHA to satisfy the work requirements of this Agreement and that are due by a particular date or on a regularly occurring schedule.

Denial is the decision by the PIHP, or formal designee, not to authorize a covered Medicaid mental health service that has been requested by a provider on behalf of an eligible Medicaid enrollee. It is also a denial if an intake is not provided upon request by a Medicaid enrollee.

Discharge Planning (Services) is the process of developing a care regimen and community integration plan for a mental health recipient leaving clinical care including appropriate residential treatment/housing supports, utilizing natural supports and community support services prior to the recipient leaving outpatient care.

Discharge Planning (Hospital) is the processes of developing a care regimen for an individual leaving inpatient care, including appropriate timing and follow-up appointments and treatment.

Discharge is (1) related to the end of an inpatient psychiatric hospital stay; (2) occurs when an eligible individual has completed an episode of care (or active service) and is no longer receiving services (i.e., closed).

Diversion means to redirect an individual from being placed in a restrictive setting (i.e., Jail, inpatient services) to clinically appropriate less restrictive alternative(s).

Early Periodic Screening Diagnosis and Treatment (EPSDT) is the program under Title XIX of the Social Security Act as amended for children/youth who have not reached their 21st birthday.

Emergent Care means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

Emerging Best-Practice or Promising-Practice means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice and is effective for the population.

Enrollee means a Medicaid recipient who is currently enrolled in a PIHP.

Evaluation and Treatment (E&T) Facility means a facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care and timely and appropriate inpatient care to persons suffering from a mental disorder and which is certified as such by DSHS.

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

Fair Hearing means a grievance hearing before Washington State Office of Administrative Hearings.

Family means

1. For adults-family means those the individual defines as family (i.e., guardians, siblings, caregivers and significant others)
2. For children-family means a child's biological parents, adoptive parents, foster parents, guardians, legal custodians authorized pursuant to Title 26 RCW; a relative with whom a child has been placed by DSHS or Tribe.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Geographic Area is NSMHA Service Area consisting of the following geographic areas:

1. Island County
2. San Juan County
3. Skagit County
4. Snohomish County
5. Whatcom County

Grievance means an expression of dissatisfaction about any matter other than an action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).

Health Insurance Portability and Accountability Act (HIPAA) of 1996 is codified in 42 USC §1320(d) et.seq. and CFR Parts 160, 162 and 164.

Individual Choice means the individual/child/families are guaranteed an opportunity to choose freely among treatment options and support services (based on identified needs) and to be full partners in the treatment process. "Choice" supports the notion that to the degree possible, individuals/children/families need to play a key role in designing their own service/support "packages", including involvement of natural supports and culturally specific services.

Involuntary Treatment Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05, 71.24.300 and 71.34.

Large Rural Area means areas with a population density of less than 20 people per square mile.

Local Funds Eligible for Match means sources of revenue that are eligible to be used as federal match are broad based taxes at the county or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Funds used for federal match under this Agreement may not be used as match for any other federal program. It can be local funds that have not been previously matched with federal funds at any point. Local funds do not include donations.

Medicaid Funds means funds provided by CMS Authority under Title XIX program of the Social Security Act.

Medicaid Waiver is a waiver granted by the Secretary of DSHS to requirements of 42 USC 1396a for the purpose of permitting DSHS/DBHR to operate a capitated managed care system to provide services to enrolled recipients of the Medicaid program. Under 42 USC 1396n, the Secretary is authorized to grant such waivers to the extent he/she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient and consistent with objectives of the Medicaid program.

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

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment/s and corresponding need/s must be the result of a mental illness. The interventions deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

Mental Disorder as defined in RCW 71.34.020(12) for children and RCW 71.05.020(2) for adults.

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

Office of Management and Budget (OMB) Circular A-133 means audits of States, Local Governments and Non-Profit Organizations.

Outcome means the results of a service period of treatment. The extents to which services are provided to individuals experiencing emotional and behavioral disorders have a positive or negative effect on their well-being, circumstances and capacity for self-management and recovery.

Outreach means a mental health service where individuals with severe and persistent mental illness or serious emotional disturbance are contacted in their place of residence or in non-traditional settings for the purpose of:

1. Improving their mental health, health, or social functioning; or
2. Increasing their utilization of human services and resources.

There are two basic approaches to outreach:

1. Mobile (going to an individual/family); and
2. Peer/Drop-in centers (i.e., shelters, clubhouses, kitchens, clothing banks).

Regardless of the approach, the outreach process has five (5) important components:

1. Locating individuals in need of services;
2. Engaging individuals into service;
3. Assessing their needs;
4. Linking individuals to an appropriate level of support services; and
5. Providing follow-up services.

Personal Information means information identifiable to any person including, but not limited to, information that relates to a person's name, health, finances, education , business , use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers and any financial identifiers.

Prepaid Inpatient Health Plan (PIHP) means an entity that provides or arranges for:

1. Mental health services to enrollees under contract with the state on the basis of prepaid capitation payments, or other payment arrangements that don't use state plan payment rates;
2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; or
3. Does not have a comprehensive risk contract.

Publish means an officially sanctioned document provided by NSMHA/DSHS Internet or Intranet websites for downloading, reading, or printing. Contractor shall be notified in writing or by e-mail when a document meets these criteria.

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

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

Quality Strategy means an overarching system/process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.

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

Reduction means the decision by a PIHP to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. The clinical decision by a CMHA to decrease or change a covered service in an Individualized Service Plan (ISP) is not a reduction.

Rehabilitation means to restore to customary activity through education, skill building and therapy. Increase independence and ability to participate in life meaning activities.

Request for Service means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an enrollee or the person authorized to consent to treatment for that enrollee.

Reserve Accounts means an allocation of fund balance at the RSN set aside for a specific purpose by the RSN governing board or local legislative authority.

1. Operating Reserve – Funds designated from mental health revenue sources that are set aside into an operating reserve account by official action of the RSN's governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.
2. Inpatient-Risk Reserve – Funds designated from mental health revenue sources to pay for future inpatient hospital claims and funds designated from mental health revenue sources that are set aside into a risk reserve account by official action of the RSN's governing body.

Residential Services are defined in WAC 388-865 and/or 388-877-0430, NSMHA Standards of Care and Clinical Eligibility Manual and NSMHA Policies and Procedures.

Resilience means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.

Risk means the possibility that Contractor may incur a loss because the cost of providing services may exceed the premium payments made by NSMHA to Contractor for services covered under this Agreement (42 CFR 434.2).

Routine Services means non-emergent and non-urgent services are offered within 14 calendar days to individuals authorized to receive services as defined in the access to care standards. Routine services are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health.

Subcontract means a separate agreement between Contractor and an individual or entity ("subcontractor") to perform all or a portion of the duties and obligations that Contractor shall perform pursuant to this Agreement.

Suspension means the decision by a PIHP or formal designee, to temporarily stop previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision of a CMHA to temporarily stop or change a covered service in the Individualized Resiliency/Recovery Plan (IRP) is not a suspension.

Termination means the decision by a PIHP or their formal designee, to stop previously authorized covered by Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a CMHA to stop or change a covered service in the ISP is not a termination.

Title 42 is the CFR Public Health Service.

Title XIX is grants with states for Medical Assistance Program.

Title XIX Eligible Month means a calendar month in which an individual is eligible for the Title XIX program for any part of the month.

Title XXI is the State Children's Health Insurance Program.

Transition Youth means anyone age 17-21.

Underserved means persons who are minorities, children, elderly, disabled and low-income. See WAC 388-865-0150.

Urban Area means areas that have a population density of at least 500 people per square mile.

Urgent Care means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

Utilization Management Services means to provide independent utilization management process that monitors provider network to ensure services provided are sufficient, but not excessive, which are predicated on the individual needs of the recipient with respect to that person's age, culture, language and abilities.

Youth means anyone age 13-17 (13-20 if Medicaid).

B. MENTAL HEALTH SUPPORT SERVICES

Contractor shall provide or purchase age, linguistic and culturally competent community mental health services for enrollees for whom services are medically necessary and clinically appropriate in accordance with the standards established herein.

1. CARE CRISIS PROGRAM

a. Contractor shall operate an integrated, coordinated and seamless care crisis program serving Medicaid enrollees in the Service Area. Contractor shall provide services for enrollees for whom services are clinically appropriate in accordance with the standards established herein. Contractor must provide for the availability of crisis mental health services on a 24-hour, 7 days per week basis.

b. Contractor shall be responsible for providing crisis services to individuals in accordance with the applicable requirements of Attachment XII.

c. Contractor shall be responsible for coordinating and cooperating with other providers in NSMHA's crisis service network in accordance with Attachment XIII.

d. Contractor shall assure the availability of a 24/7 crisis hotline staffed by Mental Health Professionals (MHP).

C. DELEGATED FUNCTION

1. COMMUNITY PSYCHIATRIC INPATIENT SERVICES MANAGEMENT – GENERAL REQUIREMENTS

Contractor shall coordinate an integrated system of access to all community inpatient services, whether care is provided on a voluntary or involuntary basis and shall comply with all NSMHA clinical policies and procedures and Exhibit B, Community Psychiatric Inpatient Process or any successors. In addition, Contractor shall provide Voluntary Inpatient Certification and Involuntary Payment Authorization Numbering services as required in Attachment XIV. Specific inpatient management services shall include:

a. Response to requests for certification of psychiatric inpatient care for enrollees in community hospital units occurs within 2 hours of the request. A decision regarding certification of psychiatric inpatient care must be made within 12 hours of the initial request.

   If the authorization is denied, a Notice of Action must be provided to the enrollee.

b. If a denial appears indicated, Contractor shall ensure the request is reviewed by a Psychiatrist/Clinical Psychologist. Only a Psychiatrist/Clinical Psychologist may issue a denial. A decision to deny psychiatric inpatient care must be made within 12 hours of the initial request.
c. Contractor shall ensure a Psychiatrist/Clinical Psychologist is available for consultations.
d. Medical necessity determinations made by Contractor may be appealed. The inpatient facility and client has a right to appeal in accordance with NSMHA's Inpatient Appeal and Dispute Policies and Procedures. Concerns regarding Contractor's or NSMHA's compliance with published requirements may be addressed through an administrative dispute process. If Contractor is contacted by the inpatient facility, Contractor must promptly inform the inpatient facility to contact NSMHA. If Contractor receives an appeal or dispute from an inpatient facility, Contractor shall promptly forward the appeal or dispute to NSMHA.
e. Contractor shall submit policy and procedures to NSMHA 30 days after contract execution and implement modified policy and procedures within 30 days of NSMHA's approval. Any modifications to the policy and procedures shall be submitted to NSMHA for review and approval.
f. Contractor shall coordinate with crisis outreach service providers for pre-hospital emergency assessments for voluntary hospitalizations.
g. Contractor shall provide support as requested to assist NSMHA in the statewide Performance Improvement Projects (PIP).
h. Contractor shall not subcontract the performance of this delegated function without prior written approval of NSMHA.

2. CUSTOMER SERVICE REQUIREMENTS

Contractor shall provide customer services that are customer friendly, flexible, proactive and responsive to individuals, families and stakeholders. Customer services staff shall:

a. Answer customer service lines via both local and toll free numbers to respond to inquiries and complaints from 8:00 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.
b. Answer calls with an average speed of within 30 seconds and a call abandonment rate of less than 3 percent.
c. Respond to benefits, claims and other inquiries or complaints and assist individuals, family members and stakeholders in a manner that resolves their inquiry, including the ability to respond to those with limited English proficiency or the hearing impaired.
d. Log all calls and arrange for appropriate follow-up, including notification of the individual of the resolution consistent with the requirements specified in PIHP and State Funded contracts.

Contractor shall train customer services staff to distinguish between a complaint, third party insurance issue, appeals and grievances, information requests and how to triage these to the appropriate party. Call logs shall, at a minimum, track date of call, type of call and resolution.

3. ACCESS LINE

a. Contractor shall provide a regionally managed integrated access system that coordinates with all NSMHA contracted CMHA's to ensure region-wide standardized initial screening, intake authorization and scheduling and linkages to crisis services.
b. Contractor will provide access to telephonic assessment and referral services provided by appropriately qualified care management staff via both local and toll free numbers.
c. Contractor will arrange for access to emergent crisis services 24 hours per day, 7 days per week.
d. Contractor will arrange for access to urgent services within 24 hours of a request for services.
e. Contractor will arrange for an intake evaluation for routine services within 10 business days of a request for services.
f. Contractor will ensure that persons eligible for State-funded mental health services shall receive an intake evaluation based on assessment of need and within available resources and in accordance with NSMHA policy and procedure.
g. Contractor will track the management of the access and referral line, including the volume of calls, call responsiveness statistics and number of referrals by category of service.
h. Contractor will have methods to monitor compliance with access requirements and report data monthly to NSMHA, including:

    i. Availability of crisis services 24 hours a day, 7 days a week including access to Designated Mental Health Professional (DMHP) for Involuntary Treatment evaluations.

ii. Monthly reports will include queue performance, total calls and disposition and referral source. Contractor shall demonstrate its performance of this function by the maintenance of written records that show routine review and discussion of access line issues by Contractor members and staff.

i. Individuals/families seeking mental health services within the North Sound region will be assisted by mental health clinicians who are adept at triage and screening functions and responsive to the caller's needs. Clinical back-up shall be made available to the Contractor staff (i.e., for supervisory or medical consultation). Response to access calls will be timely, friendly and helpful. The first level of screening will be for safety concerns. If a crisis response is needed, the caller will be immediately connected to crisis services where MHP's and Mental Health Specialists (MHS) are available for consultation. The next level of screening will be for Medicaid coverage, or financial eligibility. Individuals who are financially eligible will be connected by phone in a seamless "warm" transfer to the agency to schedule an assessment appointment. At this time, callers shall be asked about any special accommodations that might be needed at the assessment appointment and advised that they are encouraged to bring a friend or family member and/or any relevant documentation to the assessment appointment, if desired. NSMHA provider agencies shall offer an assessment appointment within 14 calendar days.

j. All callers who are financially eligible will be authorized for a face-to-face intake assessment appointment with a clinician who is an MHP as defined by the State of Washington within 10 working days (not to exceed 14 calendar days) to determine service eligibility and the appropriate level of care.

D. PERFORMANCE STANDARDS

Contractor must ensure the provision or purchase of medically necessary mental health services for all enrollees in accordance with Contractor's obligations under this Agreement. Implementation of changes in Medicaid State Plan must be completed no later than 30 days following CMS approval of State Plan.

1. GENERAL OPERATING STANDARDS

a. Contractor must ensure that enrollees and enrollees' families participate in planning activities and participate in the implementation and evaluation of Contractor's clinical functions. Contractor must be able to demonstrate how this requirement is implemented.

b. Contractor will submit to an annual External Quality Review Organization (EQRO) monitoring review and work with the EQRO Contractor set forth by DSHS to schedule a time for the monitoring review that works best for both parties. In the event Contractor or any of Contractor's subcontractors do not provide ready access to any information or facilities for the EQRO monitoring review during the scheduled time, Contractor shall incur any costs for re-scheduling the EQRO Contractor to return and finish its review.

c. Contractor must ensure Healthy Options enrollees are not referred to a Healthy Options managed care plan if the enrollee is determined to be eligible for services based on medical necessity and the ACS.

d. Contractor must maintain a written advance directive policy and procedure that respects enrollees' advance directives for psychiatric care.

e. Contractor must participate in NSMHA/DBHR offered training when requested, including training on the implementation of Evidence-Based Practices, Emerging and Promising Practices.

f. Contractor shall encourage and promote dignity and respect throughout the system of care.

g. Contractor must ensure staff is familiar with SAMHSA's 10 Components of Recovery as outlined in Attachment IX.

h. Contractor shall provide customer service that is customer-friendly, flexible, proactive and responsive to individuals, families and stakeholders. Contractor shall provide a toll free number. A local telephone number may also be provided for those individuals within the local calling area

m. Contractor shall collaborate with NSMHA on development and implementation of PIP and Performance Measures during the term of this Agreement.

n. Contractor shall collaboratively participate in NSMHA's regional coordination meetings, which currently include NSMHA's Ad Hoc Regional Integrated Provider, NSMHA's Quality Management Oversight Committee (QMOC), Regional ICRS Committee, subcommittees and work groups of these committees as necessary.

o. Contractor shall obtain written consent from the individual/family, in the event a picture or personal story will be used.

2. LOCUS/CALOCUS LEVEL OF CARE UTILIZATION SYSTEM

Contractor shall comply with NSMHA's Inpatient Certification Utilization policy and procedure on LOCUS/CALOCUS.

Contractor shall comply with their NSMHA approved LOCUS/CALOCUS Training Plan and the strategies identified in efforts toward Inter-rater reliability.

3. ALLIED SYSTEM COORDINATION

Contractor must comply with and at the request of NSMHA participate in the identification and development of Allied System Coordination plans. NSMHA's coordination plans with allied systems, includes, but is not limited to, Western State Hospital (WSH), CA, Aging and Disability Services Administration (ADSA), Department of Alcohol and Substance Abuse (DASA), Criminal Justice System (CJS), Educational Service District (ESD), Federally Qualified Health Centers (FQHC), Juvenile Rehabilitation Administration (JRA), Community Integration Assistance Program (CIAP), Healthy Options Plans, Community Health Centers, and Department of Vocational Rehabilitation (DVR). The coordination plans are intended to enable coordination of services and appropriate management of care for individuals.

Contractor shall comply with published directives from DBHR when NSMHA, Contractor, or its subcontractors are unable to resolve local disputes with other service systems (Healthy Options or other DSHS administrations as provided by DBHR) regarding service or cost responsibilities.

4. CRISIS SERVICES COORDINATION AND COOPERATION

Contractor shall coordinate and cooperate with providers in NSMHA's crisis service network to ensure the continuity of care.

Contractor shall develop protocols in collaboration with regional crisis service providers and NSMHA to utilize the Wraparound Team in the prevention and intervention with children/adolescents and families being served by a Wraparound team.

5. COMPLAINT, GRIEVANCE, APPEAL AND FAIR HEARING PROCESSES

Contractor must implement complaint, grievance, appeal and fair hearing processes that are in conformance with NSMHA policies and procedures.

Contractor and its subcontractors shall abide by NSMHA's complaint, grievance, appeal and fair hearing determinations. Contractor shall be responsible for paying 100% of all medical director/attorney fees incurred by NSMHA when an individual goes directly to a fair hearing without utilizing NSMHA's grievance processes and when the ruling favors the individual, in accordance with NSMHA policies and procedures. In addition Contractor shall:

a. Implement a Grievance process that complies with 42 CFR §438.400, WAC 388-865 and 388-877 or any successors;
b. Coordinate with NSMHA grievance process and Ombuds Services;

c. Provide assistance to clients filing a grievance;
d. Provide access to interpreter services and toll free numbers with adequate TTY/TTD and interpreter capability;
e. Incorporate concerns from grievances into CMHA services without identifying individual clients.

6. LOCAL RESPONSIVENESS AND COMMUNICATIONS

Contractor shall cooperate with NSMHA and the Counties in the service area to provide a locally responsive delivery system.

Contractor shall provide enrollees with referral sources information and education about the referral process, service availability, service population, common symptoms of mental illness and shall post and make known consumer rights and responsibilities including complaint, grievance, appeal and fair hearing procedures and the availability of Ombuds services in a conspicuous manner with accessible placement.

Contractor will maintain written policies and procedures in accordance with NSMHA's policies on enrollee communications and ensure that the provision of enrollee information complies with all requirements of 42 CFR §438.100, §438.6(i)(30), or any successors and is provided in the following prevalent languages: Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. Information on how to access the translated information must be provided prior to conducting the intake evaluation.

Contractor shall be able to demonstrate that its notification mechanisms are effective.

Additionally, Contractor will provide:

a. General rights to the enrollee as specified in WAC 388-865-0410, 388-877-0600 and 42 CFR §438.100 or their successors.
b. Information about benefits and authorization requirements.
c. Information to enrollees, which clearly explains how the enrollee can request and be provided written materials in alternate formats. Information explaining to the enrollee how to access these materials must be provided prior to an intake evaluation.
d. Upon an enrollee's request:

    i. Identification of individual MHCP who are not accepting new enrollees.
    ii. Contractor licensure, certification and accreditation status.
    iii. Information that includes, but is not limited to: education, licensure and Board certification/re-certification of MHPs and MHCPs.

Contractor shall provide communication capacity including AT&T or Washington Telecommunications Relay Services and other electronic devices shall be available, including DSHS' Language Interpreter Services and Translations (LIST) and their registry of certified and qualified interpreters.

Contractor shall guarantee enrollee access in all cases of need, by having in place a formal agreement with AT&T Language Line Interpreter Services in accordance with this Agreement and NSMHA's policies and procedures during the performance period.

7. CRITICAL INCIDENTS

Contractor and its subcontractors shall comply with NSMHA's Critical Incident Reporting policy and procedure and any successor regarding critical incidents.

8. CONFIDENTIALITY

Contractor shall not use, publish, transfer, sell, or otherwise disclose any confidential information gained by reason of this Agreement for any purpose that is not directly connected with the performance of the services contemplated there under, except:

a. As provided in NSMHA policy and procedure; or
b. As provided by law;
c. In the case of personal information, as provided by law or with the prior written consent of the individual or personal representative of the person who is the subject of the personal information.
d. Contractor shall protect and maintain all confidential information gained by reason of this Agreement against unauthorized use, access, disclosure, modification or loss. This duty requires the parties to employ reasonable security measures, which include restricting access to the confidential information by:

    i. Allowing access only to staff that have an authorized business requirement to view the confidential information.
    ii. Physically securing any computers, documents, or other media containing the confidential information.

To the extent allowed by law, at the end of the Agreement term, or when no longer needed, the parties shall return confidential information or certify in writing the destruction of confidential information upon written request by the other party.

Paper documents with confidential information may be recycled through a contracted firm, provided the contract with the recycler specifies that the confidentiality of information will be protected, and the information destroyed through the recycling process. Paper documents containing confidential information requiring special handling (i.e., Protected Health Information) must be destroyed through shredding, pulping, or incineration.

The compromise or potential compromise of confidential information must be reported to NSMHA's Deputy Director within 5 business days of discovery for breaches of less than 500 persons' protected data, and 3 business days of discovery for breaches of over 500 persons' protected data. The parties must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law

9. PERFORMANCE IMPROVEMENT AND REGIONAL MEASURES

It is NSMHA's expectation that we will meet or exceed all appropriate statewide PIP's and regional performance measures. Each of the performance indicators will be addressed in the 2012-15 NSMHA's Quality Management (QM)/Strategy Plan. In addition, Contractor shall develop a plan and submit it to NSMHA for approval within 90 days following the execution of this Agreement that addresses the action steps to be taken by Contractor that will assist in achieving the goals of the PIP's and regional performance measures identified by NSMHA's QMOC and addressed in the Regional QM/Strategy plan. Upon request, Contractor shall submit relevant data/reports to NSMHA in the development and management of the identified performance projects and measures.

10. EVIDENCE-BASED PRACTICES

Contractor will participate with NSMHA/DSHS to increase the use of research and evidence-based practices, with a particular focus on increasing these practices for children and youth as identified through legislative mandates. This includes:

a. Participation in state-sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TFCBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence-based practices including those for which state subsidy of training costs is not available. Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice.
b. Participation in state-sponsored efforts to ensure that the sites offering the TF-CBT/CBT+ evidence-based practice are operated as trauma-informed systems of care.
c. Participation in regional efforts to identify and promote evidence-based practices for adults.

11. TRAUMA-INFORMED CARE

A majority of the individuals in mental health services have experienced some form of trauma in their history. NSMHA, in collaboration with regional Contractors, shall create a trauma-informed system of care.

Contractor and NSMHA shall address the following over the course of this Agreement:

a. Develop/implement an organizational assessment tool;
b. Develop/implement a trauma screening tool; and
c. Provide and participate in trauma-informed trainings.

12. QUALITY STRATEGY/MANAGEMENT

Contractor shall participate with NSMHA in the implementation, updates and evaluation of DBHR Quality Strategy located on DBHR website that is hereby incorporated by reference.

Contractor shall comply with NSMHA QM/Strategy Plan or any successor incorporated herein as Attachment II.

Contractor shall ensure its QM activities comply with all applicable law and standards including, but not limited to: WAC 388-865-0280-0425, 388-877-400,410 and NSMHA's QM Plan, NSMHA policies and procedures; or their successors. In addition:

a. Contractor shall maintain an ongoing, planned, systematic, organization wide QM process to design, measure, analyze and improve its performance, including identification of innovations or best practice.
b. Contractor QM plan and process, which shall be reviewed and updated by provider as needed but, at a minimum, every six (6) months will be audited by NSMHA.
c. Contractor shall ensure Quality Assurance and Quality Improvement data is analyzed, reported and acted upon. This shall be demonstrated by written records maintained by Contractor.

Contractor shall present to NSMHA every six (6) months (March 31st and September 30th), a QM report integrating all quality improvement activities including NSMHA PIP's, measures and data in order to facilitate NSMHA's determination of the effectiveness of the overall regional system of care. This report shall be in a mutually agreed format and document the results of Contractor's QM plan activities and:

a. Identify areas of efficiency and effectiveness of system operations and the quality of care for individuals/families.
b. Identify areas of deficiency with plans to achieve expected improvement.
c. Status of implementation of all NSMHA approved corrective action plans.

E. CONTRACTOR RESPONSIBILITIES

Contractor shall have responsibility for the performance and responsibilities under this Agreement. Contractor shall include community and county input into planning and access to services. Contractor shall be held fully responsible for the contractual obligations and performance of its subcontractors. In the performance of these functions, Contractor shall maintain written documentation that verifies that each specific responsibility under this Agreement has been performed.

1. CAPACITY

a. Contractor must notify NSMHA in writing of any proposed change in capacity. NSMHA must approve any change that results in reduced capacity.

   i. A reduction in capacity is defined as the point in time when Contractor is not able to meet all the access standards as defined in this Agreement. Events that may affect capacity include: closing of a facility in any geographic area, a decrease in the state plan services currently available, decrease in the number or frequency of services, employee strike or other work stoppage related to union activities, or any change that may result in Contractor being unable to provide services for those enrollees who are covered by this Agreement.

   ii. Submit a report to NSMHA by November 1, 2013, with current capacity and submission biannually thereafter. Contractor shall notify NSMHA 30 days prior to implementation/public notice when Contractor adds, changes locations, or closes a facility and when the number of staff type/specialty changes at any CMHA facility by 5 staff or more. The report shall identify each Contractor facility location/address, number and FTE of individuals providing direct services that are employed or contracted at each location by type/WAC specialty and staff with specialized training/expertise in NSMHA identified treatments.

   iii. The termination or addition of a subcontract that provides mental health services is considered a significant change. Contractor must notify NSMHA 30 days in advance of public written notice to enrollees before Contractor terminates any of its subcontracts with entities that provide direct service.

   iv. Contractor must ensure the provision of written notification within 15 days to enrollees receiving services from the subcontractor upon written notification of termination by either party.

   v. If either party must terminate a subcontract in less than 30 days, Contractor must notify NSMHA as soon as there is a determination to terminate the subcontract and in advance of public notice.

   vi. If an event identified in section C.2 occurs, Contractor must submit a plan to NSMHA for enrollees and services that includes at least the following:

      a) Notification to Ombuds services;
      b) Crisis services plan;
      c) Client notification plan;

d) Plan for provision of uninterrupted services; and
e) Any information released to the media.

Contractor shall demonstrate its performance of this function by the maintenance of written records that show routine review and discussion of capacity issues by Contractor staff.

2. ACCESS STANDARDS

Ensure enrollees can access medically necessary mental health services upon request that do not exceed the access standards below.

a. Request for mental health services is defined as a point in time in which mental health services are sought or applied for through a telephone call, walk-in, or written request for mental health services.
b. Urgent and emergent medically necessary mental health services (i.e., crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations/other screening and assessment process. Contractor must ensure:
    i. Urgent care occurs within 24 hours of the request for mental health services from any source.
    ii. Emergent mental health care occurs within two (2) hours of the request for mental health services from any source.
c. Contractor shall demonstrate its performance of this function by the maintenance of written records that show routine review and discussion of access standard issues by Contractor staff.

3. STAFF COMPETENCY AND TRAINING

Contractor and its subcontractors shall comply with NSMHA credentialing policies and procedures and shall ensure that all staff is qualified for the position they hold and have at a minimum, education, experience and skills to perform their job requirements, per WAC 388-865, 388-877-500-530 including any required licenses or certifications.

Contractor shall require a criminal history background check pursuant to RCW 43.43.830; 832; 834 and 43.20A.710 and WAC 388-877-0500 be completed for all current employees, volunteers and subcontractors and that a criminal history background check shall be initiated for all prospective employees, volunteers and subcontractors who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

Contractor shall collaborate with NSMHA to implement, maintain and revise the Regional Training Plan or any successor incorporated as Attachment II.

Contractor must participate in training when requested by NSMHA/DBHR. Requests for NSMHA/DBHR to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to appropriate Contractor/subcontractor staff.

4. RESOURCE AND UTILIZATION MANAGEMENT ACTIVITIES

Contractor shall conduct resource and utilization management activities as requested by NSMHA to support NSMHA's resource and utilization management programs, after review and discussion between Contractor and NSMHA to ensure such activities are reasonable and cost-effective. Such activities will include planning and reporting in a manner that will allow NSMHA to ensure that its resource and over and under-utilization management obligations are met.

5. MANAGEMENT INFORMATION SYSTEM

Contractor shall ensure the existence and operation of an electronic health record (EHR) that is compatible with NSMHA's CIS and has the capability to transmit data timely and accurately. Contractor shall develop and maintain an information system in comport with Exhibit C and Attachment XI incorporated herein.

NSMHA will require Contractor to provide a Business Continuity and Disaster Recovery Plan (BCDRP) that insures timely reinstitution of the CIS following total loss of the primary system or a substantial loss of functionality. Contractor must submit to NSMHA the most recent version of BCDRP within 30 calendar days of execution of this agreement and within 30 calendar days of Contractor updating their BCDRP.

6. NSMHA AND DBHR REVIEW ACTIVITIES

Contractor shall ensure that remedial actions required as a result of NSMHA/DBHR review activities, as discussed in the Oversight, Remedies and Termination section are reported and acted upon. This shall be demonstrated by written records maintained by Contractor.

7. DELIVERABLES, PLANS AND REPORTS

Contractor must ensure plans or reports required by this Agreement, including those outlined in Attachment IV, Deliverables, are provided to NSMHA in compliance with the timelines/formats indicated.

If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties Contractor may provide one report or deliverable that contains the information required by both Agreements.

8. BUSINESS ASSOCIATES AGREEMENT

Contractor shall abide by the provisions of NSMHA's and Contractor's Business Associates Agreement, Attachment V.

F. FINANCIAL TERMS AND CONDITIONS

1. GENERAL FISCAL ASSURANCES

Contractor shall comply with all applicable laws and standards, including Generally Accepted Accounting Principles and maintain, at a minimum, a financial management system that is a viable, single, integrated system with sufficient sophistication and capability to effectively and efficiently process, track and manage all fiscal matters and transactions.

2. FINANCIAL ACCOUNTING REQUIREMENTS

Contractor shall:

a. Establish and maintain operating reserves at prudent levels sufficient to ensure that Contractor has the ability to pay for all expenses incurred during this Agreement period, including those whose disposition occurs after the Agreement has been terminated and to cover the risk of financial loss resulting in the event that the cost of providing services pursuant to this Agreement exceeds the revenues derived there from.

b. Ensure that all NSMHA funds, including interest earned provided pursuant to this Agreement are used to support the public mental health system within the Service Area.

c. Contractor shall ensure that under no circumstances are individuals charged for any covered services, including those out-of-network services purchased on their behalf.

d. Contractor shall produce annual audited financial statements upon completion and make such reports available to NSMHA upon request.

3. FINANCIAL REPORTING

Contractor shall provide the following reports to NSMHA:

a. Report Contractor and subcontract revenue and expenditure information to NSMHA on a biannual basis. Reports must comply with the provisions in BARS Supplemental Instructions for Mental Health Services promulgated by Washington State Auditor's Office. Reports are due within 30 days of the quarter end (quarters ending in December and June of each year).

b. Contractor shall participate in NSMHA/DBHR Unit Cost Surveys and actuarial studies, when required by NSMHA/DBHR.

4. COUNTY FUNDING

Funds received by Contractor from any one or more of the Service Area's counties may not be used to provide Medicaid covered services to Medicaid enrollees.

5. RULES COMPLIANCE

Contractor shall:

a. Ensure that Medicaid enrollees are not held liable for any of the following:

i. Insolvent community psychiatric hospitals with which PIHP has directly contracted. PIHPs are specifically exempt from the requirements of 42 CFR §438 regarding solvency.

ii. Covered mental health services, including those purchased on behalf of the enrollee.

iii. Covered mental health services provided to the enrollee for which:

a) State does not pay Contractor.

b) Contractor does not pay MHCP or CMHA that furnishes the services under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if Contractor provided the services directly.

b. Submit the amount spent throughout the Service Area on specific items at the request of NSMHA, CMS, the legislature, or DSHS in the timeframe specified.

c. Account for public mental health expenditures under this Agreement in accordance with federal circular A-133, A-122, A-87 and state requirements in accordance with BARS Manual and BARS Supplemental Instructions or any successor.

d. Limit administration costs incurred by Contractor and all subcontractors to no more than 15% of the consideration provided under this contract in any state fiscal year. Administration costs must be measured on a state fiscal year basis according to the reported information submitted by Contractor in its Revenue Certification Report (Attachment VI) and reviewed by NSMHA.

6. FINANCIAL PROVISIONS - REIMBURSEMENT REQUIREMENTS

The consideration to be paid by NSMHA for the work to be provided by Contractor pursuant to this Agreement shall consist of the available amount from primary funding sources as described in Attachment VIII of this Agreement.

a. Contractor shall submit an invoice for capacity funded/cost reimbursement portions of this agreement on a monthly basis.

b. Contractor shall submit an invoice to NSMHA 15 days after the end of the month.

Contractor shall submit encounter data per the MIS section on the fee for service portion of this agreement.

The consideration by NSMHA to Contractor pursuant to this Agreement shall be paid monthly within 15 working days of NSMHA's receipt of payment by DSHS/DBHR.

Funds for July 1, 2015, through September 30, 2015, following the end of the annual State legislative session, NSMHA shall offer an Amendment with the proposed funds for the next fiscal year. If for any reason Contractor does not agree to continue to provide services using the proposed funds, Contractor must provide the appropriate notice to NSMHA under the termination requirements of Section F.

7. FRAUD AND ABUSE

Contractor shall develop and implement administrative and management policy and procedures that are designed to guard against fraud and abuse including:

a. Comporting with Exhibit E of this Agreement
b. Mandatory compliance plan.
c. Designation of a compliance officer or compliance committee that is accountable to Contractor.
d. Effective ongoing training and education for compliance officer and Contractor staff.
e. Effective lines of communication between compliance officer, employees and subcontractors.
f. Enforcement of standards through well-publicized disciplinary guidelines.
g. Provision of internal monitoring and auditing.
h. Provision for prompt response to detected offenses and for development of corrective action initiatives.
i. Participation by Contractor and any subcontractors in Medicaid fraud and abuse training conducted by Washington State Attorney General's Medicaid Fraud Unit.
j. Written policies, procedures and standards of conduct that articulates Contractor's commitment to comply with all applicable Federal and State standards.

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

Complaints and reports should be directed to the contact listed below.

Compliance Officer
117 N First St., Ste. 8
Mt. Vernon, WA 98273
360.416.7013
1.800.684.3555
Compliance_officer@nsmha.org

G. OVERSIGHT, REMEDIES AND TERMINATION

1. OVERSIGHT AUTHORITY

NSMHA, DSHS, Office of the State Auditor, the Department of Health and Human Services (DHHS), CMS, the Comptroller General, or any of their duly-authorized representatives (i.e., EQRO) have the authority to conduct announced and unannounced: a) surveys, b) audits, c) reviews of compliance with licensing and certification requirements and compliance with this Agreement, d) audits regarding the quality, appropriateness and timeliness of mental health services of Contractor and subcontractors and e) audits and inspections of financial records of Contractor and subcontractors.

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

In addition, NSMHA will conduct reviews in accordance with its oversight of resource, utilization and QM, as well as, ensure that Contractor has the clinical, administrative and fiscal structures to enable them to perform in accordance with the terms of the contract. Such reviews may include, but are not limited to, encounter data validation, utilization reviews, clinical record reviews, program integrity, administrative structures reviews, fiscal management and contract compliance. Reviews may include desk reviews, requiring Contractor to submit requested information. NSMHA will also review any activities delegated under this contract to Contractor.

Contractor shall cooperate with and allow access to North Sound Regional Ombuds in order to conduct surveys and review activities in accordance with the terms of this contract and in accordance with Attachment VII. Contractor shall cooperate with Community Action of Skagit County in resolving any disputes that arise in the provision of North Sound Regional Ombuds services.

Findings as a result of NSMHA conducted reviews may result in remedial action as outlined below. Federal and State agencies may impose remedial action or financial penalties either directly upon Contractor or through NSMHA. Contractor shall comply with the terms of such remedial action and be responsible for the payment of financial penalties.

2. REMEDIAL ACTION

NSMHA may require Contractor to plan and execute corrective action. Corrective action plans (CAP) developed by Contractor must be submitted for approval to NSMHA within 30 calendar days of notification. CAP must be provided in a format acceptable to NSMHA. NSMHA may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by NSMHA.

a. CAP must include:

   i. A brief description of the finding.
   ii. Specific actions to be taken, timetable, description of the monitoring to be performed, steps taken and responsible individuals that will reflect the resolution of the situation.

b. CAP may:

   Require modification of any policies or procedures by Contractor relating to the fulfillment of its obligations pursuant to this Agreement.

c. CAP are subject to approval by NSMHA, which may:

   i. Accept the plan as submitted;
   ii. Accept the plan with specified modifications;
   iii. Request a modified plan; or
   iv. Reject the plan.

d. Contractor agrees NSMHA may initiate remedial action as outlined in subsection (e) below if NSMHA determines any of the following situations exist and except for instances described in subsection (d) (i), if corrective actions have not been completed within the timetable acceptable to NSMHA:

   i. If a problem exists that poses a threat to the health or safety of any person or poses a threat of property damage/incident has occurred that resulted in injury or death to any person/resulted in damage to property.
   ii. Contractor has failed to perform any of the mental health services required in this Agreement, which includes the failure to maintain the required capacity as specified by NSMHA to ensure that enrolled individuals receive medically necessary services, including delegated functions; *except*, that no remedial action pursuant to subsection (e) hereof shall be taken if such failure to maintain required capacity is due to any interruption in, or depletion of, the available amount of money to Contractor as described in Attachment VIII of this contract for purposes of performing services to enrollees as described in Section B of this contract; however, in such an instance, NSMHA may terminate all or part of this contract on as little as 30 days written notice.
   iii. Contractor has failed to develop, produce and/or deliver to NSMHA any of the statements, reports, data, data corrections, accountings, claims and/or documentation described herein, in compliance with all the provisions of this Agreement.
   iv. Contractor has failed to perform any administrative function required under this Agreement, including delegated functions. For the purposes of this

section, "administrative function" is defined as any obligation other than the actual provision of mental health services.

v. Contractor has failed to implement corrective action required by the state and within NSMHA prescribed timeframes.

e. NSMHA may impose any of the following remedial actions in response to findings of situations as outlined above.

i. Withhold one percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. NSMHA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

ii. Compound withholdings identified above by an additional one-half of one percent for each successive month during which the remedial situation has not been resolved.

iii. Revoke delegation of any function delegated under this contract.

iv. Deny any incentive payment to which Contractor might otherwise have been entitled under this Agreement or any other arrangement by which the DBHR provides incentives.

v. Termination for Default, as outlined in this Agreement.

3. ADDITIONAL FINANCIAL PENALTIES – DBHR IMPOSED SANCTIONS

Financial penalties imposed by DBHR or other regulatory agency due to the action or inaction of a Contractor may be paid by NSMHA on behalf of Contractor and the amount will be withheld from NSMHA's payments to Contractor.

4. TERMINATION DUE TO CHANGE IN FUNDING

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to its normal completion, either party may terminate this Agreement, subject to re-negotiations.

5. TERMINATION DUE TO CHANGE IN 1915(B) MENTAL HEALTH SERVICES WAIVER

In the event that changes to terms of 1915(b) (Medicaid) Mental Health Services Waiver render this Agreement invalid in any way after the effective date of this Agreement and prior to its normal completion, either party may terminate this Agreement, subject to re-negotiation, if applicable, under those new special terms and conditions.

6. TERMINATION FOR CONVENIENCE

Except, as otherwise provided in this Agreement, NSMHA may terminate this Agreement in whole or in part for convenience by giving Contractor at least 30 calendar days' written notice. Contractor may terminate this Agreement for convenience by giving NSMHA at least 30 calendar days' written notice addressed to NSMHA's Program Administrator (or his/her successor) listed on the last page of this Agreement.

7. TERMINATION FOR DEFAULT

NSMHA's Program Administrator may terminate this Agreement for default, in whole or in part, by written notice to Contractor if NSMHA or DSHS has a reasonable basis to believe that Contractor has:

a. Failed to meet or maintain any requirement for contracting with NSMHA;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement; or
d. Otherwise breached any provision or condition of this Agreement.

Before the Program Administrator may terminate this Agreement for default, NSMHA shall provide Contractor with written notice of Contractor's noncompliance with this Agreement and provide Contractor a reasonable opportunity to correct noncompliance. If Contractor does not correct the noncompliance within the period of time specified in the written notice of noncompliance, the Program Administrator may then terminate this Agreement. The Program Administrator may terminate this Agreement for default without such written notice and without opportunity for correction if NSMHA has a reasonable basis to believe that a client's health or safety is in jeopardy, and/or:

a. Contractor has violated any law, regulation, rule, or ordinance applicable to services provided under this agreement.
b. Continuance of this Agreement with Contractor poses a material risk of injury or harm to any person.

Contractor may terminate this Agreement in whole or in part, by written notice to NSMHA in accordance with Section 7 above, if Contractor has a reasonable basis to believe that NSMHA has:

a. Failed to meet or maintain any requirement for contracting with Contractor;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to work performed under this Agreement; or
d. Otherwise breached any provision or condition of this Agreement.

8. TERMINATION PROCEDURE

The following provisions shall survive and be binding on the parties in the event this Agreement is terminated:

a. Contractor and any applicable subcontractors shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services. Each party shall be responsible only for its performance in accordance with the terms

of this Agreement rendered prior to the effective date of termination. Contractor and any applicable subcontractors shall assist in the orderly transfer/transition of the individuals served under this Agreement. Contractor and any applicable subcontractors shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

b. Contractor and any applicable subcontractors shall immediately deliver to NSMHA's Program Administrator or his/her successor, all DSHS and NSMHA assets (property) in Contractor and any applicable subcontractor's possession and any property produced under this Agreement. Contractor and any applicable subcontractors grants NSMHA and DSHS the right to enter upon Contractor and any applicable subcontractors premises for the sole purpose of recovering any NSMHA/DSHS property that Contractor and any applicable subcontractors fails to return within 10 working days of termination of this Agreement. Upon failure to return NSMHA/DSHS property within 10 working days of the termination of this Agreement, Contractor and any applicable subcontractors shall be charged with all reasonable costs of recovery, including transportation and attorney's fees. Contractor and any applicable subcontractors shall protect and preserve any property of NSMHA/DSHS that is in the possession of Contractor and any applicable subcontractors pending return to NSMHA/DSHS.

c. NSMHA shall be liable for and shall pay for only those services authorized and provided through the date of termination. NSMHA may pay an amount agreed to by the parties for partially completed work and services, if work products are useful to or usable by NSMHA.

d. If the Program Administrator terminates this Agreement for default, NSMHA may withhold a sum from the final payment to Contractor that NSMHA determines is necessary to protect NSMHA against loss or additional liability occasioned by the alleged default. NSMHA shall be entitled to all remedies available at law, in equity, or under this Agreement. If it is later determined that Contractor was not in default, or if Contractor terminated this Agreement for default, Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement.

e. Should the contract be terminated by either party, NSMHA will require the spend-down of all remaining reserves and fund balances within the termination period. Funds will be deducted from the final months' payments until reserves and fund balances are spent. Should the contract be terminated by either party, Contractor shall be responsible to provide all mental health services through the end of the month for which they have received payment.

9. NOTICE REQUIREMENTS

Either party to this Agreement must provide 180 days' notice of any issue that may cause the party to voluntarily terminate, refuse to renew, or refuse to sign a mandatory amendment to this Agreement.

a. If Contractor at any time decides it shall no longer be a Contractor with NSMHA for any reason, Contractor must provide NSMHA's Program Administrator, or his/her successor, listed on the last page of this Agreement with written notice at least 90 days

prior to the effective date of termination and work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services. The transition plan shall address all issues leading to the transition of individuals in service and of all items/requirements of Contractor that extend beyond the termination of services.

b. NSMHA must provide Contractor's Program Administrator or his/her successor listed on the last page of this Agreement with written notice at least 90 days prior if NSMHA decides to voluntarily terminate, refuses to renew, or refuses to sign a mandatory amendment to this Agreement. Contractor shall work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services.

If Contractor terminates this Agreement or will not be entering into any subsequent Agreements, NSMHA shall require at least 90 days' written notice prior to the end of the contract if a decision is made not to enter into a subsequent agreement. Any funds not spent for the provision of services under this Agreement shall be returned to NSMHA within 60 days of the last day this Agreement is in effect.

H. GENERAL TERMS AND CONDITIONS FOR Contractor

1. BACKGROUND

NSMHA is an entity formed by inter-local agreement between Island, San Juan, Skagit, Snohomish and Whatcom Counties, each county authority is recognized by the Secretary of DSHS ("Secretary"). These counties entered into an inter-local agreement to allow NSMHA to contract with the Secretary pursuant to RCW 71.24.025(13), to operate a single managed system of services for persons with mental illness living in the service area covered by Island, San Juan, Skagit, Snohomish and Whatcom Counties ("Service Area"). NSMHA is party to an interagency agreement with the Secretary, pursuant to which NSMHA has agreed to provide integrated community support, crisis response and inpatient management services to people needing such services in its Service Area. NSMHA, through this Agreement, is subcontracting with Contractor for the provision of specific mental health services as required by the agreement with the Secretary. Contractor, by signing this Agreement, attests that it is willing and able to provide such services in the Service Area.

2. MUTUAL COMMITMENTS

The parties to this Agreement are mutually committed to the development of an efficient, cost effective, integrated, person-centered, age specific recovery and resilience model approach to the delivery of quality community mental health services. To that end, the parties are mutually committed to maximizing the availability of resources to provide needed mental health services in the Service Area, maximizing the portion of those resources used for the provision of direct services and minimizing duplication of effort.

3. ASSIGNMENT

Except as otherwise provided within this Agreement, this Agreement may not be assigned, delegated, or transferred by Contractor without the express written consent of NSMHA and any attempt to transfer or assign this Agreement without such consent shall be void. The terms "assigned", "delegated", or "transferred" shall include change of business structure to a limited liability company of any Contractor Member or Affiliate Agency.

4. AUTHORITY

Concurrent with the execution of this Agreement, Contractor shall furnish NSMHA with a copy of the explicit written authorization of its governing body to enter into this Agreement and accept the financial risk and responsibility to carry out all terms of this Agreement including the ability to pay for all expenses incurred during the contract period. Likewise, concurrent with the execution of this Agreement, NSMHA shall furnish Contractor with a written copy of the motion, resolution, or ordinance passed by NSMHA's Board authorizing NSMHA to execute this Agreement.

5. COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND OPERATIONAL POLICIES

Contractor and its subcontractors shall comply with all applicable federal and state statutes, regulations, and operational policies whether or not a specific citation is identified in various sections of this Agreement and all amendments thereto that are in effect when the

Agreement is signed or that come into effect during the term of the Agreement which may include, but are not limited to, the following ("Federal/State Law"):

a. Title XIX and Title XXI of the Social Security Act and Title 42 CFR.
b. All applicable Office of the Insurance Commissioner (OIC) statutes and regulations.
c. All local, State and Federal professional and facility licensing and certification requirements/standards that apply to services performed under the terms of this Agreement.
d. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738 and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS and the EPA.
e. Any applicable mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conservation Plan issued in compliance with the federal Energy Policy and Conservation Act.
f. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
g. Those specified in Title 18 RCW for professional licensing.
h. Reporting of abuse as required by RCW 26.44.030.
i. Industrial insurance coverage as required by Title 51 RCW.
j. RCW 38.52, 70.02, 71.05, 71.24, and 71.34.
k. WAC 388-865 and 388-877 and 388-877A.
l. Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not Contract with any subcontractor operating such a plan.
m. State of Washington Medicaid State Plan and 1915(b) Medicaid Mental Health Waiver or their successors which documents are incorporated by reference.
n. DBHR Quality Strategy.
o. State of Washington mental health system mission statement, value statement and guiding principles for the system attached hereto as Exhibit D.
p. State Medicaid Manual (SMM), OMB Circulars, BARS Manual and BARS Supplemental Mental Health Instructions.
q. Any applicable federal and state laws that pertain to Medicaid enrollee or consumer rights. Contractor shall ensure that its staff takes those rights into account when furnishing services to individuals.
r. DSHS Administrative policies, to the extent that they are applicable to this contract, which are attached as Exhibits F, G and H.
s. 42 USC 1320a-7 and 1320a-7b (Section 1128 and 1128(b) of the Social Security Act), which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit mental health services provided to individuals.
t. Any policies and procedures developed by DSHS/Health Care Authority which governs the spend-down of client assets.

u. Contractor and any subcontractors must comply with 42-USC 1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of Contractor, CMHA, or subcontractor's equity or an employee, Contractor, or consultant who is significant or material to the provision of services under this Agreement, who has been or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency.
v. Federal and State non-discrimination laws and regulations.
w. HIPAA (45 CFR parts 160-164).
x. DBHR-CIS Data Dictionary and its successors.
y. Federal funds must not be used for any lobbying activities.

If Contractor is in violation of a federal law or regulation, and Federal Financial Participation is recouped from NSMHA, Contractor shall reimburse the federal amount to NSMHA within 20 days of such recoupment.

Upon notification from DSHS, NSMHA shall notify Contractor in writing of changes/modifications in CMS policies and DSHS/DBHR contract requirement (Attachment III) changes.

6. COMPLIANCE WITH NSMHA OPERATIONAL POLICIES

Contractor shall comply with all NSMHA operational policies that pertain to the delivery of services under this Agreement that are in effect when the Agreement is signed or that come into effect during the term of the Agreement. NSMHA policies shall not exceed that required to implement federal and state requirements or to implement continuous quality improvement efforts determined by the Integrated QM Process as approved by NSMHA's Board. All proposed new policies shall specifically reference the federal or state requirements they implement and shall be limited to such requirements. NSMHA shall notify Contractor of any proposed change in federal or state requirements affecting this agreement immediately upon NSMHA receiving knowledge of such change. Such policies shall include, but not limited to:

a. NSMHA Core Values and Principles attached hereto as Attachment I provide a framework of principles for the regional system and Contractor shall take these principles into account when providing services under this Agreement.
b. Contractor and its subcontractors must recognize the unique social/legal status of Indian nations as required by both the Supremacy and Indian Commerce Clauses of the United States Constitution; federal treaties; executive orders; Indian Citizens Act of 1924 statutes; and State and Federal court decisions; or any Memorandum of Agreement or MOU signed by State of Washington and a federally recognized tribe of recognized organization; shall maintain compliance with Exhibit G, DSHS Admin. Policy No. 7.01 American Indian Policy or any successor pursuant to the Centennial Accord between Washington State government and Washington Tribes and maintain compliance with NSMHA 7.01 Plan or any successor incorporated as Attachment II.
c. NSMHA's Strategic Plan.

d. NSMHA's clinical policies and procedures, including crisis services policies.
e. NSMHA's medical records documentation and data reporting policies and procedures.
f. NSMHA's QM/strategy plan.
g. NSMHA's consumer rights policies and procedures, including complaint, grievance, appeal and fair hearing policies.
h. Any other policies designated by NSMHA as applicable to Contractor.

Along with all NSMHA stakeholders, Contractor will be included in the process for developing relevant operational policies and procedures. NSMHA's policies and procedures are posted on NSMHA's website as indicated on Attachment II. NSMHA shall notify Contractor of new and revised policies through its Numbered Memoranda. Training will be provided on policies that impact providers, upon request.

In the event there is disagreement between NSMHA and Contractor in an operational committee regarding a proposed new policy or modification to a current policy, the following process will apply. NSMHA will provide a summary of the regulatory requirement or other rationale for the proposed policy or policy modification. Contractor will provide an analysis of its objection to the proposed policy or policy modification within 30 days from the receipt of NSMHA's summary. If the objection is primarily due to increased cost, Contractor will provide substantiation of the additional costs and, if possible, an alternative to achieving the policy goal in a less costly manner. The proposed policy or policy modification will be discussed at the next Regional Management Council. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next QMOC meeting. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next NSMHA's Board meeting.

NSMHA will make best efforts to maintain currency of policies with applicable Federal or State laws, regulations, or policies. In the event of a conflict, Federal or State laws or policies supersede NSMHA policies and procedures and requirements of this contract.

7. CONFIDENTIALITY OF PERSONAL INFORMATION

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

a. Establishing eligibility;
b. Determining the amount of medical assistance;
c. Providing services for recipients;

d. Conducting or assisting in investigation, prosecution, or civil or criminal proceeding related to the administration of the plan;
e. Assuring compliance with Federal and State laws, regulations, terms and requirements of this Agreement; and/or
f. Improving quality.

Contractor shall comply with all confidentiality requirements of HIPAA (45 CFR 160 and 164).

Contractor shall have a process in place to ensure that all components of its CMHA and system understand and comply with confidentiality requirements for publicly funded mental health services.

Contractor shall ensure that access to the information is restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of NSMHA and DSHS.

The parties acknowledge that coordination, planning, screening and referral require the sharing of information among the various treatment providers. Disclosure of information to verify eligibility, determine the amount of assistance and provide medically necessary mental health services are all "purposes directly connected with the administration of the Agreement" and are all appropriate justifications for sharing information.

Contractor shall assure that all staff and subcontractors providing services under this Agreement receive annual training on confidentiality policies and procedures. In addition, Contractor shall ensure that all staff and subcontractors providing services under this Agreement sign an annual Oath of Confidentiality statement. Signed copies of the Oath of Confidentiality shall be kept in Contractor's personnel files.

8. CONTRACT PERFORMANCE/ENFORCEMENT

NSMHA shall be vested with the rights of a third party beneficiary, including the "cut through" right to enforce performance should Contractor be unwilling or unable to enforce action on the part of its subcontractor(s). In the event that Contractor dissolves or otherwise discontinues operations, NSMHA may, at its sole option, assume the right to enforce the terms and conditions of this Agreement directly with subcontractors; provided NSMHA shall keep Contractor reasonably informed concerning such enforcement. Contractor shall include this clause in its contracts with its subcontractors. In the event of the dissolution of Contractor, NSMHA's rights in indemnification shall survive.

9. COOPERATION

The parties to this Agreement shall cooperate in good faith to effectuate the terms and conditions of this Agreement.

10. DEBARMENT CERTIFICATION

Contractor certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any federal or state department or agency. If requested by DSHS or NSMHA, Contractor shall complete a certification regarding debarment, suspension, ineligibility, or voluntary exclusion. Any certification regarding debarment, suspension, ineligibility, or voluntary exclusion pertaining to this Agreement shall be incorporated into this Agreement by reference.

11. EXCLUDED PARTIES

Contractor is prohibited from paying with funds received under this Contract for goods and services furnished, ordered, or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 455.106, and 1001.1901(b)). Contractor shall:

a. Monitor for excluded individuals and entities as outlined in Exhibit E and by:
b. Screening Contractor and subcontractor's employees, individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract.
c. Screening monthly newly added Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.
d. Screening monthly Contractor and subcontractor's employees and individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

Report to NSMHA:

a. Any excluded individuals and entities discovered in the screening within 10 business days.
b. Any payments made by Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.
c. Any actions taken by Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.
d. Any Contractor, subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 with 10 business days of Contractor becoming aware of the conviction.
e. Any subcontractor terminated for cause within 10 business days of the effective date of termination to include full details of the reason for termination.
f. Any Contractor, subcontractor's individuals and entities with an ownership or control interest.

Contractor must provide a list with details of ownership and control no later than 30 days from the date of ratification in comport with Attachment X herein incorporated by reference. Contractor shall keep the list up-to-date thereafter.

Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

Contractor will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

Civil monetary penalties may be imposed against Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2)).

An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of five (5) percent or more, or are a managing employee (i.e., a general manager, business manager, administrator, or director) who exercises operational or managerial control or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR 455.104(a), and 1001.1001(a)(1)).

In addition, if NSMHA/DSHS notifies Contractor that an individual or entity is excluded from participation by DSHS in RSN's, Contractor shall terminate all beneficial, employment, contractual and control relationships with the excluded individual or entity immediately (WAC 388-502-0030) and 388-877-0500.

The list of excluded individuals will be found at: http://exclusions.oig.hhs.gov/

SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

12. DECLARATION THAT CLIENTS UNDER THE MEDICAID AND OTHER MENTAL HEALTH PROGRAMS ARE NOT THIRD-PARTY BENEFICIARIES UNDER THIS CONTRACT

Although NSMHA, Contractor and subcontractors mutually recognize that services under this Agreement may be provided by Contractor and subcontractors to clients under the Medicaid program, RCW 71.05 and 71.34 and the Community Mental Health Services Act, RCW 71.24, it is not the intention of either NSMHA or Contractor that such individuals or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement. Such third parties shall have no right to enforce this agreement.

13. EXECUTION, AMENDMENT AND WAIVER

This Agreement shall be binding on all parties only upon signature by authorized representatives of each party. This Agreement or any provision may be amended during the contract period, if circumstances warrant, by a written amendment executed by all parties. Only NSMHA's Program Administrator or designee has authority to waive any provision of this Agreement on behalf of NSMHA.

14. HEADINGS AND CAPTIONS

The headings and captions used in this Agreement are for reference and convenience only and in no way define, limit, or decide the scope or intent of any provisions or sections of this Agreement.

15. INDEMNIFICATION

Contractor shall be responsible for and shall indemnify and hold NSMHA harmless (including all costs and attorney fees) from all claims for personal injury, property damage, disclosure of confidential information and/or from the imposition of governmental fines or penalties resulting from the acts or omissions of Contractor and its subcontractors related to the performance of this contract. NSMHA shall be responsible and shall indemnify and hold Contractor harmless (including all costs and attorney fees) from all claims for personal injury, property damage and disclosure of confidential information and from the imposition of governmental fines or penalties resulting from the acts or omissions of NSMHA. For the purposes of these indemnifications, the Parties specifically and expressly waive any immunity granted under the Washington Industrial Insurance Act, Title 51 RCW. This waiver has been mutually negotiated and agreed to by the Parties. The provision of this section shall survive the expiration or termination of the Agreement.

16. INDEPENDENT CONTRACTOR FOR NSMHA

The parties intend that an independent Contractor relationship be created by this contract. Contractor acknowledges that Contractor, its employees, or subcontractors are not officers, employees, or agents of NSMHA. Contractor shall not hold Contractor, Contractor's employees and subcontractors out as, nor claim status as, officers, employees, or agents of NSMHA. Contractor shall not claim for Contractor, Contractor's employees, or subcontractors any rights, privileges, or benefits which would accrue to an employee of NSMHA. Contractor shall indemnify and hold NSMHA harmless from all obligations to pay or withhold Federal or State taxes or contributions on behalf of Contractor, Contractor's employees and subcontractors unless specified in this Agreement.

17. INSURANCE

NSMHA certifies it is a member of Washington Governmental Entity Pool for all exposure to tort liability, general liability, property damage liability and vehicle liability, if applicable, as provided by RCW 43.19.

Contractor shall maintain Commercial General Liability Insurance (CGL). If Contractor is not a member of a risk pool, Contractor shall carry CGL to include coverage for bodily injury, property damage and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000; shall include liability arising out of premises, operations, independent contractors, personal injury, advertising injury and liability assumed under an insured contract. Contractor shall provide evidence of such insurance to NSMHA within 15 days of execution of this Agreement and 15 days post renewal date thereafter. All non-risk pool policies shall name NSMHA as a covered entity under said policy(s).

18. INTEGRATION

This Agreement, including Exhibits and Attachments contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

19. MAINTENANCE OF RECORDS

During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records set forth below is started before expiration of the six (6) year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the six (6) year period, whichever is later. Contractor shall maintain records sufficient to:

a. Maintain the content of all Medical Records in a manner consistent with utilization control requirements of 42 CFR 456, 434.34 (a), 456.111, and 456.211.
b. Document performance of all acts required by law, regulation, or this Agreement.
c. Substantiate Contractor statement of its organizations' structures, tax status, capabilities, and performance.
d. Demonstrate accounting procedures, practices, and records, which sufficiently and properly document Contractor invoices to NSMHA and all expenditures made by Contractor to perform as required by this Agreement.
e. Contractor and its subcontractors shall cooperate in all reviews including, but not limited to, surveys, and research conducted by NSMHA, DSHS, or other Washington State Departments.
f. Evaluations shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services performed under this Agreement and to determine whether Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable state and federal regulations as existing or hereafter amended.

20. NO WAIVER OF RIGHTS

A failure by either party to exercise its rights under this Agreement shall not preclude that party from subsequent exercise of such rights and shall not constitute a waiver of any other rights under this Agreement unless stated to be such in writing signed by an authorized representative of the party and attached to the original Agreement.

Waiver of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent breach and shall not be construed to be a modification of the terms and conditions of this Agreement.

21. ONGOING SERVICES

Contractor and its subcontractors shall ensure that in the event of labor disputes or job actions, including work slowdowns, such as "sick outs", or other activities within its service CMHA network, uninterrupted services shall be available as required by the terms of this Agreement

22. ORDER OF PRECEDENCE

In the event of an inconsistency in the terms of this Agreement or any inconsistency between the terms of this Agreement and any applicable statute, rule, or contract, unless otherwise provided herein, the conflict shall be resolved by giving precedence in the following order, to:

a. Applicable Medicaid 1915(b) Waiver, Provisions of Title XIX of the Social Security Act and Federal regulations concerning the operations of PIHP.
b. State statutes and regulations concerning the operation of the community mental health programs.
c. Federal and State law.
d. NSMHA-DSHS agreement or its successors, that covers the provision of the mental health services covered under this Agreement, which shall include any exhibit, document, or material incorporated by reference. NSMHA shall promptly notify Contractor of any amendment to NSMHA-DSHS agreement which affects any term or condition herein.
e. This Agreement.

23. OVERPAYMENTS

In the event Contractor fails to comply with any of the terms and conditions of this Agreement and that failure results in an overpayment, NSMHA may recover the amount due DSHS, CMS, or other federal or state agency subject to dispute resolution as set forth in the contract. In the case of overpayment, Contractor shall cooperate in the recoupment process and return to NSMHA the amount due upon demand.

24. OWNERSHIP OF MATERIALS

Materials created by Contractor and its subcontractors and paid for by NSMHA as a part of this Agreement shall be owned by NSMHA and shall be, "works for hire" as defined by the U.S. Copyright Act of 1976. This material includes, but is not limited to: books, computer programs, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes and/or training materials. Material which Contractor and its subcontractors use to perform this Agreement but which is not created for or paid for by NSMHA is owned by Contractor or relevant subcontractors; however, NSMHA and DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

25. PERFORMANCE

Contractor shall furnish the necessary personnel, materials/mental health services and otherwise do all things for, or incidental to, the performance of the work set forth here and as attached. Unless specifically stated, Contractor is responsible for performing or ensuring all fiscal and program responsibilities required in this contract. No subcontract will terminate the legal responsibility of Contractor to perform the terms of this Agreement.

26. RESOLUTION OF DISPUTES

The parties wish to provide for prompt, efficient, final, and binding resolution of disputes and controversies that may arise under this Agreement; therefore establish this dispute resolution procedure. All claims, disputes and other matters in question between the parties arising out of, or relating to, this Agreement shall be resolved exclusively by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

a. The parties shall use their best efforts to resolve issues prior to giving written Notice of Dispute.
b. Within 10 working days of receipt of the written Notice of Dispute, the parties (or a designated representative) shall together or, if both parties agree, with a mediator meet, confer, and attempt to resolve the claim within 5 working days.
c. The terms of the resolution of all claims concluded in meetings shall be memorialized in writing and signed by each party.

Arbitration: If the claim is not resolved within 30 days, the parties shall proceed to arbitration as follows:

a. Demand for arbitration shall be made in writing to the other party. The parties shall select one person as arbitrator.
b. If there is a delay of more than 10 days in the naming of the arbitrator, either party can ask the presiding judge of Skagit County to name the arbitrator.
c. The prevailing party shall be entitled to recover from the other party all costs and expenses, including reasonable attorney fees. The arbitrator shall determine which party, if any, is the prevailing party.
d. The parties agree that the arbitrator's decision shall be binding, final and enforceable subject to timely appeal to Skagit County Superior Court only as provided in Chapter 7.04A RCW.
e. Unless the parties agree in writing otherwise, the unresolved claims in each notice of dispute shall be considered at an arbitration session which shall occur in Skagit County no later than 30 days after the close of the meeting described in paragraph (b) above.
f. The Provisions of this section shall, with respect to any controversy or claim, survive the termination or expiration of this Agreement.
g. Nothing contained in this Agreement shall be deemed to give the arbitrator the power to change any of the terms and conditions of this Agreement in any way.
h. The prevailing party in any action to compel arbitration or to enforce an arbitration award shall be awarded its costs, including attorney fees. Venue for any such action is exclusively Skagit County Superior Court.
i. This Agreement shall be governed by laws of the State of Washington, both as to interpretation and performance.

27. SEVERABILITY AND CONFORMITY

The provisions of this Agreement are severable. If any provision of this Agreement, including any provision of any document incorporated by reference is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

28. SINGLE AUDIT ACT

If Contractor or its subcontractor is a subrecipient of Federal awards as defined by OMB Circular A-133, Contractor and its subcontractors shall maintain records that identify all Federal funds received and expended. Such funds shall be identified by the appropriate OMB Catalog of Federal Domestic Assistance titles and numbers, award names and numbers, award years if awards are for research and development, as well as, names of the Federal agencies. Contractor and its subcontractors shall make Contractor and its subcontractors records available for review or audit by officials of the Federal awarding agency, the General Accounting Office, and DSHS. Contractor and its subcontractors shall incorporate OMB Circular A-133 audit requirements into all contracts between Contractor and its subcontractors who are subrecipients. Contractor and its subcontractors shall comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation.

If Contractor/subcontractors are a subrecipient and expends $500,000 or more in Federal awards from any/all sources in any fiscal year, Contractor and applicable subcontractors shall procure and pay for a single or program-specific audit for that fiscal year. Upon completion of each audit, Contractor and applicable subcontractors shall submit to NSMHA's Program Administrator the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide, if applicable and a copy of any management letters issued by the auditor.

For purposes of "subrecipient" status under the rules of OMB Circular A-133 205(i) Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part of the rule unless a State requires the fund to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.

29. SUBCONTRACTS

Contractor may subcontract services to be provided under this Agreement subject to the following requirements.

a. Contractor shall be responsible for the acts and omissions of any subcontractor.
b. Contractor must ensure that the subcontractor neither employs any person nor contracts with any person or CMHA excluded from participation in federal health care programs under either 42 USC 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions.

c. Contractor shall require subcontractors to comply with all applicable federal and state laws, regulations, and operational policies as specified in this Agreement.
d. Contractor shall require subcontractors to comply with all applicable NSMHA operational policies as specified in this Agreement, including ACS, Exhibit A, distance standards and access standards.
e. Subcontracts for the provision of mental health services must require subcontractors to provide individuals access to translated information and interpreter services.
f. Contractor shall ensure a process is in place to demonstrate that all third-party resources are identified and pursued.
g. Contractor shall oversee, be accountable for and monitor all functions and responsibilities delegated to a subcontractor for conformance with any applicable statement of work in this agreement on an ongoing basis including written reviews.
h. Contractor will monitor performance of the subcontractors on an annual basis and notify NSMHA of any identified deficiencies or areas for improvement requiring corrective action by Contractor.
i. Contractor shall ensure that all subcontracts are in writing and that subcontracts specify all duties, reports, and responsibilities delegated under this Agreement. Those written subcontracts shall:

    i. Require subcontractors to hold all necessary licenses, certifications and/or permits as required by law for the performance of the services to be performed under this Agreement.
    ii. Subcontracts must require subcontractors to notify Contractor in the event of a change in status of any required license or certification.
    iii. Include clear means to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.
    iv. Require the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by Contractor, NSMHA/DBHR.
    v. Require best efforts to provide written or oral notification within 15 working days of termination of a MHCP to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the subcontractor.

30. SURVIVABILITY

The terms and conditions contained in this Agreement that by their sense and context are intended to survive the expiration of this Agreement shall so survive. Surviving terms include, but are not limited to: Order of Precedence, Contract Performance and Enforcement, Confidentiality of Client Information, Resolution of Disputes, Indemnification, Oversight Authority, Maintenance of Records and Ownership of Materials.

31. TREATMENT OF CLIENT PROPERTY

Unless otherwise provided in this Agreement, Contractor shall ensure that any adult individual receiving services from Contractor under this Agreement has unrestricted access to the individual's personal property. Contractor shall not interfere with any adult individual's ownership, possession, or use of the individual's property unless clinically indicated. Contractor shall provide individuals under age 18 with reasonable access to their personal property that is appropriate to the individual's age, development and needs. Upon termination of this Agreement, Contractor shall immediately release to the individual and/or guardian or custodian all of the individual's personal property.

32. WARRANTIES

The parties' obligations are warranted and represented by each to be individually binding, for the benefit of the other party. Contractor warrants and represents that it is able to perform its obligations set forth in this Agreement and that such obligations are binding upon Contractor and other subcontractors for the benefit of NSMHA.

33. CONTRACT ADMINISTRATION

The Program Administrator for each of the parties shall be responsible for and shall be the contact person for all communications and billings regarding the performance of this Agreement.

The Program Administrator for NSMHA is:

Joe Valentine
Executive Director
North Sound Regional Support Network
117 N. 1st Street, Suite 8
Mount Vernon, WA 98273

The Program Administrator for Contractor is:

Phil Smith, CEO
2802 Broadway Ave
Everett, WA 98201

Changes shall be provided to the other party in writing within 10 working days.

THIS AGREEMENT, consisting of 52 Pages, plus Exhibits and Attachments, is executed by the persons signing below who warrant that they have the authority to execute this Agreement.

NORTH SOUND MENTAL HEALTH ADMINISTRATION	**CONTRACTOR**
Signature Date	Signature Date
Joe Valentine, Executive Director Name/Title	Alex Heart, Chief Program Officer Name/Title

NORTH SOUND
MENTAL HEALTH ADMINISTRATION

STATE MENTAL HEALTH CONTRACT

WITH

VOLUNTEERS OF AMERICA

CONTRACT #NSMHA-VOA-SMHC-13-15

OCTOBER 1, 2013 TO SEPTEMBER 30, 2015

TABLE OF CONTENTS

A. DEFINITIONS 6

B. STATE FUNDED SERVICES

1. Contracted Services 14

C. DELEGATED FUNCTIONS

1. Community Psychiatric Inpatient Services Management – General Requirements 15
2. Customer Service Requirements 15
3. Access Line 16

D. PERFORMANCE STANDARDS

1. General Operating Standards 18
2. LOCUS/CALOCUS Level of Care Utilization System 18
3. Allied Systems Coordination 18
4. Crisis Services Coordination and Cooperation 19
5. Disaster Response 19
6. Confidentiality 20
7. Complaint, Grievance, Appeal and Fair Hearing Processes 20
8. Local Responsiveness and Communications 21
9. Critical Incidents 21
10. Performance Improvement and Regional Measures 21
11. Outcome Measures 22
12. Evidence-Based Practices 22
13. Trauma-Informed Care 22
14. Quality Management/Strategy 22
15. Coordination of Care Among Outpatient Providers 23
16. Coordination with Tribal Authorities 23
17. DDD Enrolled Individuals 23

E. CONTRACTOR RESPONSIBILITIES

1. Capacity 24
2. Access Standards 25
3. Staff Competency and Training 25
4. Peer Employment 26
5. Resource and Utilization Management Activities 26
6. Management Information System 26
7. Medicaid Eligibility 27
8. NSMHA and DBHR Review Activities 27
9. Deliverables, Plans and Reports 27
10. Business Associates Agreement 27

TABLE OF CONTENTS - cont.

F. FINANCIAL TERMS AND CONDITIONS 28
1. General Fiscal Assurances 28
2. Financial Accounting Requirements 28
3. Financial Reporting 28
4. County Funding 29
5. Rules Compliance 29
6. Liability for Payment and the Pursuit of Third Party Revenue 29
7. Financial Provisions - Reimbursement Requirements 30
8. Fraud and Abuse 30

G. OVERSIGHT, REMEDIES AND TERMINATION 31
1. Oversight Authority 31
2. Remedial Action 33
3. Additional Financial Penalties – DBHR Imposed Sanctions 33
4. Termination Due to Change in Funding 33
5. Termination for Convenience 33
6. Termination for Default 34
7. Termination Procedure 35
8. Notice Requirements 36

H. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR 36
1. Background 36
2. Mutual Commitments 36
3. Assignment 36
4. Authority 36
5. Compliance with Applicable Laws, Regulations and Operational Policies 38
6. Compliance with NSMHA Operational Policies 39
7. Confidentiality of Personal Information 40
8. Contract Performance/Enforcement 40
9. Cooperation 41
10. Debarment Certification 41
11. Declaration that Individuals Under the Medicaid and Other Mental Health Programs are not Third-Party Beneficiaries Under this Contract 41
12. Execution, Amendment and Waiver 41
13. Headings and Captions 41
14. Indemnification 42
15. Independent Contractor for NSMHA 42
16. Insurance 42
17. Integration 42
18. Maintenance of Records 43
19. No Waiver of Rights 43
20. Ongoing Services 44

TABLE OF CONTENTS - cont.

21. Order of Precedence 43
22. Overpayments 44
23. Ownership of Materials 44
24. Performance 44
25. Resolution of Disputes 44
26. Severability and Conformity 44
27. Single Audit Act 45
28. Subcontracts 45
29. Survivability 46
30. Treatment of Individual Property 47
31. Warranties 47
32. Contract Administration 47

EXHIBITS AND ATTACHMENTS

Exhibit A- Mission Statement

Exhibit C – Data Security Requirements

Exhibit D – Community Psychiatric Inpatient Process

Exhibit F – DSHS Admin Policy No. 7.21

Exhibit G – DSHS Admin Policy No. 07.01

Exhibit H – DSHS Admin Policy No. 07.20

Attachment I – Core Values and Principles

Attachment II – Contract Document links

Attachment III – DBHR-Contract – link

Attachment IV – Deliverables

Attachment V – Business Associate Agreement

Attachment VI – Revenue and Expenditure-Certification Report

Attachment VII – Ombuds Services

Attachment VIII – Budget

Attachment IX – SAMHSA's 10 Components of Recovery

Attachment X – Voluntary and Involuntary Crisis Response

Attachment XI – ICRS Cooperation Agreement

Attachment XII – Management Information System

Attachment XVI – Voluntary Inpatient Certification and Involuntary Payment Authorization Number Assignment

AGREEMENT FOR THE PROVISION
OF
STATE FUNDED
MENTAL HEALTH SERVICES

THIS MENTAL HEALTH SERVICES AGREEMENT (the "Agreement"), pursuant to Chapter 71.24 RCW and all relevant and associated statutes, as amended, is made and entered into by and between the NORTH SOUND REGIONAL SUPPORT NETWORK, dba THE NORTH SOUND MENTAL HEALTH ADMINISTRATION ("NSMHA"), 117 North 1st Street, Suite 8, Mount Vernon, Washington 98273 and VOLUNTEERS OF AMERICA ("Contractor") PO Box 839, Everett, WA 98206.

This Agreement incorporates the Exhibits and Attachments to the Agreement and other documents incorporated by reference.

The effective date of this Agreement is October 1, 2013, through September 30, 2015.

A. DEFINITIONS

7.01 Plan is NSMHA's Board approved plan, which outlines NSMHA's commitment to planning and service delivery for American Indian governments and communities.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for health care.

Access refers to the initial request for services and initial screening and related response time requirements.

Accessibility means the extent to which an eligible recipient can obtain available services. Accessibility includes both the ability to contact the organization and availability of providers and services.

Accountability means responsibility of Contractor for achieving defined outcomes, goals and contract obligations.

Administrative Costs means costs for the general operation of the public mental health system. These activities cannot be identified with specific direct services or direct services support function.

Advance Directive means a written document in which a principal makes a declaration of instructions, preferences, or appoints an agent to make decisions on behalf of the principal regarding their mental health treatment, or both and is consistent with the provisions of Washington's Mental Health Advance Directive statute.

Allied Systems means State or local services which provide individuals with assistance to reduce the impact of disabilities, functional impairments, or skill deficits and promote stable community living.

Ancillary Crisis Services means costs associated with providing medically necessary crisis services which cannot be covered under the Medicaid State plan including, but not limited to, the cost of room and board for individuals in hospital diversion beds.

Annual Revenue means all revenue received by the Regional Support Network (RSN) pursuant to the Agreement for July of any year through June of the next year.

Arbitration means the process by which the parties to a dispute submit their differences to the judgment of an impartial person or group appointed by mutual consent or statutory provision.

Assessment means a process which provides sufficient information to determine medical necessity for mental health services covered under this Agreement.

Case Management means assistance to a recipient and family (or significant other) to obtain, maintain, or develop appropriate resources.

Census Alert means notification provided to the RSN of near-full census at the State psychiatric hospital. This may include notification of changes in hospital admission criteria.

Children's Long-Term Inpatient Program (CLIP) means the State appointed authority for policy and clinical decision-making regarding admission to and discharge from State-funded beds in CLIP (Child Study and Treatment Center, Pearl Street Center, McGraw Center, Tamarack Center and Martin Center).

Child Study and Treatment Center (CSTD) mean the Department of Social and Health Services (DSHS)/Division of Behavioral Health and Recovery (DBHR) child psychiatric hospital.

Community Mental Health Agency (CMHA) means community mental health centers that are subcontracted by the RSN and licensed to provide mental health services covered under this Agreement.

Community Support Services is all community-based, outpatient services as defined in RCW 71.24.025(8), WAC 388-865 and 388-877.

Complaint means a verbal or written statement by an individual or enrollee that expresses dissatisfaction with some aspect of services covered under this Agreement, Primary Care Provider, or Contractor.

Consultation is the review and recommendations regarding the task responsibilities, activities and decisions of administrative, clerical and clinical staff, along with contracted employees, volunteers and interns by persons with appropriate knowledge and experience, in the pursuit of quality services.

Consumer means an individual who has applied for, is eligible for, or who has received mental health services. For a child, under the age of 13, or for a child age 13 or older whose parents or legal guardians are involved in the treatment plan the definition of consumer includes parents or legal guardians.

Contractor means an independent Contractor, its employees, agents and subcontractors.

Coordinated Quality Improvement Program (CQIP) the purpose of CQIP is to improve the quality of health care services by identifying and preventing health care malpractice under RCW 43.70.15

Corrective Action/Compliance Review is when findings from NSMHA/DBHR review or other monitoring efforts or audits show there are apparent violations of this Agreement. Contractor shall implement corrective action within specified timeframes determined by NSMHA/DBHR/Departments other auditors.

Corrective Action Plan (CAP) is a written plan specifying what the Contractor is required to do to be in compliance. This includes required improvements and a timeline for such action(s) to be accomplished.

Crisis may be self-defined or a situation where an individual is acutely mentally ill, or experiencing serious disruption in cognitive, volitional, psychosocial/neurophysiological functioning.

Crisis Plan is a blueprint for action in the case of an individual (or child/family) that is experiencing imminent or substantial risk of harm to self/others or at risk of decompensation that could lead to future use of psychiatric inpatient services. Plans are developed in collaboration with the individual and natural supports.

Crisis Services means a face-to-face evaluation and treatment of mental health emergencies and crises to non-enrolled, as well as, enrolled individuals experiencing a crisis. Crisis services shall be available on a 24-hour basis with the goal of stabilizing the person in crisis and providing immediate or short-term treatment and support in the least restrictive environment available. Crisis services may be provided prior to an intake evaluation/assessment.

Cultural Competence means a set of congruent behaviors, attitudes and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

Day for purposes of this Agreement means calendar day unless otherwise specified.

Deliverable means any written information required for submission to NSMHA to satisfy the work requirements of this Agreement and that are due by a particular date or on a regularly occurring schedule.

Direct Care Staff means persons employed by CMHA's whose primary responsibility is providing direct treatment and support to people with mental illness or whose primary responsibility is providing direct support to such staff in areas such as scheduling, intake, reception, records-keeping and facilities maintenance.

Disaster Outreach means persons contacted in their place of residence or in non-traditional settings for the purpose of:

1. Assessing their mental health or social functioning following a disaster; or
2. Increasing their utilization of human services and resources.

There are two basic approaches to outreach:

1. Mobile (ongoing to person-to-person);
2. Community settings (i.e., temporary shelters, disaster assistance sites, disaster information forums).

Regardless of the approach, the outreach process has five (5) important components:

1. Locating persons in need of disaster relief services;
2. Assessing their needs;
3. Engaging or linking persons to an appropriate level of support or disaster relief services; and
4. Providing follow-up mental health services when clinically indicated.
5. Disaster outreach can be performed by trained volunteers, peers and/or persons hired under a Federal Crisis Counseling Grant. These persons should be trained in disaster outreach, which is different than traditional mental health crisis intervention.

Discharge is (1) related to end of individual's inpatient psychiatric hospital stay; (2) occurs when an eligible individual has completed an episode of care (or active service) and is no longer receiving services (i.e., closed).

Discharge Planning (hospital) is the processes of developing a care regimen for an individual leaving inpatient care, including appropriate timing, follow-up appointments and treatment.

Discharge Planning (services) is the process of developing a care regimen and community integration plan for a mental health recipient leaving clinical care including appropriate residential treatment/housing supports and community support services prior to the recipient leaving outpatient care.

Diversion means to redirect an individual from being placed in a restrictive setting (i.e., jail, inpatient services) to clinically appropriate less restrictive alternative(s).

Emergent Care means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

Emerging Best Practice or Promising Practice means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

Evaluation and Treatment (E&T) Facility means a facility which can provide directly or by direct arrangement with other public or private agencies, emergency E&T, outpatient care and timely, appropriate inpatient care to persons suffering from a mental disorder and is certified as such by DSHS.

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

Fair Hearing means a hearing before Washington State Office of Administrative Hearings.

Family means:

1. For adults, those the individual defines as family (i.e., guardians, siblings, caregivers and significant others) to the individual.
2. For children, a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by DSHS or Tribe.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to self or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Full-Time Equivalent (FTE) is the term used to define number of full-time staff. One FTE shall be defined as 40 hours' work per week.

Geographic Area is NSMHA's service area consisting of the following geographic areas:

1. Island County
2. San Juan County
3. Skagit County
4. Snohomish County
5. Whatcom County

Grievance means an expression of dissatisfaction about any matter. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, such as, rudeness of a provider or employee, or failure to respect the mental health consumer's rights.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 is codified in 42 USC §1320(d) et.seq. and 45 CFR Parts 160, 162 and 164.

Individual Choice means the individual/child/families guaranteed opportunity to choose freely among treatment options and support services (based on identified needs) and to be full partners in the treatment process. "Choice" supports the notion that to the degree possible, individuals/child/families need to play a key role in designing their own service/support "packages" including involvement of natural supports and culturally specific services.

Individual Voice means indicators of ownership in and involvement with planning his/her own supports and services. In individualized plans, voice is best indicated by the use of the individual's own words and stated goals in "quotations".

In-Residence Census (IRC) means the in-residence census of all voluntary and involuntary individuals, regardless of where in the State hospital they are housed. Individuals who are committed to the State hospital under RCW 10.77 are not included in the IRC. Individuals who are committed by municipal or district court judges after failed competency restoration are considered committed under RCW 10.77 until a petition for 90 day civil commitment under RCW 71.05 has been filed in court.

Involuntary Treatment includes all services and administrative functions required for the evaluation of involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05, 71.24.300 and 71.34.

Local Funds Eligible for Match means sources of revenue that are eligible to be used as Federal match are broad based taxes at the county or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Funds used for Federal match under this Agreement may not be used as match for any other Federal program. It can be local funds that have not been previously matched with Federal funds at any point. Local funds do not include donations.

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

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

Mental Disorder as defined in RCW 71.34.020(12) for children and RCW 71.05.020(2) for adults.

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

Office of Management and Budget (OMB) Circular A-133 means audits of States, local governments and non-profit organizations.

Outcome means the results of a service period of treatment. The extents to which services are provided to individuals experiencing emotional and behavioral disorders have a positive or negative effect on their well-being, circumstances and capacity for self-management and recovery.

Outreach means a mental health service where individuals with severe and persistent mental illness or serious emotional disturbance are contacted in their place of residence or in non-traditional settings for the purpose of:

1. Improving their mental health, health, or social functioning; or
2. Increasing their utilization of human services and resources.

There are two basic approaches to outreach:

1. Mobile (going to individual/family); and
2. Peer/Drop-in centers (i.e., shelters, clubhouses, kitchens, clothing banks).

Regardless of the approach, the outreach process has five (5) important components:

1. Locating individuals in need of services;
2. Engaging individuals into service;
3. Assessing their needs;
4. Linking individuals to an appropriate level of support services; and
5. Providing follow-up services.

Personal Information means information identifiable to any person including, but not limited to, information that relates to a person's name, health, finances, education , business , use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers and any financial identifiers.

Publish means an officially sanctioned document provided by DBHR on their Internet or Intranet websites for downloading, reading, or printing.

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

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

Quality Strategy means an overarching system/process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.

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

Region is known as NSMHA or North Sound Regional Support Network (NSRSN). This region is comprised of five counties: Island, San Juan, Skagit, Snohomish and Whatcom.

Rehabilitation means to restore to customary activity through education, skill building and therapy. Increase independence and ability to participate in life meaning activities.

Reserve Accounts means an allocation of fund balance at the RSN set aside for a specific purpose by the RSN governing board or local legislative authority.

1. Operating Reserve - Funds designated from mental health revenue sources that are set aside into an operating reserve account by official action of the RSN's governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.
2. Inpatient Risk Reserve – Funds designated from mental health revenue sources to pay for future inpatient hospital claims.

Residential Services are defined in WAC 388-865 and 388-877, NSMHA Standards of Care and Clinical Eligibility Manual and NSMHA Policies and Procedures.

Resilience means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.

Risk means the possibility the Contractor may incur a loss because the cost of providing services may exceed the premium payments made by NSMHA to Contractor for services covered under this Agreement.

Subcontract means any written agreement between Contractor and subcontractor or between Contractor, subcontractor and another subcontractor to provide services or activities otherwise performed under this Agreement.

Subcontractor means an individual or entity performing all or part of the services under this Agreement under a separate contract with Contractor or its subcontractors.

Transition Youth means anyone age 17-21.

Underserved means persons who are minorities, children, elderly, disabled and low-income (See WAC 388-865-0150).

Urgent Care means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

Utilization Management Services means to provide independent utilization management process that monitors provider network to ensure services provided are sufficient, but not excessive, which are predicated on the individual needs of the recipient with respect to that person's age, culture, language and abilities.

Youth means anyone age 13-17 (13-20 if Medicaid).

B. STATE FUNDED SERVICES

Contractor must collaborate in the provision of core services (crisis services) with NSMHA. Contractor shall provide the following services to individuals in the service area: Crisis Services 24 hours/7 days a week regional crisis line and delegated responsibilities as outline below.

Contractor shall mutually develop and routinely review policies and procedures that address how the availability of resources for these services is determined including how decisions are made to reduce services due to insufficient resources.

1. CONTRACTED SERVICES

Contractor shall provide the following Mental Health Services, within available resources, as defined in the provision of this Agreement, NSMHA Policy and in accordance with Attachment VIII:

a. Regional Crisis line
b. Delegated Functions: Community Inpatient Certification and Payment Authorization; Customer Service and Access.

Contractor shall operate an integrated, coordinated and seamless Care Crisis program serving individuals in the service area. Contractor shall provide services for individuals for whom services are clinically appropriate in accordance with the standards established herein. Contractor must provide for the availability of crisis mental health crisis line and triage services 24-hours/7-days per week.

a. Contractor shall be responsible for providing crisis triage services to individuals including Tribal Members who are within NSMHA's service area and are experiencing a mental health crisis in accordance with the applicable requirements of Attachment X.
b. Contractor shall be responsible for coordinating and cooperating with other providers in NSMHA's crisis service network in accordance with Attachment XI.
c. Contractor shall participate in training and ongoing development of NSMHA policies and protocols implementing crisis services as a result of the crisis redesign process.

Contractor shall participate in required research and evaluation including collection of desired data elements upon request.

C. DELEGATED FUNCTIONS

1. COMMUNITY PSYCHIATRIC INPATIENT SERVICES MANAGEMENT – GENERAL REQUIREMENTS

Contractor shall coordinate an integrated system of access to all community inpatient services, whether care is provided on a voluntary or involuntary basis and shall comply with all NSMHA Clinical Policies and Procedures and Exhibit D, Community Psychiatric Inpatient Process or any successors. In addition, Contractor shall provide Voluntary Inpatient Certification and Involuntary Payment Authorization Numbering services as required in Attachment XIV. Specific inpatient management services shall include:

a. Response to requests for certification of psychiatric inpatient care for enrollees in community hospital units occurs within two (2) hours of the request. A decision regarding certification of psychiatric inpatient care must be made within 12 hours of the initial request.
b. If a denial appears indicated, Contractor shall ensure the request is reviewed by a psychiatrist. Only a psychiatrist/Clinical Ph.D. Psychologist may issue a denial. A decision to deny psychiatric inpatient care must be made within twelve (12) hours of the initial request.
c. Contractor shall ensure a Psychiatrist/Clinical Ph.D. Psychologist is available for consultations.
d. Medical necessity determinations made by Contractor may be appealed. The inpatient facility and client has a right to appeal in accordance with NSMHA Inpatient Appeal and Dispute Policies and Procedures. Concerns regarding Contractor's or NSMHA's compliance with published requirements may be addressed through an administrative dispute process. If Contractor is contacted by the inpatient facility, Contractor must promptly inform the inpatient facility to contact NSMHA. If Contractor receives an appeal or dispute from an inpatient facility, Contractor shall promptly forward the appeal or dispute to NSMHA.
e. Contractor shall submit policy and procedures to NSMHA 30 days after contract execution and implement modified policy and procedures within 30 days of NSMHA approval. Any modifications to the policy and procedures shall be submitted to NSMHA for review and approval.
f. Contractor shall coordinate with crisis outreach service providers for pre-hospital emergency assessments for voluntary hospitalizations.
g. Contractor shall not subcontract the performance of this delegated function without prior written approval of NSMHA.

2. CUSTOMER SERVICE REQUIREMENTS

Contractor shall provide customer services that are customer friendly, flexible, proactive and responsive to consumers, families and stakeholders. Customer services staff shall:

a. Answer customer service lines via both local and toll free numbers to respond to inquiries and complaints from 8:00 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.

b. Answer calls with an average speed within 30 seconds and a call abandonment rate of less than 3 percent.
c. Respond to benefits, claims and other inquiries or complaints and assist consumers, family members and stakeholders in a manner that resolves their inquiry including the ability to respond to those with limited English proficiency or hearing impaired.
d. Log all calls and arrange for appropriate follow-up including notification of the consumer of the resolution consistent with the requirements specified in Prepaid Inpatient Health Plan and State funded contracts.

Contractor shall train customer services staff to distinguish between a complaint, third party insurance issue, appeals and grievances, information requests and how to triage these to the appropriate party. Call logs shall, at a minimum, track date of call, type of call and resolution.

3. ACCESS LINE

a. Contractor shall provide a regionally managed integrated access system that coordinates with all NSMHA contracted CMHA's to ensure region-wide standardized initial screening, intake authorization, scheduling and linkages to crisis services.
b. Contractor will provide access to telephonic assessment and referral services provided by appropriately qualified care management staff via both local and toll free numbers.
c. Contractor will arrange for access to emergent crisis services 24 hours/7 days per week.
d. Contractor will arrange for access to urgent services within 24 hours of a request for services.
e. Contractor will arrange for an intake evaluation for routine services within 10 business days of a request for services.
f. Contractor will ensure persons eligible for State-funded mental health services shall receive an intake evaluation based on assessment of need and available resources.
g. Contractor will track the management access and referral line including the volume of calls, call responsiveness statistics and number of referrals by category of service.
h. Contractor will have methods to monitor compliance with access requirements and report data monthly to NSMHA, including:

    i. Availability of crisis services 24 hours/7 days a week including access to Designated Mental Health Professionals (DMHP) for Involuntary Treatment evaluations.
    ii. Monthly reports will include queue performance, total calls and disposition and referral source. Contractor shall demonstrate its performance of this function by maintenance of written records that show routine review and discussion of access line issues by Contractor members and staff.
    iii. Individuals/families seeking mental health services within the North Sound region will be assisted by mental health clinicians who are adept at triage and screening functions and responsive to the caller's needs. Clinical back-up shall be made available to Contractor staff (i.e., for supervisory or medical consultation). Response to access calls will be timely, friendly and helpful. The

first level of screening will be for safety concerns. If a crisis response is needed, the caller will be immediately connected to crisis services where Mental Health Professionals (MHP) and Mental Health Specialists (MHS) are available for consultation. The next level of screening will be for Medicaid coverage or financial eligibility. Individuals who are financially eligible will be connected by phone in a seamless "warm" transfer to the agency to schedule an assessment appointment. At this time, callers shall be asked about any special accommodations that might be needed at the assessment appointment and advised they are encouraged to bring a friend or family member/any relevant documentation to the assessment appointment, if desired. NSMHA provider agencies shall offer an assessment appointment within 14 calendar days.

All callers who are financially eligible will be authorized for a face-to-face intake assessment appointment with a clinician who is an MHP as defined by State of Washington within 10 working days (not to exceed 14 calendar days) to determine service eligibility and appropriate level of care.

D. PERFORMANCE STANDARDS

1. GENERAL OPERATING STANDARDS

a. Contractor must ensure individuals and individuals' families participate in planning activities, implementation and evaluation of Contractor's clinical functions. Contractors must demonstrate how this requirement is implemented.

b. Contractor must maintain a written Advance Directive policy and procedure that respects enrollees' advance directives for psychiatric care. Policy and procedures must comply with NSMHA's Advance Directive Policy and Procedure or use NSMHA's policy.

c. Contractor must participate in NSMHA/DBHR offered training, consultation and program development when requested including training on the implementation of Evidence-based Practices, Emerging and Promising Practices.

d. Contractor shall encourage and promote Dignity and Respect throughout the system of care.

e. Contractor shall ensure staff incorporates SAMHSA's 10 Components of Recovery (Attachment IX) in service delivery.

f. Contractor shall consult with NSMHA on the review of a minimum of two practice guidelines during the contract period and shall adopt and implement the practice guidelines including training impacted staff on the use of the guidelines. In addition, Contractor shall participate in the implementation of a consistent Child and Family Team (CFT) protocol under the timelines and guidance published by DSHS.

g. Contractor shall provide customer service that is customer-friendly, flexible, proactive and responsive to individuals, families and stakeholders. Contractor shall provide a toll free number for individuals. A local telephone number may also be provided for those individuals within the local calling area.

h. Contractor shall collaboratively participate in NSMHA's regional coordination meetings that currently include NSMHA Ad Hoc Regional Integrated Provider, NSMHA Quality Management Oversight Committee (QMOC), Regional ICRS Committee, subcommittees and workgroups of these committees as necessary.

i. Contractor shall obtain written consent from an individual in the event a picture or personal story will be used.

2. LOCUS/CALOCUS LEVEL OF CARE UTILIZATION SYSTEM

Contractor shall comply with NSMHA policy and procedure on LOCUS/CALOCUS.

Contractor shall comply with NSMHA Inpatient Certification Utilization Policy and Procedure on LOCUS/CALOCUS.

3. ALLIED SYSTEMS COORDINATION

Contractor must comply with and at the request of NSMHA participate in the identification and development of Allied System Coordination plans. NSMHA's coordination plans with allied systems includes, but is not limited to, Western State Hospital (WSH), Children's Administration (CA), Aging and Disabilities Services Administration (ADSA), Department of Alcohol and Substance Abuse (DASA), Criminal Justice System, Educational Service District

(ESD), Federally Qualified Health Centers (FQHC), Juvenile Rehabilitation Administration (JRA), Community Integration Assistance Program (CIAP), Healthy Options Plans, Community Health Centers and Department of Vocational Rehabilitation (DVR). The coordination plans are intended to enable coordination of services and appropriate management of care for individuals.

Contractor shall comply with published directives from DBHR when NSMHA, Contractor, or its subcontractors are unable to resolve local disputes with other service systems (Healthy Options, other DSHS administrations as provided by DBHR) regarding service or cost responsibilities.

4. CRISIS SERVICES COORDINATION AND COOPERATION

Contractor shall coordinate and cooperate with providers in NSMHA's crisis service network to ensure the continuity of care.

Contractor shall develop protocols in collaboration with regional crisis service providers and NSMHA to utilize the Wraparound Team in the prevention and intervention with children/adolescents and families being served by a Wraparound team.

5. DISASTER RESPONSE

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

a. Attend DBHR sponsored training regarding the role of the public mental health system in disaster preparedness and response.
b. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
c. Provide disaster outreach as defined in Section A, Definition of Terms.
d. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.
e. Provide the name and contact information to NSMHA for person(s) coordinating Contractor's disaster/emergency preparedness and response upon request.
f. Provide information and preliminary disaster response plans to NSMHA within seven (7) days of a disaster/emergency or upon request.
g. Partner in disaster preparedness and response activities with NSMHA, DBHR and other DSHS entities, State Emergency Management Division, Federal Emergency Management Agency, American Red Cross and other volunteer organizations. This must include:

    i. Participation when requested in local and regional disaster planning and preparedness activities.
    ii. Coordination of disaster outreach activities following an event.

6. CONFIDENTIALITY

Contractor shall not use, publish, transfer, sell, or otherwise disclose any confidential information gained by reason of this Agreement for any purpose that is not directly connected with the performance of the services contemplated there under, except:

a. As provided in NSMHA policy and procedure; or
b. As provided by law;
c. In the case of personal information, as provided by law or with the prior written consent of the person or personal representative of the person who is the subject of the personal information.

Contractor shall protect and maintain all confidential information gained by reason of this Agreement against unauthorized use, access, disclosure, modification, or loss. This duty requires the parties to employ reasonable security measures, which include restricting access to confidential information by:

a. Allowing access only to staff that have an authorized business requirement to view confidential information.
b. Physically securing any computers, documents, or other media containing confidential information.

To the extent allowed by law, at the end of the Agreement term, or when no longer needed, the parties shall return confidential information or certify in writing the destruction of confidential information upon written request by the other party.

Paper documents with confidential information may be recycled through a contracted firm, provided the contract with the recycler specifies the confidentiality of information will be protected and the information destroyed through the recycling process. Paper documents containing confidential information requiring special handling (i.e., protected health information) must be destroyed through shredding, pulping, or incineration.

The compromise or potential compromise of confidential information must be reported to NSMHA's Deputy Director within 5 business days of discovery for breaches of less than 500 persons' protected data and 3 business days of discovery for breaches of over 500 persons' protected data. The parties must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law

7. COMPLAINT, GRIEVANCE, APPEAL AND FAIR HEARING PROCESSES

Contractor must implement complaint, grievance, appeal and fair hearing processes that are in conformance with NSMHA policies and procedures.

Contractor and its subcontractors shall abide by NSMHA complaint, grievance, appeal and fair hearing determinations. Contractor shall be responsible for paying 100% of all medical director/attorney fees incurred by NSMHA when an individual goes directly to a fair hearing without utilizing NSMHA's grievance processes and when the ruling favors the individual, in accordance with NSMHA policies and procedures. In addition, Contractor shall:

a. Implement a grievance process that complies with WAC 388-865, 388-877, or any successors;
b. Coordinate with NSMHA grievance process and Ombuds Services;
c. Provide access to interpreter services and toll free numbers with adequate TTY/TTD and interpreter capability;
d. Provide assistance to individuals filing a grievance; and
e. Incorporate concerns from grievances into Contractor services without identifying individuals.

8. LOCAL RESPONSIVENESS AND COMMUNICATIONS

Contractor shall cooperate with NSMHA and Counties in the service area to provide a locally responsive delivery system. Contractor shall provide individuals with referral sources information and education about the referral process, service availability, service population, common symptoms of mental illness and shall post and make known consumer rights and responsibilities including complaint, grievance, appeal and fair hearing procedures and availability of Ombuds services.

Contractor shall have written policy and procedures that comply with NSMHA's policies on consumer rights and address the following:

a. Individual mental health rights applicable to non-Medicaid individuals as defined in WAC 388-865-0410 and 388-877-0600.
b. Oral interpretation services provided free of charge to the individual.
c. Information that states written materials are available when requested in alternate formats. These materials must be available and easily understood by individuals.

Contractor shall post, in a conspicuous place, a translated copy of the consumer rights as listed in the Mental Health Benefits Booklet in each of DSHS's prevalent languages. Access to translated copies may be downloaded at: http://www.dshs.wa.gov/dbhr/pubs.shtml#dbhr

9. CRITICAL INCIDENTS

Contractor and its subcontractors shall comply with NSMHA's Critical Incident Reporting Policy and Procedure and any successor regarding critical incidents.

10. PERFORMANCE IMPROVEMENT AND REGIONAL MEASURES

It is NSMHA's expectation that we will meet or exceed all appropriate statewide Performance Improvement Projects (PIP) and regional Performance Measures (PM). Each of the performance indicators will be addressed in the 2012-15 NSMHA's Quality Management (QM)/Strategy Plan. In addition, Contractor shall develop a plan and submit it to NSMHA for approval within 90 days following the execution of this Agreement that addresses the action steps to be taken by Contractor that will assist in achieving the goals of the PIP and PM as identified by NSMHA's QMOC and addressed in the Regional QM/Strategy plan. Upon request, the Contractor shall submit relevant data/reports to NSMHA in the development and management of the identified PIPs and PMs.

11. OUTCOME MEASURES

Contractor shall collaborate with NSMHA on identifying and incorporating outcome measurement tools used to measure an individual or group of individual's recovery and improved wellness.

Contractor shall participate in meetings/workgroups to determine the target population and measurement tool or tools to be used in the region during this contract cycle.

12. EVIDENCE-BASED PRACTICES

Contractor will participate with NSMHA/DSHS to increase the use of research and evidence-based practices, with a particular focus on increasing these practices for children and youth as identified through legislative mandates. This includes:

a. Participation in State-sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TFCBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence-based practices including those for which State subsidy of training costs is not available. Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice.
b. Participation in State-sponsored efforts to ensure that the sites offering the TF-CBT/CBT+ evidence-based practice are operated as trauma-informed systems of care.
c. Participation in regional efforts to identify and promote evidence-based practices for adults.

13. TRAUMA-INFORMED CARE

A majority of the individuals in mental health services have experienced some form of trauma in their history. NSMHA, in collaboration with regional Contractors, shall create a trauma-informed system of care.

Contractor and NSMHA shall address the following during the course of this Agreement:

a. Develop/implement an organizational assessment tool;
b. Develop/implement a trauma screening tool; and
c. Provide and participate in regional trauma-informed trainings.

14. QUALITY MANAGEMENT/STRATEGY

Contractor shall participate with NSMHA in the implementation, updates and evaluation of DBHR Quality Strategy located on DBHR website that is hereby incorporated by reference.

Contractor shall comply with NSMHA's QM/Strategy Plan or any successor incorporated herein as Attachment II.

Contractor shall ensure its QM activities comply with all applicable law and standards including, but not limited to: WAC 388-865-0280, -0425 and NSMHA QM Plan, NSMHA Clinical Policies and Procedures or their successors. In addition:

a. Contractor shall maintain an ongoing, planned, systematic, organization-wide quality management process to design, measure, analyze and improve its performance, including identification of innovations or best practice.
b. Contractor quality management plan and process, which shall be reviewed and updated by provider as needed but, at a minimum, every six-months, will be audited by NSMHA.
c. Contractor shall ensure Quality Assurance and Quality Improvement data is analyzed, reported and acted upon by its members and affiliates. This shall be demonstrated by written records maintained by Contractor.

Contractor shall present to NSMHA every six (6) months cycle, ending March 31st and September 30th, a QM report integrating all QM program activities and data, in order to facilitate NSMHA's determination of the effectiveness of the overall regional system of care. This report shall be in a mutually agreed format, due 35 days after the end of the six (6)month cycle and document the results of the Contractor QM plan activities and:

a. Identify areas of efficiency and effectiveness of system operations and the quality of care for individuals;
b. Identify areas of deficiency with plans to achieve expected improvement; and
c. Status of implementation of all NSMHA approved corrective action plans.

15. COORDINATION OF CARE AMONG OUTPATIENT PROVIDERS

Contractor shall comply with NSMHA policy on care coordination. Contractor shall procure and maintain written Memorandums of Understanding (MOU), when necessary, with outpatient provider(s) to ensure an individual receives medically necessary services.

At a minimum, the MOU must state the primary agency and methods of communiqué between agencies to ensure the individual is receiving coordinated care and monitoring.

MOU will clarify if Contractor and provider disagree about the medical necessity of the outpatient modality, the matter will be brought to NSMHA for resolution and NSMHA will make the final decision.

16. COORDINATION WITH TRIBAL AUTHORITIES

If an enrollee is a Tribal Member of a Washington Tribe and is referred to or presents for non-crisis services and the enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or Recognized American Indians Organizations (RAIO) to assist in treatment planning and service provision for the enrollee. If the enrollee chooses to be served only by Tribal Mental Health Services, Contractor will ensure enrollee is referred to appropriate Tribal Mental Health Service Provider.

17. DDD ENROLLED INDIVIDUALS

Contractor and its subcontractors must respond to requests to provide information and staff to participate in meetings as a part of monitoring reviews for individuals enrolled with DDD, formerly hospitalized at WSH or ESH, currently living in the community.

E. CONTRACTOR RESPONSIBILITIES

Contractor shall have responsibility for the performance of this Agreement.

Contractor shall include community and county input into planning and access to services.

Contractor shall be held fully responsible for the contractual obligations and performance of its subcontractors. In the performance of these functions, Contractor shall maintain written documentation that verifies each specific responsibility under this Agreement has been performed.

1. CAPACITY

Contractor must notify NSMHA in writing of any proposed change in capacity. NSMHA must approve any change that results in reduced capacity.

a. A reduction in capacity is defined as the point in time when Contractor is not able to meet all the access standards as defined in this Agreement. Events that may affect capacity include: closing of a facility in any geographic area, decrease in the State plan services currently available, decrease in the number or frequency of services, employee strike or other work stoppage related to union activities, or any change that may result in Contractor being unable to provide services for those enrollees who are covered by this Agreement.
b. Submit a report to NSMHA by November 1, 2013, or within 30 days of ratification, with current capacity and submission biannually thereafter. Contractor shall notify NSMHA 30 days prior to implementation/public notice when Contractor adds, changes location, or closes a facility and when the number of staff type/specialty changes at any CMHA facility by five (5) staff or more. The report shall identify each Contractor facility location/address, number and FTE of individuals providing direct services that are employed or contracted at each location by type/WAC specialty and staff with specialized training/expertise in NSMHA identified treatments.
c. The termination or addition of a subcontract that provides mental health services is considered a significant change in the provider network. Contractor must notify NSMHA 30 days in advance of public written notice to enrollees before Contractor terminates any of its subcontracts with entities that provide direct service.
d. Contractor must ensure the provision of written notification within 15 days to enrollees receiving services from subcontractor upon written notification of termination by either party.
e. If either party must terminate a subcontract in less than 30 days, Contractor must notify NSMHA as soon as there is a determination to terminate the subcontract and in advance of public notice.
f. If an event identified in section E.2 occurs, Contractor must submit a plan to NSMHA that includes at least the following:

    i. Notification to Ombuds services;
    ii. Crisis services plan;

iii. Notification plan;
iv. Plan for provision of uninterrupted services; and
v. Any information released to the media.

g. Contractor shall demonstrate its performance of this function by maintenance of written records that show routine review and discussion of network maintenance issues by Contractor staff.

2. ACCESS STANDARDS

a. Ensure individuals can access medically necessary mental health services upon request that do not exceed the access standards specified in NSMHA policies. A request for mental health services is defined as a point in time in which mental health services are sought or applied for through a telephone call, walk-in, or written request for mental health services.
b. Urgent and emergent medically necessary mental health services (i.e., crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations/other screening and assessment processes. Contractor must ensure:

i. Urgent care occurs within 24 hours of the request for mental health services from any source.
ii. Emergent mental health care occurs within two (2) hours of the request for mental health services from any source.

c. Contractor shall demonstrate its performance of this function by maintenance of written records that show routine review and discussion of access standard issues by Contractor staff.

3. STAFF COMPETENCY AND TRAINING

Contractor and its subcontractors shall comply with NSMHA credentialing policies and procedures and shall ensure all staff is qualified for the position they hold and have at a minimum, education, experience and skills to perform their job requirements, per WAC 388-865, 388-877 and 388-877A including any required licenses or certifications.

Contractor shall require a criminal history background check pursuant to RCW 43.43.830; 832; 834 and 43.20A.710 and WAC 388-877-0500 be completed for all current employees, volunteers and subcontractors and a criminal history background check shall be initiated for all prospective employees, volunteers and subcontractors who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

Contractor shall collaborate with NSMHA to implement, maintain and revise the Regional Training Plan or any successor incorporated as Attachment II.

Contractor must participate in training when requested by NSMHA/DBHR. Requests for NSMHA/DBHR to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to appropriate Contractor/subcontractor staff.

4. PEER EMPLOYMENT

NSMHA is promoting the increase of peer counselor employment throughout the North Sound Region. Peer Counselors with lived experience have the ability to provide a unique perspective and holistic approach to recovery. Their experience in managing symptoms and expertise in recovery strategies will provide individuals an opportunity to benefit from their experience.

As part of the regional strategy of increasing peer support throughout the region, Contractor shall work in partnership with NSMHA in the development of a peer workforce. NSMHA shall sponsor ongoing Peer Counselor training and continued education opportunities for Certified Peer Counselors. Contractor shall work with NSMHA to identify needs within the workforce and identify individuals that are work ready and interested in becoming a Certified Peer Counselor.

Contractor shall actively promote peer counselor training in coordination with NSMHA. Contractor shall offer pre-employment opportunities, such as volunteering, internships, on site observation and informal/formal introductory meetings with prospective peer counselors.

Contractor shall work with NSMHA to increase regional peer service encounters by 2% over the contract period.

5. RESOURCE AND UTILIZATION MANAGEMENT ACTIVITIES

Contractor shall conduct resource and utilization management activities as requested by NSMHA after discussion between Contractor and NSMHA to ensure that such activities are reasonable and cost-effective. Such activities will include planning and reporting in a manner that will allow NSMHA to ensure that its over- and under-utilization management obligations are met.

6. MANAGEMENT INFORMATION SYSTEM

Contractor shall:

Ensure the existence and operation of an electronic health record (EHR) that is compatible with NSMHA's CIS and has the capability to transmit data timely and accurately. Contractor shall develop and maintain an information system in comport with Exhibit C and Attachment XII, incorporated herein.

NSMHA will require Contractor to provide a Business Continuity and Disaster Recovery Plan (BCDRP) that ensures timely reinstitution of the CIS following total loss of the primary system or a substantial loss of functionality. Contractor must submit to NSMHA the most recent version of the BCDRP within 30 calendar days of execution of this agreement and within 30 calendar days of Contractor updating their BCDRP.

7. MEDICAID ELIGIBILITY

Contractor shall verify an individual's Medicaid eligibility for access to Medicaid funded services. For individuals not currently enrolled in Medicaid, Contractor shall refer individuals to the designated in-person assistor agency in their catchment area. Contractor shall act in accordance with NSMHA policy on eligibility verification herein incorporated by reference.

8. NSMHA AND DBHR REVIEW ACTIVITIES

Contractor shall ensure that remedial actions required as a result of NSMHA/DBHR review activities, as discussed in the Oversight, Remedies and Termination section, are reported and acted upon. This shall be demonstrated by written records maintained by Contractor.

9. DELIVERABLES, PLANS AND REPORTS

Contractor must ensure plans or reports required by this Agreement, including those outlined in Attachment IV, Deliverables, are provided to NSMHA in compliance with the timelines/formats indicated.

If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties, the Contractor may provide one report or deliverable that contains the information required by both Agreements.

10. BUSINESS ASSOCIATES AGREEMENT

Contractor shall abide by the provisions of NSMHA's and Contractor's Business Associates Agreement, Attachment V.

F. FINANCIAL TERMS AND CONDITIONS

1. GENERAL FISCAL ASSURANCES

Contractor shall comply with all applicable laws and standards, including Generally Accepted Accounting Principles and maintain, at a minimum, a financial management system that is a viable, single, integrated system with sufficient sophistication and capability to effectively and efficiently process, track and manage all fiscal matters and transactions.

2. FINANCIAL ACCOUNTING REQUIREMENTS

Contractor shall:

a. Establish and maintain operating reserves at prudent levels sufficient to ensure Contractor has the ability to pay for all expenses incurred during this Agreement period, including those whose disposition occurs after the Agreement has been terminated and to cover the risk of financial loss resulting in the event the cost of providing services pursuant to this Agreement exceeds the revenues derived therefrom;

b. Ensure all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system within the service area.

c. Reimburse within 60 calendar days subcontractors and any crisis service providers accessed by individuals while out-of-the-state.

d. Contractor shall produce annual audited financial statements upon completion and make such reports available to NSMHA upon request.

3. FINANCIAL REPORTING

Contractor shall provide the following reports to NSMHA:

a. Report Contractor and subcontract revenue and expenditure information to NSMHA on a biannual basis. Reports must comply with the provisions in the Budget, Accounting and Reporting System (BARS) Supplemental Instructions for Mental Health Services promulgated by Washington State Auditor's Office. Reports are due within 30 days of the quarter end (quarters ending in December and June of each year).

b. Contractor shall participate in NSMHA/DBHR Unit Cost Surveys and actuarial studies, when required by NSMHA/DBHR.

4. COUNTY FUNDING

Funds received by Contractor from any one or more of the service area counties specifically for the purpose of providing services to individual county programs during the term of this Agreement are not intended to reduce or supplant funds provided under this Agreement. County funds shall be used as additional funds in furnishing those additional local services for which such county funds were provided.

5. RULES COMPLIANCE

Contractor shall:

a. Contractor shall have a sliding fee scale, which is posted and accessible to staff and service recipients and does not require payment from service recipients with income levels equal to or below the grant standards for the general assistance program of the State of Washington;
b. Submit the amount spent throughout the service area on specific items at the request of NSMHA, Centers for Medicare and Medicaid Services (CMS), legislature, or DSHS in the timeframe specified;
c. Account for public mental health expenditures under this Agreement in accordance with Federal circular A-133, A-122, A-87 and State requirements in accordance with BARS Manual and BARS Supplemental Instructions or any successor
d. Limit administration costs incurred by Contractor and all subcontractors to no more than 15% of the consideration provided under this contract in any State fiscal year. Administration costs must be measured on a State fiscal year basis according to the reported information submitted by Contractor in its Revenue and Expenditure reports (Attachment VI) and reviewed by NSMHA.

6. LIABILITY FOR PAYMENT AND THE PURSUIT OF THIRD PARTY REVENUE

Contractor shall be responsible for developing financial processes that enable them to reasonably ensure all third-party resources available to individuals are identified and pursued in accordance with the reasonable collection practices which Contractor's apply to all other payers for services covered under this Agreement. NSMHA shall actively provide Contractor support in the pursuit of third-party payments for all services including crisis services.

Contractor shall maintain necessary records to document all third-party resources and report to NSMHA on a biennial basis or upon the reasonable request of NSMHA, the amount of such third-party resources collected for all service recipients during the quarter by source of payment.

7. FINANCIAL PROVISIONS - REIMBURSEMENT REQUIREMENTS

The consideration to be paid by NSMHA for the work to be provided by Contractor pursuant to this Agreement shall consist of the available amount from primary funding sources as described in Attachment VIII of this Agreement.

a. Contractor shall submit an invoice for capacity funded/cost reimbursement portions of this agreement on a monthly basis.
b. Contractor shall submit an invoice to NSMHA 15 days after the end of the month.

   Contractor shall submit encounter data per the MIS section on the fee-for-service portion of this agreement.

The consideration by NSMHA to Contractor pursuant to this Agreement shall be paid monthly within 15 working days of NSMHA's receipt of payment by DSHS/DBHR.

Funds for July 1, 2015, through September 30, 2015, following the end of the annual State legislative session, NSMHA shall offer an Amendment with the proposed funds for the next fiscal year. If for any reason Contractor does not agree to continue to provide services using the proposed funds, Contractor must provide the appropriate notice to NSMHA under the termination requirements of Section G.

8. FRAUD AND ABUSE

Contractor shall develop and implement administrative and management procedures designed to guard against fraud and abuse including:

a. Mandatory compliance plan;
b. Designation of compliance officer or compliance committee that is accountable to Contractor;
c. Effective ongoing training and education for compliance officer and Contractor staff;
d. Effective lines of communication between compliance officer, employees and any subcontractors;
e. Enforcement of standards through well-publicized disciplinary guidelines;
f. Provision of internal monitoring and auditing;
g. Provision for prompt response to detected offenses and for development of corrective action initiatives;
h. Participation by Contractor and any subcontractors in Medicaid fraud and abuse training conducted by Washington State Attorney General's Medicaid Fraud Unit.
i. Written policies, procedures and standards of conduct that articulate Contractor's commitment to comply with all applicable Federal and State standards.

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

Complaints and reports should be directed to NSMHA contact listed below.

Compliance Officer
117 N First St., Ste. 8
Mt. Vernon, WA 98273
360.416.7013
1.800.684.3555
compliance_officer@nsmha.org

G. OVERSIGHT, REMEDIES AND TERMINATION

1. OVERSIGHT AUTHORITY

NSMHA, DSHS, Office of the State Auditor, the Department of Health and Human Services (DHHS), CMS, the Comptroller General, or any of their duly-authorized representatives (i.e., External Quality Review Organizations), have the authority to conduct announced and unannounced: a) surveys; b) audits; c) reviews of compliance with licensing and certification requirements and compliance with this Agreement; d) audits regarding the quality, appropriateness and timeliness of mental health services of Contractor and subcontractors; and e) audits and inspections of financial records of Contractor and subcontractors. Contractor shall notify NSMHA when an entity other than NSMHA performs any audit described above related to any activity contained in this Agreement.

In addition, NSMHA will conduct reviews in accordance with its oversight of resource, utilization and quality management, as well as, ensure Contractor has the clinical, administrative and fiscal structures to enable them to perform in accordance with the terms of the contract. Such reviews may include, but are not limited to, encounter data validation, utilization reviews, clinical record reviews, administrative structures reviews, fiscal management and contract compliance. Reviews may include desk reviews, requiring Contractor to submit requested information. NSMHA will also review any activities delegated under this contract to Contractor.

Contractor shall cooperate with and allow access to North Sound Regional Ombuds to review activities in accordance with the terms of this contract and in accordance with Attachment VII. Contractor shall cooperate with Community Action of Skagit County in resolving any disputes that arise in the provision of Ombuds services.

Findings as a result of NSMHA conducted reviews may result in remedial action as outlined below. Federal and State agencies may impose remedial action or financial penalties either directly upon Contractor or through NSMHA. Contractor shall comply with the terms of such remedial action and be responsible for the payment of financial penalties.

2. REMEDIAL ACTION

NSMHA may require Contractor to plan and execute corrective action. Corrective action plans (CAP) developed by Contractor must be submitted for approval to NSMHA within 30 calendar days of notification. CAPs must be provided in a format acceptable to NSMHA. NSMHA may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by NSMHA.

a. CAP must include:

   i. A brief description of the finding.
   ii. Specific actions to be taken, timetable, description of the monitoring to be performed, steps taken and responsible individuals that will reflect the resolution of the situation.

b. CAP may:

Require modification of any policies or procedures by Contractor relating to the fulfillment of its obligations pursuant to this Agreement.

c. CAP are subject to approval by NSMHA, which may:

i. Accept the plan as submitted;
ii. Accept the plan with specified modifications;
iii. Request a modified plan; or
iv. Reject the plan.

d. Contractor agrees NSMHA may initiate remedial action with or without a CAP as outlined in subsection below if NSMHA determines any of the following situations exist:

i. A problem exists that poses a threat to the health or safety of any person or that poses a threat of property damage/incident has occurred that resulted in injury or death to any person/resulted in damage to property;
ii. Contractor has failed to perform any of the mental health services required in this Agreement, which includes the failure to maintain the required capacity as specified by NSMHA to ensure individuals receive medically necessary services, including delegated functions; *except*, that no remedial action pursuant to subsection (e) hereof shall be taken if such failure to maintain required capacity is due to any interruption in, or depletion of, the available amount of money to Contractor as described in Attachment VIII of this contract for purposes of performing services to enrollees as described in Section B of this contract; however, in such an instance, NSMHA may terminate all or part of this contract on as little as 30 days written notice.
iii. Contractor has failed to develop, produce/deliver to NSMHA any of the statements, reports, data, data corrections, accountings, claims and/or documentation described herein in compliance with all the provisions of this Agreement;
iv. Contractor has failed to perform any administrative function required under this Agreement, including delegated functions. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of mental health services;
v. Contractor has failed to implement corrective action required by the State and within NSMHA prescribed timeframes.

e. NSMHA may impose any of the following remedial actions in response to findings of situations as outlined above:

i. Withhold one percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. NSMHA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved;
ii. Compound withholdings identified above by an additional one-half of one percent for each successive month during which the remedial situation has not been resolved;
iii. Revoke delegation of any function delegated under this contract;
iv. Deny any incentive payment to which Contractor might otherwise have been entitled under this Agreement or any other arrangement by which DBHR provides incentives; or
v. Termination for Default, as outlined in this Agreement.

3. ADDITIONAL FINANCIAL PENALTIES – DBHR IMPOSED SANCTIONS

Financial penalties imposed by DBHR or other regulatory agency due to the action or inaction of Contractor may be paid by NSMHA on behalf of Contractor and the amount will be withheld from NSMHA's payments to Contractor.

4. TERMINATION DUE TO CHANGE IN FUNDING

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to its normal completion, either party may terminate this Agreement subject to re-negotiations.

5. TERMINATION FOR CONVENIENCE

Except, as otherwise provided in this Agreement, NSMHA may terminate this Agreement in whole or in part for convenience by giving Contractor at least 30 calendar days' written notice. Contractor may terminate this Agreement for convenience by giving NSMHA at least 30 calendar days' written notice addressed to NSMHA Program Administrator or his/her successor listed on the last page of this Agreement.

6. TERMINATION FOR DEFAULT

NSMHA's Program Administrator may terminate this Agreement for default, in whole or in part, by written notice to Contractor if NSMHA or DSHS has a reasonable basis to believe that Contractor has:

a. Failed to meet or maintain any requirement for contracting with NSMHA;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement; and/or
d. Otherwise breached any provision or condition of this Agreement.

Before the Program Administrator may terminate this Agreement for default, NSMHA shall provide Contractor with written notice of non-compliance with this Agreement and provide Contractor a reasonable opportunity to correct non-compliance. If Contractor does not

correct non-compliance within the period of time specified in the written notice of non-compliance, the Program Administrator may then terminate this Agreement. The Program Administrator may terminate this Agreement for default without such written notice and without opportunity for correction if NSMHA has a reasonable basis to believe an individual's health or safety is in jeopardy and/or:

a. Contractor has violated any law, regulation, rule, or ordinance applicable to services provided under this agreement or
b. Continuance of this Agreement with Contractor poses a material risk of injury or harm to any person.

Contractor may terminate this Agreement in whole or in part, by written notice to NSMHA, if Contractor has a reasonable basis to believe NSMHA has:

a. Failed to meet or maintain any requirement for contracting with the Contractor;
b. Failed to perform under any provision of this Agreement;
c. Violated any law, regulation, rule, or ordinance applicable to work performed under this Agreement; and/or
d. Otherwise breached any provision or condition of this Agreement.

7. TERMINATION PROCEDURE

The following provisions shall survive and be binding on the parties in the event this Agreement is terminated:

a. Contractor and any applicable subcontractors shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of individuals, distribution of property and termination of services. Each party shall be responsible only for its performance in accordance with the terms of this Agreement rendered prior to the effective date of termination. Contractor and any applicable subcontractors shall assist in the orderly transfer/transition of the individuals served under this Agreement. Contractor and any applicable subcontractors shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.
b. Contractor and any applicable subcontractors shall immediately deliver to NSMHA's Program Administrator or his/her successor, all NSMHA/DSHS assets (property) in Contractor and any applicable subcontractor's possession and any property produced under this Agreement. Contractor and any applicable subcontractors grants NSMHA/DSHS the right to enter upon Contractor and any applicable subcontractors premises for the sole purpose of recovering any NSMHA/DSHS property Contractor and any applicable subcontractors fail to return within 10 working days of termination of this Agreement. Upon failure to return NSMHA/DSHS property within 10 working days of the termination of this Agreement, Contractor and any applicable subcontractors shall be charged with all reasonable costs of recovery, including transportation and attorney's fees. Contractor and any applicable subcontractors shall

protect and preserve any property of NSMHA/DSHS that is in the possession of Contractor and any applicable subcontractors pending return to NSMHA/DSHS.

c. NSMHA shall be liable for and shall pay for only those services authorized and provided through the date of termination. NSMHA may pay an amount agreed to by the parties for partially completed work and services, if work products are useful to or usable by NSMHA.
d. If the Program Administrator terminates this Agreement for default, NSMHA may withhold a sum from the final payment to Contractor that NSMHA determines is necessary to protect NSMHA against loss or additional liability occasioned by the alleged default. NSMHA shall be entitled to all remedies available at law, in equity, or under this Agreement. If it is later determined Contractor was not in default, or if Contractor terminated this Agreement for default, Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement.
e. If Contractor terminates this Agreement, NSMHA will require the spend-down of all remaining State fund reserves and fund balance within the termination period. State funds shall be deducted from the final months' payments until reserves and fund balances are spent.

8. NOTICE REQUIREMENTS

Either party to this Agreement must provide 180 days' notice of any issue that may cause the party to voluntarily terminate, refuse to renew, or refuse to sign a mandatory amendment to this Agreement.

a. If Contractor at any time decides it shall no longer be a Contractor with NSMHA for any reason, Contractor must provide NSMHA's Program Administrator or his/her successor listed on the last page of this Agreement with written notice at least 90 days prior to the effective date of termination and work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services. The transition plan shall address all issues leading to the transition of individuals in service and all items/requirements of Contractor that extend beyond the termination of services.
b. NSMHA must provide Contractor's Program Administrator or his/her successor listed on the last page of this Agreement with written notice at least 90 days prior if NSMHA decides to voluntarily terminate, refuses to renew, or refuses to sign a mandatory amendment to this Agreement. Contractor shall work with NSMHA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services.

If Contractor terminates this Agreement or will not be entering into any subsequent Agreements, NSMHA shall require at least 90 days' notice prior to the end of the contract if a decision is made not to enter into a subsequent agreement. Any funds not spent for the provision of services under this Agreement shall be returned to NSMHA within 60 days of the last day this Agreement is in effect.

H. GENERAL TERMS AND CONDITIONS FOR CONTRACTOR

1. BACKGROUND

NSMHA is an entity formed by inter-local agreement between Island, San Juan, Skagit, Snohomish and Whatcom Counties, each county authority is recognized by the Secretary of DSHS ("Secretary"). These counties entered into an inter-local agreement to allow NSMHA to contract with the Secretary pursuant to RCW 71.24.025(13), to operate a single managed system of services for persons with mental illness living in the service area covered by Island, San Juan, Skagit, Snohomish and Whatcom Counties. NSMHA is party to an interagency agreement with the Secretary, pursuant to which NSMHA has agreed to provide integrated community support, crisis response and inpatient management services to people needing such services in its service area. NSMHA, through this Agreement, is subcontracting with Contractor for the provision of specific mental health services as required by the agreement with the Secretary. Contractor, by signing this Agreement, attests it is willing and able to provide such services in the service area.

2. MUTUAL COMMITMENTS

The parties to this Agreement are mutually committed to the development of an efficient, cost effective, integrated, person-centered, age-specific resilience and recovery model approach to the delivery of quality community mental health services. To that end, the parties are mutually committed to maximizing the availability of resources to provide needed mental health services in the service area, maximizing the portion of those resources used for the provision of direct services and minimizing duplication of effort.

3. ASSIGNMENT

Except as otherwise provided within this Agreement, this Agreement may not be assigned, delegated, or transferred by Contractor without the express written consent of NSMHA and any attempt to transfer or assign this Agreement without such consent shall be void. The terms "assigned", "delegated", or "transferred" shall include change of business structure to a limited liability company of any Contractor Member or Affiliate Agency.

4. AUTHORITY

Concurrent with the execution of this Agreement, Contractor shall furnish NSMHA with a copy of the explicit written authorization of its governing body to enter into this Agreement and accept the financial risk and responsibility to carry out all terms of this Agreement including the ability to pay for all expenses incurred during the contract period. Likewise, concurrent with the execution of this Agreement, NSMHA shall furnish Contractor with a written copy of the motion, resolution, or ordinance passed by NSMHA's Board authorizing NSMHA to execute this Agreement.

5. COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND OPERATIONAL POLICIES

Contractor and its subcontractors shall comply with all applicable Federal and State statutes, regulations and operational policies whether or not a specific citation is identified in various sections of this Agreement and all amendments thereto that are in effect when the

Agreement is signed or come into effect during the term of the Agreement which may include, but are not limited to, the following ("Federal/State law"):

a. Title XIX and Title XXI of the Social Security Act and Title 42 CFR.
b. All applicable Office of the Insurance Commissioner (OIC) statutes and regulations.
c. All local, Federal and State professional and facility licensing and certification requirements/standards that apply to services performed under the terms of this Agreement.
d. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738 and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS and the EPA.
e. Any applicable mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.
f. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
g. Those specified in Title 18 RCW for professional licensing.
h. Reporting of abuse as required by RCW 26.44.030.
i. Industrial insurance coverage as required by Title 51 RCW.
j. RCW 38.52, 70.02, 71.05, 71.24 and 71.34.
k. WAC 388-865 and 388-877, 877A.
l. 42 CFR 438, including 438.58 (conflict of interest) and 438.106 (physician incentive plans).
m. State of Washington Medicaid State Plan and 1915(b) Medicaid Mental Health Waiver or their successors which documents are incorporated by reference.
n. DBHR Quality Strategy.
o. State of Washington mental health system mission statement, value statement and guiding principles for the system attached hereto as Exhibit A.
p. State Medicaid Manual (SMM), OMB Circulars, BARS Manual and BARS Supplemental Mental Health Instructions.
q. Any applicable Federal and State laws that pertain to Medicaid enrollee or consumer rights. Contractor shall ensure its staff takes those rights into account when furnishing services to individuals.
r. DSHS Administrative policies, to the extent they are applicable to this contract are attached as Exhibits F, G and H.
s. 42 USC 1320a-7 and 1320a-7b (Section 1128 and 1128 (b) of the Social Security Act) which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit mental health services provided to individuals.
t. Any policies and procedures developed by DSHS/Health Care Authority which governs the spend-down of an individual's assets.
u. Contractor and any subcontractors must comply with 42-USC 1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of

more than 5% of Contractor, CMHA, or subcontractor's equity or an employee, Contractor, or consultant who is significant or material to the provision of services under this Agreement who has been or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any Federal agency.

v. Federal and State non-discrimination laws and regulations.
w. HIPAA (45 CFR parts 160-164).
x. DBHR-CIS Data Dictionary and its successors.
y. Federal funds must not be used for any lobbying activities.

If Contractor is in violation of a Federal law or regulation and Federal Financial Participation is recouped from NSMHA, Contractor shall reimburse the Federal amount to NSMHA within 20 days of such recoupment.

Upon notification from DSHS, NSMHA shall notify Contractor in writing of changes/modifications in CMS policies and DSHS/DBHR contract requirement (Attachment III) changes.

6. COMPLIANCE WITH NSMHA OPERATIONAL POLICIES

Contractor shall comply with all NSMHA operational policies that pertain to the delivery of services under this Agreement that are in effect when the Agreement is signed or come into effect during the term of the Agreement. NSMHA policies shall not exceed that required to implement Federal and State requirements or to implement continuous quality improvement efforts determined by the Integrated QM Process as approved by NSMHA's Board. All proposed new policies shall specifically reference the Federal or State requirements they implement and shall be limited to such requirements. NSMHA shall notify Contractor of any proposed change in Federal or State requirements affecting this agreement immediately upon NSMHA receiving knowledge of such change. Such policies shall include, but not limited to:

a. NSMHA Core Values and Principles, attached hereto as Attachment I provide a framework of principles for the regional system and Contractor shall take these principles into account when providing services under this Agreement.
b. Contractor and its subcontractors must recognize the unique social/legal status of Indian nations as required by both the Supremacy and Indian Commerce Clauses of the United States Constitution, Federal treaties, executive orders, Indian Citizens Act of 1924 statutes, and Federal and State court decisions, or any Memorandum of Agreement or MOU signed by State of Washington and Federally recognized tribe of recognized organization; shall maintain compliance with Exhibit G, DSHS Admin. Policy No. 7.01 American Indian Policy or any successor pursuant to the Centennial Accord between Washington State Government and Washington Tribes and maintain compliance with NSMHA 7.01 Plan or any successor incorporated as Attachment II.
c. NSMHA's Strategic Plan.
d. NSMHA's clinical policies and procedures including crisis services policies.
e. NSMHA's medical records documentation and data reporting policies and procedures.
f. NSMHA's QM/Strategy plan.

g. NSMHA's consumer rights policies and procedures including complaint, grievance, appeal and fair hearing policies.
h. Any other policies designated by NSMHA as applicable to Contractor.

Along with all NSMHA stakeholders, Contractor will be included in the process for developing relevant operational policies and procedures. NSMHA's policies and procedures are posted on NSMHA's website as indicated on Attachment II. NSMHA shall notify Contractor of new and revised policies through its Numbered Memoranda. Training will be provided on policies that impact providers, upon request.

In the event there is a disagreement between NSMHA and Contractor in an operational committee regarding a proposed new policy or modification to a current policy, the following process will apply:

a. NSMHA will provide a summary of the regulatory requirement or other rationale for the proposed policy or policy modification.
b. Contractor will provide an analysis of its objection to the proposed policy or policy modification within 30 days from the receipt of NSMHA's summary. If the objection is primarily due to increased cost, Contractor will provide substantiation of the additional costs and, if possible, an alternative to achieving the policy goal in a less costly manner.
c. The proposed policy or policy modification will be discussed at the next Regional Management Council.
d. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next QMOC meeting.
e. If resolution is not obtained, the proposed policy or policy modification will be discussed at the next NSMHA Board meeting.

NSMHA will make best efforts to maintain currency of policies with applicable Federal or State laws, regulations, or policies. In the event of a conflict, Federal or State laws or policies supersede NSMHA policies and procedures and requirements of this contract.

7. CONFIDENTIALITY OF PERSONAL INFORMATION

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

a. Establishing eligibility;
b. Determining the amount of medical assistance;
c. Providing services for recipients;
d. Conducting or assisting in investigation, prosecution, or civil/criminal proceeding related to the administration of the plan;
e. Ensuring compliance with Federal and State laws, regulations, terms and requirements of this Agreement; and/or
f. Improving quality.

Contractor shall comply with all confidentiality requirements of HIPAA (45 CFR 160 and 164).

Contractor shall have a process in place to ensure all components of its CMHA and system understand and comply with confidentiality requirements for publicly funded mental health services.

Contractor shall ensure access to the information is restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of NSMHA and DSHS.

The parties acknowledge coordination, planning, screening and referral require the sharing of information among the various treatment providers. Disclosure of information to verify eligibility, determine the amount of assistance and provide medically necessary mental health services are all "purposes directly connected with the administration of the Agreement" and are all appropriate justifications for sharing information.

Contractor shall ensure all staff and subcontractors providing services under this Agreement receive annual training on confidentiality policies and procedures. In addition, Contractor shall ensure all staff and subcontractors providing services under this Agreement sign an annual Oath of Confidentiality statement. Signed copies of the Oath of Confidentiality shall be kept in Contractor's personnel files.

8. CONTRACT PERFORMANCE/ENFORCEMENT

NSMHA shall be vested with the rights of a third party beneficiary including the "cut through" right to enforce performance should Contractor be unwilling or unable to enforce action on the part of its subcontractor(s). In the event Contractor dissolves or otherwise discontinues operations, NSMHA may, at its sole option, assume the right to enforce the terms and conditions of this Agreement directly with subcontractors; provided, NSMHA keeps Contractor reasonably informed concerning such enforcement. Contractor shall include this clause in its contracts with its subcontractors. In the event of the dissolution of Contractor, NSMHA's rights in indemnification shall survive.

9. COOPERATION

The parties to this Agreement shall cooperate in good faith to effectuate the terms and conditions of this Agreement.

10. DEBARMENT CERTIFICATION

Contractor certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal or State department or agency. If requested by DSHS or NSMHA, Contractor shall complete a certification regarding debarment, suspension, ineligibility, or voluntary exclusion. Any certification regarding debarment, suspension, ineligibility, or voluntary exclusion pertaining to this Agreement shall be incorporated into this Agreement by reference.

11. DECLARATION THAT INDIVIDUALS UNDER THE MEDICAID AND OTHER MENTAL HEALTH PROGRAMS ARE NOT THIRD-PARTY BENEFICIARIES UNDER THIS CONTRACT

Although NSMHA, Contractor and subcontractors mutually recognize services under this Agreement may be provided by Contractor and subcontractors to individuals under the Medicaid program, RCW 71.05 and 71.34 and the Community Mental Health Services Act, RCW 71.24, it is not the intention of either NSMHA or Contractor that such individuals or any other persons occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement. Such third parties shall have no right to enforce this agreement.

12. EXECUTION, AMENDMENT AND WAIVER

This Agreement shall be binding on all parties only upon signature by authorized representatives of each party. This Agreement or any provision may be amended during the contract period, if circumstances warrant, by a written amendment executed by all parties. Only NSMHA's Program Administrator or designee has authority to waive any provision of this Agreement on behalf of NSMHA.

13. HEADINGS AND CAPTIONS

The headings and captions used in this Agreement are for reference and convenience only and in no way define, limit, or decide the scope or intent of any provisions or sections of this Agreement.

14. INDEMNIFICATION

Contractor shall be responsible for and shall indemnify and hold NSMHA harmless (including all costs and attorney fees) from all claims for personal injury, property damage/disclosure of confidential information/imposition of governmental fines or penalties resulting from the acts or omissions of Contractor and its subcontractors related to the performance of this contract. NSMHA shall be responsible and shall indemnify and hold Contractor harmless (including all costs and attorney fees) from all claims for personal injury, property damage, disclosure of confidential information and imposition of governmental fines or penalties resulting from the acts or omissions of NSMHA. For the purposes of these indemnifications, Parties specifically and expressly waive any immunity granted under Washington Industrial Insurance Act, Title 51 RCW. This waiver has been mutually negotiated and agreed to by the Parties. The provision of this section shall survive the expiration or termination of the Agreement.

15. INDEPENDENT CONTRACTOR FOR NSMHA

The parties intend that an independent contractor relationship be created by this contract. Contractor acknowledges the Contractor, its employees, or subcontractors are not officers, employees, or agents of NSMHA. Contractor shall not hold Contractor, Contractor's employees and subcontractors out as, nor claim status as, officers, employees, or agents of NSMHA. Contractor shall not claim for Contractor, Contractor's employees, or subcontractors any rights, privileges, or benefits which would accrue to an employee of NSMHA. Contractor shall indemnify and hold NSMHA harmless from all obligations to pay or withhold Federal or State taxes or contributions on behalf of Contractor, Contractor's employees and subcontractors unless specified in this Agreement.

16. INSURANCE

NSMHA certifies it is a member of Washington Governmental Entity Pool for all exposure to tort liability, general liability, property damage liability and vehicle liability, if applicable, as provided by RCW 43.19.

Contractor shall maintain Commercial General Liability Insurance (CGL). If Contractor is not a member of a risk pool, Contractor shall carry CGL to include coverage for bodily injury, property damage and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000; shall include liability arising out of premises, operations, independent contractors, personal injury, advertising injury and liability assumed under an insured contract. Contractor shall provide evidence of such insurance to NSMHA within 15 days of execution of this Agreement and 15 days post renewal date thereafter. All non-risk pool policies shall name NSMHA as a covered entity under said policy(s).

17. INTEGRATION

This Agreement, including Exhibits and Attachments, contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

18. MAINTENANCE OF RECORDS

During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records set forth below is started before expiration of the six (6) year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the six (6) year period, whichever is later. Contractor shall maintain records sufficient to:

a. Maintain the content of all Medical Records in a manner consistent with utilization control requirements of 42 CFR 456, 434.34 (a), 456.111 and 456.211.
b. Document performance of all acts required by law, regulation, or this Agreement.
c. Substantiate Contractor statement of its organizations' structures, tax status, capabilities and performance.

d. Demonstrate accounting procedures, practices and records which sufficiently and properly document Contractor invoices to NSMHA and all expenditures made by Contractor to perform as required by this Agreement.
e. Contractor and its subcontractors shall cooperate in all reviews including, but not limited to, surveys and research conducted by NSMHA, DSHS, or other Washington State Departments.
f. Evaluations shall be done by inspection or other means to measure quality, appropriateness and timeliness of services performed under this Agreement and to determine whether Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable Federal and State regulations as existing or hereafter amended.

19. NO WAIVER OF RIGHTS

A failure by either party to exercise its rights under this Agreement shall not preclude that party from subsequent exercise of such rights and shall not constitute a waiver of any other rights under this Agreement unless stated to be such in writing signed by an authorized representative of the party and attached to the original Agreement.

Waiver of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent breach and shall not be construed to be a modification of the terms and conditions of this Agreement.

20. ONGOING SERVICES

Contractor and its subcontractors shall ensure that in the event of labor disputes or job actions including work slowdowns, such as "sick outs", or other activities within its service CMHA network, uninterrupted services shall be available as required by the terms of this Agreement

21. ORDER OF PRECEDENCE

In the event of an inconsistency in the terms of this Agreement or any inconsistency between the terms of this Agreement and any applicable statute, rule, or contract, unless otherwise provided herein, the conflict shall be resolved by giving precedence in the following order to:

a. State statutes and regulations concerning the operation of the community mental health programs.
b. Federal and State law.
c. NSMHA-DSHS agreement or its successors, that covers the provision of the mental health services covered under this Agreement, which shall include any exhibit, document, or material incorporated by reference. NSMHA shall promptly notify Contractor of any amendment to NSMHA-DSHS agreement which affects any term or condition herein.
d. This Agreement.

22. OVERPAYMENTS

In the event Contractor fails to comply with any of the terms and conditions of this Agreement and that failure results in an overpayment, NSMHA may recover the amount due DSHS, CMS, or other Federal or State agency subject to dispute resolution as set forth in the contract. In the case of overpayment, Contractor shall cooperate in the recoupment process and return to NSMHA the amount due upon demand.

23. OWNERSHIP OF MATERIALS

Materials created by Contractor and its subcontractors and paid for by NSMHA as a part of this Agreement shall be owned by NSMHA and shall be "works for hire" as defined by the U.S. Copyright Act of 1976. This material includes, but is not limited to: books, computer programs, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes and/or training materials. Material which Contractor and its subcontractors use to perform this Agreement but which is not created for or paid for by NSMHA is owned by Contractor or relevant subcontractors; however, NSMHA and DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

24. PERFORMANCE

Contractor shall furnish the necessary personnel, materials/mental health services and otherwise do all things for, or incidental to, the performance of the work set forth here and as attached. Unless specifically stated, Contractor is responsible for performing or ensuring all fiscal and program responsibilities required in this contract. No subcontract will terminate the legal responsibility of Contractor to perform the terms of this Agreement.

25. RESOLUTION OF DISPUTES

The parties wish to provide for prompt, efficient, final and binding resolution of disputes and controversies that may arise under this Agreement; therefore, establish this dispute resolution procedure. All claims, disputes and other matters in question between the parties arising out of, or relating to, this Agreement shall be resolved exclusively by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

a. The parties shall use their best efforts to resolve issues prior to giving written Notice of Dispute.
b. Within 10 working days of receipt of the written Notice of Dispute, the parties (or a designated representative) shall together or, if both parties agree, with a mediator meet, confer and attempt to resolve the claim within the next five (5) working days.
c. The terms of the resolution of all claims concluded in meetings shall be memorialized in writing and signed by each party.

Arbitration: If the claim is not resolved within 30 days, the parties shall proceed to arbitration as follows:

a. Demand for arbitration shall be made in writing to the other party. The parties shall select one person as arbitrator.

b. If there is a delay of more than 10 days in the naming of the arbitrator, either party can ask the presiding judge of Skagit County to name the arbitrator.
c. The prevailing party shall be entitled to recover from the other party all costs and expenses including reasonable attorney fees. The arbitrator shall determine which party, if any, is the prevailing party.
d. The parties agree the arbitrator's decision shall be binding, final and enforceable subject to timely appeal to Skagit County Superior Court only as provided in Chapter 7.04A RCW.
e. Unless the parties agree in writing otherwise, the unresolved claims in each notice of dispute shall be considered at an arbitration session which shall occur in Skagit County no later than 30 days after the close of the meeting described in paragraph (b) above.
f. Provisions of this section shall, with respect to any controversy or claim, survive the termination or expiration of this Agreement.
g. Nothing contained in this Agreement shall be deemed to give the arbitrator the power to change any of the terms and conditions of this Agreement in any way.
h. The prevailing party in any action to compel arbitration or to enforce an arbitration award shall be awarded its costs including attorney fees. Venue for any such action is exclusively Skagit County Superior Court.
i. This Agreement shall be governed by laws of State of Washington both as to interpretation and performance.

26. SEVERABILITY AND CONFORMITY

The provisions of this Agreement are severable. If any provision of this Agreement, including any provision of any document incorporated by reference is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

27. SINGLE AUDIT ACT

If Contractor or its subcontractor is a subrecipient of Federal awards as defined by OMB Circular A-133, Contractor and its subcontractors shall maintain records that identify all Federal funds received and expended. Such funds shall be identified by the appropriate OMB Catalog of Federal Domestic Assistance titles and numbers, award names and numbers, award years if awards are for research and development, as well as, names of the Federal agencies. Contractor and its subcontractors shall make Contractor and its subcontractors' records available for review or audit by officials of the Federal awarding agency, the General Accounting Office and DSHS. Contractor and its subcontractors shall incorporate OMB Circular A-133 audit requirements into all contracts between Contractor and its subcontractors who are subrecipients. Contractor and its subcontractors shall comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation.

If Contractor/its subcontractors are a subrecipient and expends $500,000 or more in Federal awards from any/all sources in any fiscal year, Contractor and applicable subcontractors shall procure and pay for a single or program-specific audit for that fiscal year. Upon completion of each audit, Contractor and applicable subcontractors shall submit to NSMHA's Program

Administrator the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide, if applicable and a copy of any management letters issued by the auditor.

28. SUBCONTRACTS

Contractor may subcontract services to be provided under this Agreement subject to the following requirements.

a. Contractor shall be responsible for the acts and omissions of any subcontractor.
b. Contractor must ensure the subcontractor neither employs any person nor contracts with any person or CMHA excluded from participation in Federal healthcare programs under either 42 USC 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions.
c. Contractor shall require subcontractors to comply with all applicable Federal and State laws, regulations and operational policies as specified in this Agreement.
d. Contractor shall require subcontractors to comply with all applicable NSMHA operational policies as specified in this Agreement.
e. Subcontracts for the provision of mental health services must require subcontractors to provide individuals access to translated information and interpreter services.
f. Contractor shall ensure a process is in place to demonstrate all third-party resources are identified and pursued.
g. Contractor shall oversee, be accountable for and monitor all functions and responsibilities delegated to a subcontractor for conformance with any applicable statement of work in this agreement on an ongoing basis including written reviews.
h. Contractor will monitor performance of the subcontractors on an annual basis and notify NSMHA of any identified deficiencies or areas for improvement requiring corrective action by Contractor.
i. Contractor shall ensure all subcontracts are in writing and subcontracts specify all duties, reports and responsibilities delegated under this Agreement. Those written subcontracts shall:

    i. Require subcontractors to hold all necessary licenses, certifications/permits as required by law for the performance of the services to be performed under this Agreement.
    ii. Subcontracts must require subcontractors to notify Contractor in the event of a change in status of any required license or certification.
    iii. Include clear means to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.
    iv. Require the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by Contractor, NSMHA/DBHR.
    v. Require best efforts to provide written or oral notification within 15 working days of termination of a MHCP to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the medical record at the subcontractor.

29. SURVIVABILITY

The terms and conditions contained in this Agreement that by their sense and context are intended to survive the expiration of this Agreement shall so survive. Surviving terms include, but are not limited to: Order of Precedence, Contract Performance and Enforcement, Confidentiality of personal information, Resolution of Disputes, Indemnification, Oversight Authority, Maintenance of Records and Ownership of Materials.

30. TREATMENT OF INDIVIDUAL PROPERTY

Unless otherwise provided in this Agreement, Contractor shall ensure any adult individual receiving services from Contractor under this Agreement has unrestricted access to the individual's personal property. Contractor shall not interfere with any adult individual's ownership, possession, or use of the individual's property unless clinically indicated. Contractor shall provide individuals under age 18 with reasonable access to their personal property that is appropriate to the individual's age, development and needs. Upon termination of this Agreement, Contractor shall immediately release to the individual and/or individual's guardian or custodian all of the individual's personal property.

31. WARRANTIES

The parties' obligations are warranted and represented by each to be individually binding for the benefit of the other party. Contractor warrants and represents it is able to perform its obligations set forth in this Agreement and such obligations are binding upon Contractor and other subcontractors for the benefit of NSMHA.

32. CONTRACT ADMINISTRATION

The Program Administrator for each of the parties shall be responsible for and shall be the Program Administrator for all communications and billings regarding the performance of this Agreement.

The Program Administrator for NSMHA is:
Joe Valentine, Executive Director
North Sound Regional Support Network
117 North First Street, Suite 8
Mount Vernon, WA 98273

The Program Administrator for Volunteers of America is:
Phil Smith, CEO
Volunteers of America
2802 Broadway
Everett, WA 98206

Changes shall be provided to the other party in writing within 10 working days.

THIS AGREEMENT, consisting of 48 Pages, plus Exhibits and Attachments, is executed by the persons signing below who warrant that they have the authority to execute this Agreement.

NORTH SOUND MENTAL HEALTH ADMINISTRATION	**VOLUNTEERS OF AMERICA**
_____	_____
Signature Date	Signature Date
Joe Valentine, Executive Director	Alex Heart, Chief Program Officer
Name/Title	Name/Title

Effective Date: 10/9/2003, Approved by BOD, Motion #03-055
Revised Date: 11/22/2005
Review Date:

North Sound Mental Health Administration

Section 5000 – Contract/Audit: Administrative, Fiscal & Quality Assurance/Improvement
Contract Compliance Monitoring

Authorizing Source:
Cancels:
See Also:
Responsible Staff: Contracts Manager

Approved by: Executive Director
Motion #:

Date: 11/23/2005

POLICY #5001.00

SUBJECT: ADMINISTRATIVE, FISCAL & QUALITY ASSURANCE/IMPROVEMENT CONTRACT COMPLIANCE MONITORING

POLICY

All agencies providing services to or on behalf of NSMHA will be monitored for administrative, fiscal, and quality management systems assurance/improvement compliance. Whenever possible, NSMHA will collaborate and coordinate with State of Washington Mental Health Division (MHD) to jointly conduct NSMHA's Administrative and Clinical Reviews with MHD's Licensing Reviews of NSMHA contracted providers.

PURPOSE

The purpose of conducting an on-site review is to assure contracted providers and their subcontractors are providing services in compliance with:

1. NSMHA Contract(s)
2. Washington Administrative Codes (WAC's)
3. Revised Codes of Washington (RCW's)
4. Washington State Medicaid Waiver
5. Federal Rules and Regulations (i.e., HIPAA, Balanced Budget Act (BBA), etc.)

This audit is a limited review and the primary purpose is to ensure compliance with the terms of the contract that the provider agency has with NSMHA. This On-site Review is not a clinical review. Clinical quality assurance reviews are conducted by NSMHA Quality Assurance Department (Concurrent Reviews, Selective Reviews, etc.). This audit is limited in scope. It is not intended to encompass all areas that are covered under an MHD licensing review, however findings and recommendations will be reported to the MHD to assist them. It is not intended to encompass all federal, state and local laws and regulations that may apply to a provider agency, its primary focus is to ensure compliance with those laws and regulations that govern the contract between NSMHA and the agency. If NSMHA becomes aware of a potential legal violation that is outside of the scope of the audit, NSMHA will report the alleged violation to the appropriate authorities.

ON-SITE AUDIT TEAM

The Administrative, Fiscal and Quality Management On-site Review Team shall be made up of one or more of the following:

1. NSMHA Contracts Manager
2. NSMHA Fiscal Officer
3. Quality Manager

4. Quality Specialist
5. Quality Review Team Member
6. County Coordinators

ON-SITE MONITORING COMPONENTS

The following risk factors shall be analyzed prior to the On-Site Review to determine the extent of the Administrative Review: The individual components of the Administrative, Fiscal and Quality Management On-site Review consist of the following:

1. Frequency of outside audits;
2. State MHD Licensing Review Results
3. Prior NSMHA audit findings;
4. Current national accreditation or Certification (i.e., JACHO, CQUIP, NCQA, other);
5. Responses to Monitoring Questionnaire;
6. Responsibilities required under NSMHA's contract with MHD that the agency is performing under its contract with NSMHA
7. RCW, WAC and other state requirements that NSMHA is required to ensure the fulfillment of through its contract with MHD and that the agency is performing under its contract with NSMHA
8. Federal requirements that NSMHA is required to ensure the fulfillment of through its contract with MHD and that the agency is performing under its contract with NSMHA
9. Date of the last monitoring visit;
10. Type of contract;
11. History of marginal performance;
12. Prior audit findings;
13. Abnormal frequency of personnel turnover;

The individual components of the Administrative, Fiscal and Quality Management On-site Review consist of the following:

1. **Administrative Review**

   a. Contract General Terms and Conditions
   b. Benefits Package or Statement of Work Requirements
   c. Performance Standards
   d. Personnel Policies and Records, in order to ensure that the agency has an appropriate credentialing process.
   e. Agency Compliance Program
   f. Board meeting minutes, for indications of problem areas

2. **Fiscal Review**

   a. Review of agency fiscal policies and procedures
   b. Review of the financial system
   c. Review of documentation relative to the tracking of all revenue awarded by NSMHA.
   d. Review of documentation related to identifying, pursuing and recording Third Party Resources, including collections and write-offs.
   e. Eligibility Verification process

f. Desk review of the contractor's annual audit report, with particular attention to any notes that indicate issues with financial viability and stability;
g. Desk review of the agency's answers to questions in the "Administrative, Fiscal and Quality Management System Monitoring Questionnaire;"
h. The following risk factors shall be analyzed prior to the On-site Review in order to determine the extent of the Fiscal Review:

   i. Prior audit findings;
   ii. Responses to Monitoring Questionnaire;
   iii. Date of the last monitoring visit;
   iv. Type of contract;
   v. Dollar amount of contract;
   vi. Internal control structure;
   vii. Review of Agency's accounting system
   viii. Review of Agency's most recent Independent Financial Audit
   ix. If a sub-recipient, Length of time as a sub-recipient;
   x. Has not provided NSMHA with required Financial Reports on a timely basis;
   xi. Has not conformed to conditions of previous contracts.

3. **Quality Assurance/Improvement**

   a. Review of Agency's internal quality assurance, quality improvement systems, and peer review systems policies and procedures,
   b. Agency Internal Complaints Process
   c. Quality Review Team observations
   d. Quality Review Team Interviews and Survey results
   e. Ombuds complaints/grievances

ON-SITE MONITORING PROCESS

An onsite review shall be accomplished by following the steps outlined below:

1. 30 days prior to the scheduled on-site visit, NSMHA shall send the following to the provider:

   a. Administrative, Fiscal & Quality Assurance/Improvement Monitoring Questionnaire,
   b. Personnel Records Review Worksheet,
   c. On-site Review Checklist,
   d. Independent Audit Review of Service Provider Checklist, and
   e. On-site Schedule and Agenda

   The provider shall have 14 days to answer each question on the Monitoring Questionnaire and return it to NSMHA.

2. NSMHA Audit Team shall review the completed Questionnaire prior to the first scheduled day of the site visit. This questionnaire, the Personnel Records Review Worksheet, On-site Review Checklist and Independent Audit Review of Service Provider Checklist will be the tools used by NSMHA Audit Team in reviewing the providers contract compliance.
3. On the first scheduled day of the site visit, an entrance interview with the agency director and/or his/her designee(s) shall occur. The entrance interview consists of the following:

a. Introductions – Identify for Agency which NSMHA Audit Team Member will be reviewing each on-site component
b. Sign Confidentiality Statements (when applicable)
c. NSMHA Re-State Purpose of On-site Review
d. Review On-site Schedule
e. Give Agency staff an opportunity to present a description of the various programs they provide through NSMHA contract(s).
f. Tour of Agency Facility

4. NSMHA Audit Team shall conduct a review of fiscal, administrative and quality management systems. This is accomplished by :

   a. Reviewing with the provider the On-site Questionnaire,
   b. Verifying the provider's answers,
   c. Reviewing source documentation for validation,
   d. Conducting interviews and discussions with appropriate personnel.

   Clinical Files will not be reviewed. Clinical reviews are accomplished during other NSMHA review processes.

5. NSMHA Audit Team shall reconvene as a group at least two hours prior to the scheduled Exit Review to share the results of their monitoring efforts.
6. NSMHA Audit Team shall conduct an exit interview with agency director and his/her designated staff. At the exit review the following will be presented and discussed:

   a. Areas of excellence,
   b. Areas of strengths,
   c. Areas in need of corrective action (findings), and
   d. Recommendations.

7. Once the on-site review is completed, a written On-Site Review Report will be prepared.

   a. Each NSMHA Audit Team Section Lead will prepare a written report documenting areas of excellence, strength, findings and recommendations of the section(s) their team reviewed; Administration, Fiscal and Quality Management.
   b. This documentation shall be submitted to the Contracts Manager who shall be responsible for finalizing the report.
   c. The completed report shall be submitted to the Executive Director of the contract agency within 45 days of the exit review date.
   d. The report consists of four sections:

      i. Scope of review;
      ii. Summary of review;
      iii. Findings and Recommendations,
      iv. Corrective action plan request and timeline.

      The agency will have 30 days to respond in writing to all findings and recommendations.

8. NSMHA Audit Team will review the agency written response to findings and recommendations and provide a written response to the contract agency of those areas of correction that are acceptable and those areas that are unacceptable within 45 days of receipt.
9. When an agency's response has areas that are unacceptable, NSMHA Audit Team will inform the agency in writing and request further action.
10. The Contract agency will be responsible and accountable for correcting all findings.

    Failure of a provider to correct findings may result in NSMHA imposing sanctions and/or withholding payment(s) until the finding in question is resolved to the satisfaction of NSMHA.

11. NSMHA shall submit to the Quality Management Oversight Committee (QMOC) a copy of the On-Site Review Report prepared by NSMHA Audit Team, a copy of the Agency's Response, if available and further action requirements.

    NSMHA Executive Director may recommend to NSMHA Board of Directors that NSMHA Impose sanctions, financial penalties and/or withhold payment(s) if findings are not corrected

    The Monitoring Report and Response becomes a permanent part of the provider's file.

ATTACHMENTS

None

NORTH SOUND MENTAL HEALTH ADMINISTRATION
MONITORING QUESTIONNAIRE
2014-2015

Agency: _____ **Address:** _____

Phone Number: _____ **E-mail:** _____ **Contact:** _____

State of Washington Community Mental Health Program License Number: _____ Expiration Date: _____

List Services Licensed/Certified to Provide: _____

Sttate of Washington Community Mental Health Certification Number: _____ Expiration Date: _____

List of Services Certified to Provide: _____

Materials Needed by NSMHA Audit Team at Agency Monitoring Entrance Review:			
Agency Policies and Procedures	X	QM/QI Plan and Activities	X
Personnel Records	X	Clinical Supervision Records	X
Complaint, Grievance, Appeal, Fair Hearing & Notice Policies and any procedures developed by your organization. Please submit with monitoring questionnaire	X	Complaint & Grievance tracking Logs, forms/checklist - Please submit with monitoring questionnaire	X
Copy of Individual Rights	X	EPSDT Data	X
Crisis Log (if applicable)	X	List of Clinical/Medical Staff	X
Medication Inventory Records (if applicable)	X	Training Plans and Records	X
Staff Evaluation Records	X	Staff Credentialing Files/Records	X
Notice of Privacy Practices	X	Sliding Fee Scale	X
Interim Financial Report	X	Copy Applicable Liability Insurances	X
Fraud and Abuse Compliance Plan Proof of exclusion searches	X	Subcontracts	X
Board of Directors and Subcommittee minutes	X	Business Associate Agreements	X

Admission Packet	X	Marketing Materials	X

Do you subcontract any portion of your NSMHA contract? [ ] YES [ ] NO ***If yes, provide NSMHA with complete list.***

NSMHA Contract Number	**Contract Period**	**Contract $ Award**	**Funding Source(s)**

Do you have other grant awards? *If yes, identify and briefly summarize:*

Other Grant Awarding Agency	***Dollar Amount of Other Awards***	***Purpose of Award***

Has the CONTRACTOR been accredited by a national accreditation agency? If so please provide:

Agency name and date of accreditation:_____

1. Have corrective actions and/or recommendations from the previous audit been addressed?	**YES**	**NO**	**NA**	**Comments/source documents**
INDIVIDUAL RIGHTS WAC 388-865-561;780;880, 388-877-0600 and ENROLLEE RIGHTS CFR §438.100	**YES**	**NO**	**NA**	**Comments/source documents**
1. Contractor has Policies and Procedures consistent with the NSMHA individual rights policy #4505. 2. Contractor has complied with all elements of NSMHA Facility Checklist (attached) 3. Contractor has a welcome packet for new enrollees that include individual rights (please have available at on site visit)				
4. Each Enrollee (including parents/foster parents, assigned/appointed guardians of children, and youth) is able to choose a participating Mental Health Care Provider(MHPC) to comply with WAC 388-865-0345, or its successor, and in accordance with the approved Medicaid waiver or its successor				
CULTURAL COMPETENCE AND SENSITIVITY	**YES**	**NO**	**NA**	**Comments/source documents**
1. The Contractor has policies and procedures consistent with WAC 388-865-0405, 388-877-0420, and NSMHA Policy #1521, Cultural and Linguistic Competency: ❑ Provision of competent and culturally sensitive services to: 1. All people of diverse cultures including hearing impaired, GLBTA, developmentally disabled, non-English speaking, etc.; 2. Tribal communities; and 3. Children, Adults and Older Adults; ❑ Does competent and culturally sensitive services occur in the following settings: a. Through recruitment, training and ongoing staff development;				
b. Through clinical supervision; c. Through peer review; d. At access; e. Through service satisfaction; and f. Through appropriate consultation services, when necessary.				

2.	Does the Contractor ensure sure services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the individual?				
3.	Provide alternative methods of delivery models to make services available to underserved persons as defined in WAC 388-865-0150 and 388-877-420				
4.	Does the Contractor maintain a long of interpreter and translation requests? (please have available for the on-site review)				
5.	How does the Contractor ensure culturally competent services are being provided?				
LOCAL RESPONSIVENESS AND COMMUNICATIONS		**YES**	**NO**	**NA**	**Comments/source documents**
1.	How does your agency ensure the following: ❑ Work with the Regional Ombuds to facilitate their access to facilities, personnel, necessary documents, and individuals in service. ❑ Posts and makes known to service recipients their rights and responsibilities (including complaint, grievance, appeal, and fair hearing procedures, and the availability of Ombuds services). ❑ Delivery of services that are locally responsive; please include the participation and collaboration with community partners and identify the community activities/meetings your agency participates in by county. ❑ Make available upon request the information that includes, but not limited to: education, licensure, certification and/or re-certification of MHP's and MHCP's .				

COMPLAINT / GRIEVANCE / APPEAL / FAIR HEARINGS

	Yes	No	N/A	Comments/source documents
1. Have corrective action/recommendations/quality improvements from previous audits been addressed? If yes, describe how each has been addressed.				Please describe and include any source documents
2. Contractor has Policies and Procedures adopted/consistent with NSMHA Policies #1001-1005, and any successor • Were recommendations made regarding above policies and procedures in past audits? If yes, please describe any changes that were made.				Please describe and include any policies or procedures developed
3. Contractor identified Quality Improvements or areas of further study and review related to complaint or grievance information during the audit period on their semiannual reports.				Please describe and include any source documents
4. Describe efforts to incorporate individual/family dignity, respect, recovery & voice into the complaint & grievance process.				Please describe and include any source documents
5. Provider Complaints/Grievances timelines for acknowledgement and resolution to individuals with complaint & grievances were met throughout audit period				Please describe and include any tracking documents or other source documents
6. Provider Grievances: Documentation of notification to RSN for all provider level grievances was within required timelines during audit period. (see provider/formal				Please describe process to notify NSMHA of these requirements so that NSMHA can track provider timelines for grievances. Please include any tracking documents that show requirements were met

designee level grievance –policy 1002) Please note that this includes: • written notification to NSMHA of date of receipt of a grievance (within 2 business days) and written notification of whether grievance was received orally or in writing • A copy of written grievance is also forwarded to NSMHA upon receipt • A copy of written notice of resolution is forwarded to NSMHA with dates of distribution to all parties noted. • Please see policy 1002.				
7. Provide evidence that a written copy of Contractor responses to complaints are forwarded to NSMHA (written response is only required when individual is unsatisfied with resolution)				Please describe and include any tracking documents
8. Enrollee benefits were uninterrupted (if applicable) • Please describe process for ensuring previously authorized services were continued or reinstated during any complaint, grievance appeal or fair hearing process				Please describe and include any source documents developed
9. Describe process to assure that requested follow up, quality improvement/corrective action resulting from RSN level grievances (or complaints				Please describe and include any tracking documents or other source documents

or appeals) occurs.				

MENTAL HEALTH SERVICE DELIVERY

ACCESS AND ASSESSMENT SYSTEM	YES	NO	NA	Comments/ source documents
1. How does your organization ensure and monitor that all enrolled recipients are offered a face-to-face appointment that is within ten (10) working days of seeking treatment, not to exceed 14 calendar days? 2. Does your organization work under an open access model? If so, please identify the facility and describe the process, such as days, hours and number of intakes on average. Contractor can show how the following assurances are met: ❑ Medicaid individuals have access to services upon request and ensure they are not placed on waiting lists. ❑ Medically necessary services are provided and not contingent upon full completion of an intake evaluation. ❑ Not discriminate against enrolled individuals who are considered difficult to serve. ❑ During business hours staff respond to individuals in crisis, when and where appropriate and necessary. ❑ Prior authorization is not required for emergency services. ❑ Not arbitrarily deny, reduce the amount, duration or scope of required services solely because of the diagnosis, type of illness or condition. ❑ Designated Mental Health Professionals, crisis intervention staff, individuals and their families (when authorized) have 24-hour, 7 days per week access to current crisis plans. ❑ Maintain the ability to provide an intake evaluation in the individual's residence, including adult family				

homes, assisted living facilities or skilled nursing facilities, including state hospital or evaluation and treatment facilities when an individual requires an on-site service.				
CARE COORDINATION AND RECOVERY ORIENTED SERVICES	**YES**	**NO**	**NA**	**Comments/ source documents**
Please describe the way in which your agency ensures the following occurs: A. Provision of uninterrupted care when transferring service to another agency. B. Evidence of facilitating the access/coordination of primary care and/or other health needs for an individual with complex needs. C. A streamlined process for the transfer of medication management to an individual's primary care physician. D. Contractor has working relationships with health plans and actively promotes and provides coordinated care. E. Facilitation of Medicaid eligibility and/or referrals to local in-person assisters for individuals not currently enrolled in Medicaid. F. Ensure children are referred to physical health care when the MHCP determines a referral is needed based on the periodicity schedule consistent with NSMHA EPSDT Policy #1550.				
Strength-based/Recovery Oriented Services A. Please indicate how Peer Counselors/Parent Partners are utilized within your organization. B. Does your agency use Collaborative Documentation? If so, please describe the process and if not, please indicate whether it will be implemented? C. What systematic steps does your organization take to help individuals with their education or work goals?				

D. What steps has your agency taken to address the needs of Transition Age Youth (ages 16-21) E. How is your organization providing services to individuals living in rural areas of the region?				
F. Describe the process your agency uses to actively promote and inquire on whether an individual would like to develop a Mental Health Advance Directive in compliance with NSMHA Policy #1518. G. How is information provided to an individual about developing a medical advance directive? H. How does your organization prepare and participate in a coordinated response to emergency/disaster events (i.e., natural disasters). I. What EBPs is your organization currently utilizing? J. What EBPs will your organization be implementing over the next 12-24 months? K. Indicate whether fidelity standards are being met in the Evidence Based Practices (EBPs) that are currently in use. L. How does your agency ensure continuity and fidelity of the EBPs? Please identify which of the EBPS are being measured for fidelity.				
RESIDENTIAL AND HOUSING SUPPORT	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Does Contractor participate in ending homelessness initiatives in their respective county/counties? Please list the committees/workgroups by county. 2. How does your agency promote individual access and choice in safe and affordable independent housing?				

3. Please indicate the housing options your organization is supporting and/or developing for individuals with mental illness.				

INPATIENT COORDINATION/CONTINUITY IN CARE	YES	NO	NA	Comments/ source documents
1. Per Policy # 1572, please identify and describe the inpatient coordination/continuity processes your agency uses for: o Emergency assessments for voluntary hospitalizations o Contact made within 3 working days of inpatient admission notification o Coordination with crisis response system emergency assessment for voluntary hospitalizations during business hours o Non-crisis service offered within 7 days business days of discharge in coordination with the Inpatient Transition Team o Participate in the treatment and discharge planning with the inpatient team o Provision of the most recent psychiatric assessment/intake assessment, prescriber notes, medication sheet, advance directive, progress notes and/or other information as requested by the inpatient unit o Actively work with the NSMHA WSH Liaison, to ensure community residential placement and implementation of mental health services to individuals discharged from Western State ("WSH") on a no decline policy, regardless of recipient's Medicaid eligibility and/or perceived difficulty in serving o Procedure for offering covered mental health services for follow-up and aftercare as needed when an enrolled individual has been treated in an emergency room for a psychiatric condition o Coordinate with residential providers regarding admission, course of treatment and discharge planning to maximize use of least restrictive care alternatives				

2. Actively work with NSMHA and Service Area's CLIP Committee, to ensure the provision of medically necessary mental health services to individuals discharged from CLIP programs, consistent with Policy #1529 and #1574 Provide clinician contact the inpatient staff within three (3) business days of a child's admission to an inpatient facility. For any hospitalization exceeding seven (7) days, ensure that child's MHCP be present for at least one face-to-face meeting with the child and their treatment team before the child's discharge from any inpatient facility.				
SERVICE RECIPIENTS WHO HAVE A MENTAL ILLNESS AND ARE HOMELESS	**YES**	**NO**	**NA**	**Comments/ source documents**
Describe how your agency provides support and services to individuals and families who are homeless. Please include collaborations with other community service organizations.				
ALLIED SYSTEM COORDINATION	**YES**	**NO**	**NA**	**Comments/ source documents**
Describe how your organization collaborates with the Criminal Justice System. 1. Does your organization provide the following services? ❑ Assistance to law enforcement and the criminal justice system, upon request by providing: • Relevant information and referral services, within legal limits; • In-jail screening and assessment services; • Court ordered mental health treatment; ❑ Discharge planning for individuals returning to the community, including medication monitoring, linkage with community supports and medically necessary mental health services. ❑ Mental health services brochures and educational materials are prominently displayed and available to individuals and their family members/advocates at jails, juvenile detention facilities, prisons and juvenile rehabilitation facilities receptions areas. ❑ Does your organization track individuals involved in the criminal justice system receiving ITA investigations, which resulted in placement.				

- To voluntary outpatient services;
- To crisis bed placement
- To inpatient services;
- Detention to hospital or E&T for 72-hour hold
- Voluntary hospitalization.

- ❑ Number of individuals provided with discharge planning services over the past 12 months prior to release from prison, jail, or community detention.

- ❑ Number of individual involved in the criminal justice system over the past 12 months that were provided mental health assessments, screenings and/or diagnostic services while in jail or detention.

VOLUNTARY AND INVOLUNTARY CRISIS RESPONSE SERVICES	YES	NO	NA	Comments/ source documents
Contractor contracts for Involuntary Treatment Act Services				
Contractor contracts for Voluntary Crisis Response Services 1. CONTRACTOR provides outpatient services to individuals under an LRO 2. CONTRACTOR operates an E&T facility 3. CONTRACTOR participates on a County Local Oversight Committee for each of the counties in which it provides crisis services. 4. CONTRACTOR participates on the NSMHA Integrated Crisis Response Committee 5. Does the organization provide the following services consistent with NSMHA Policy #1717 and Policy #1720 (if applicable) • Outreach services • Emergency services to enrolled customers • Emergency walk-in services • Urgent appointments • Coordination with Family and other natural support • In-home/In-community stabilization aides • Stabilization services • Crisis residential/Respite options • Psychiatric and Medical services • Follow-up services • Transportation • Cross-system coordination • Cross-RSN coordination • Interpreter services				

QUALITY MANAGEMENT	YES	NO	NA	Comments/source documents
Have Quality Management corrective actions and recommendations from the last NSMHA On-site been addressed? Does CONTRACTOR have a QM plan that is consistent with the NSMHA QM Plan? ❑ How often does the QA/QI committee meet? ❑ Does a QA/QI committee oversee QA/QI activities? If yes, the committee members are comprised of: a. Individuals in service/previously in service (How many:) b. Peers/Parents/Advocates (How many:) c. Other, please list: _____ _____ _____ ❑ Please list any Quality Improvements that have resulted from QA/QI activities in the current contracting period: _____ _____ _____ _____ ❑ Contractor has policies and procedures that ensure: • An ongoing, planned, systematic organization-wide quality management process to design, measure, assess and improve its programs • Processes to identify and correct areas of non-compliance • Opportunities for issues raised by staff, individuals, advocates, and/or Ombuds to be addressed and incorporated into ongoing Quality Management activities. • Communication of Quality Management issues and activities at all levels of the organization including the governing board and advisory bodies. • Provide member list for the Governing Board and Advisory Board/Committee • Corrective action plans are written in accordance with NSMHA requirements.				

• Adherence to NSMHA Quality Management principles as outlines in the NSMHA QM Plan. • Attendance at NSMHA Quality Management Oversight Committee (QMOC) and sub-committees as required.				
CAPACITY	**YES**	**NO**	**NA**	**Comments/ source documents**
1. CONTRACTOR ensures the following by having policies and procedures consistent with NSMHA Policy #1506, # 1520, #1522, #1541, #2002, #4505, #4506 : a. Does the organization maintain capacity to adjust the number, mix, and geographic distribution of MHCP's and other qualified personnel to meet access and travel standards as the population or enrollees needing mental health services shift within the Service Area. Any change that results in reduced capacity must be approved in advance by NSMHA. b. Notify NSMHA 30 days in advance of public notice if the CONTRACTOR terminates any of its direct care mental health services subcontracts. c. Mental health professionals and MHCP's, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to: 1) The enrollee's mental health status, or mental health treatment options, including any alternative treatment, in a culturally-competent manner; 2) The enrollee's right to be free to exercise his/her rights and to do so does not adversely affect the way the CONTRACTOR or MHCP treats the enrollee. 3) Any information the enrollee needs in order to decide among all relevant mental health treatment options; 4) The risks, benefits and consequences of mental health treatment (including the option of no mental health treatment); 5) The enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment, and to express preferences about future treatment decisions; 6) The MHCP may refer the enrollee outside the network to acquire medically necessary services when service is not available in region. 7) The enrollee's right to be treated with respect and with due consideration for his/her dignity and privacy 8) The enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;				

2. 9) The enrollee's right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164;				
3. Ensure resources and/or technical assistance are provided or purchased to support peer-run/driven services, peer support, individual involvement, clubhouse, and peer centers for adults.				
4. Ensure that resource and utilization management activities are not structured so as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any individual. 5. Ensure the provision of a second opinion, upon request, from a qualified mental health professional within the network. If an additional qualified mental health professional is not currently available within the network, the CONTRACTOR shall provide or pay for a mental health professional outside the network, at no cost to the individual. The second opinion shall be offered to occur within 30 days of the request for a second opinion.				
REGULATORY COMPLIANCE PROGRAMS	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Have Regulatory Compliance corrective actions and/or recommendations from last NSMHA Review been addressed? 2. Does the CONTRACTOR have administrative and management policy and procedures that are designed to guard against fraud and abuse and consistent with NSMHA Policy #2001,: ❑ A compliance plan; ❑ Designation of a compliance officer or compliance committee that is accountable to the governing body ❑ Name of Compliance Officer: ❑ Member list of Compliance Committee (if applicable): ❑ Effective training and education for the compliance officer and Contractor staff; ❑ Effective lines of communication between the compliance officer and Contractor staff; ❑ Enforcement of standards through well-publicized disciplinary guidelines; ❑ Provision on internal monitoring and auditing; ❑ Provision for prompt response to detected offenses and for development of corrective action initiatives; ❑ Participation by the CONTRACTOR and any subcontractors in Medicaid fraud and abuse training conducted by the Washington State Attorney General Medicaid Fraud Unit; ❑ Written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable Federal and State standards;				

☐ Reporting fraud and/or abuse information of the CONTRACTOR or subcontractors to NSMHA as soon as it is discovered or suspected, including the individual name/ID number if applicable, the source of the complaint, type of, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.				

3. Does the CONTRACTOR have privacy policies and procedures that comply with state and federal regulations and NSMHA Policies #2501-2522? Is there an appointed privacy officer? Name of Officer: Ongoing education and staff training? Date of last training: A process for investigating alleged violations?				
MANAGEMENT INFORMATION SYSTEM	**YES**	**NO**	**N A**	**Comments/ source documents**
CONTRACTOR shall: a. Does the Contractor have a single integrated information system, with the ability to collect, use internally and report data as required by NSMHA in order to provide a centralized, seamless system of mental health services and to provide timely monitoring. Does the data contain sufficient information to track termination from services (42 CFR 434.53c)? Does the Contractor has evidence of quality improvement measures based on internal data monitoring? b. Comply with HIPAA implementation requirements and standards (i.e., data collection, submission, privacy, and security). c. Contractor shows evidence of compliance with NSMHA Policies 4202, 4203 & 4205 d. Contractor ensures the data is transmitted to NSMHA timely and accurate in compliance with the contract? e. Contractor ensures servers are in a locked and secure area?				

PER SONNEL SYSTEM **Total Number of Paid Employees:** _____ ***(attach list of employees, including title and pay rate)*** **Total Number of Facilities:** ***(attach list of location/address for each facility)***	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Is there a current organizational chart? Attach a copy of chart				
2. Have personnel system corrective actions and recommendations from last NSMHA On-site been addressed? 3. Does the CONTRACTOR have a current, up-to-date personnel manual (policies and procedures)? Does the manual: ❑ Contain provisions for a periodic review and update to reflect board and management decisions? ❑ Specify vacation, sick time, holiday, and other leave policies? ❑ Contain non-discrimination policy that prohibits discrimination on the basis of race, color, religion, creed, national origin, sex, marital status, disabled veteran status, Vietnam Era Veteran status or disability? • Policies and Procedures include: ❑ Ensure all staff is qualified for the positions they hold (education, experience, skills) to perform the job? ❑ Ensure all staff providing direct care are licensed, certified or registered, as required for the position? ❑ Ensure all staff has been credentialed as applicable? ❑ Ensure all staff having contact with clients has a current Washington State background check? ❑ Ensure services are provided by or under the clinical supervision of a MHP? ❑ Ensure Mental Health Services staff has access to consultation with psychiatrist/physician? (Psychiatrist/physician must have at least one-year experience in direct treatment of mental/emotional disorders) ❑ Ensure children receive services by, under supervision of CMHS? ❑ Ensure older adults receive services by, under supervision, or with consultation, of geriatric MHS?				

- ❑ Ensure minority or ethnic individual receive services by, under supervision or with consultation of appropriate Minority MHS?
- ❑ Ensure individuals with a disability receive services by, under supervision or with consultation of disability MHS?
- ❑ Ensure staff receives regular supervision?
- ❑ Ensure staff has annual performance evaluations?

4. Does the CONTRACTOR training plan comply with the NSMHA-Regional Plan?
5. Does direct staff, including case managers, supervisors, MHP, MHS, DMHP, therapists, psychiatrists, etc., have an annual training plan that is pertinent to their position, improves quality of care and incorporates a recovery, strength-based system of care?
6. Does your agency employ Peers?
   - Please identify the number of individuals; FTE; type of work performed.
   - If you do not employ peers, please provide a plan on how your agency will incorporate peers into your service model.
7. What method do you use to provide notice of non-discrimination policies and discrimination complaint/grievance procedures to employees and applicants for employment services?
8. List staff training on use of all alternative communication methods (Braille interpreter/translation, TTY's, etc)

Type of Training:

9. Do you have an Affirmative Action Plan necessary to maintain eligibility for Federal funds?
10. Do you have a Section 504 Coordinator? An ADA Coordinator?

    Name and title:

Each organization with 15 or more employees is required to designate a Section 504 Coordinator. If less than 15 employees, the administrator/director is responsible for 504 compliance. With 50 or more employees, organizations are required to designate an ADA Coordinator. If less than 50 employees, the administrator/director is responsible for ADA compliance. [Section 504 refers to the Rehabilitation Act of 1973]

11. Has a Non Discrimination and ADA Self-Evaluation been completed?
    Date:

12. Are all employees given a copy of their current job description?				
13. Are personnel actions initiated and approved only by authorized individuals, Please list title of individuals authorized:				

14. Are complete personnel files maintained for each employee of the CONTRACTOR?				
15. Are wages paid at or above the federal minimum wage?				
Do the employee personnel files contain: ❑ Application? ❑ Verification of credentials? ❑ OIG check? ❑ Record of interviews and reference checks? ❑ Schedule of compensation, including written authorization for salary increases? ❑ Copies of performance evaluations? ❑ Proof of citizenship? ❑ Job description, which specifies in detail responsibilities and duties? ❑ Annual training plan and training records? ❑ Current criminal background clearance? ❑ Copies of current registrations, licenses and certifications? ❑ Annual Oath of Confidentiality?				
16. Do employee personnel files with respect to payroll consist of the following: ❑ Position description? ❑ Hiring document showing how initial salary was set? ❑ Authorizing tax-withholding forms? W-4 ❑ Promotion data showing how selected with CONTRACTOR's policy? ❑ Reassignment data? ❑ Termination and final payment?				
17. Are files maintained in such a manner that unauthorized persons cannot access to them?				
18. What steps does the CONTRCTOR take to ensure that you do not employ/contract with individuals/organizations that have been excluded from participation in Federal Healthcare Programs?				
19. How often does the CONTRACTOR check to see whether an individual/organization has been excluded from participation in Federal Healthcare Programs?				

FISCAL SECTION

	YES	NO	NA	Comments/ source documents
1. Has the CONTRACTOR been accredited by a national accreditation agency? If yes, please provide agency name and date of accreditation: 2. Does the CONTRACTOR have other grant awards? If yes, identify and summarize: attach schedule of federal expenditures. Other Grant Awarding Agency _____ Dollar Amount of Other Awards _____ Purpose of Award _____ _____ _____ _____ _____ _____ _____				
FINANCIAL MANAGEMENT AUDITING	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Has the CONTRACTOR been audited by an independent CPA within last year and the accounting system been reviewed and approved? If the audit has not been submitted to the NSMHA, supply a copy. 2. Was the audit a fiscal audit only? 3. Did the audit report include a management letter? If yes, a copy will be reviewed during the on sight visit. 4. Has the CONTRACTOR been audited by an Accreditation Agency during the last two years? If so, attach copy. 5. Has the CONTRACTOR been audited by a federal audit agency (HEW, GAO, etc.) during the last two years? If yes, attach a copy. 6. Did any audit reports contain recommendations? If yes: ❑ They have been implemented. ❑ They have not been implemented. Explain. 7. Did any audit report include immaterial or material weaknesses or questioned costs? If yes: ❑ They have been resolved.				

❑ They have not been resolved. Explain. 8. How do you do client eligibility verification? Explain. ❑ Do you have a policy? ❑ How often do you check eligibility? ❑ What do you do when you find out a change in eligibility?				
INTERNAL CONTROLS	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Does the CONTRACTOR maintain a policy covering such matters as signatures required to authorize financial transactions? 2. Are duties and responsibilities separated so that no one employee has sole control over cash receipts, disbursements, reconciliation of bank accounts, receivables, etc.? If no, give detailed explanation. 3. Are timesheets maintained, adequately safeguarded and approved only by properly designated officials? If no, explain. 4. Are there any special procedures (analytical reviews, reconciliation, comparison to budget, etc.) to ensure the completeness and accuracy of payroll information? 5. Does your agency have a policy on third party billings? Is it consistent with RSN policy #3044.00? 6. Do you have a policy that provides for eligibility verification (see policy #3045.00)? 7. How does your agency handle write off of receivables?				
BUDGETARY CONTROLS	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Have line item budgets been established for each contract award? ❑ Are supporting documents for budget estimates on file?				

❑ Is budget approved by top management? 2. Are actual expenditures periodically compared with budgeted costs? 3. Are there controls to prevent expenditures or invoicing of funds in excess of approved budgeted amounts? 4. Are cost category budget over runs (or under runs) within a program year analyzed and evaluated to determine reasons and possible corrective action required? ❑ Is management approval required for variations? 5. Are cost allocated in accordance with A-87 or A-128 cost guidelines?				.
COMPENSATION PLAN	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Does the CONTRACTOR have an established written compensation plan? 2. Do you have a Physician incentive plan or do you pay people not to work? 3. Does the CONTRACTOR have time and attendance records for each employee by pay period showing: ❑ Distributions by grant or contract?				
INVENTORY CONTROLS	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Does the CONTRACTOR have an inventory control system for equipment as demonstrated by: ❑ A general ledger control account? Date of receipt? Cost? Location? 2. Is equipment tagged or otherwise marked to identify it as organizational property? 3. Have annual physical inventories been made?				.
PURCHASING	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Does the CONTRACTOR have policies, procedures and controls which: ❑ Are approved by the governing board and authorized individuals/management? ❑ Are in writing? 2. The policies, procedures and controls contain the following functional elements: ❑ Formal purchase order system? ❑ Bids obtained? 3. Are purchases limited in amount before requiring executive or board approval? (e.g., do purchases over $300 require special approval?)				.

4. Does the CONTRACTOR have documentation verifying that its subcontractors are absent of a history of exclusion or debarment from participation in Medicare, Medicaid or other state or federal health care programs? 5. Do you have flex fund policies?				
TRAVEL	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Is there a written travel policy, which clearly defines the CONTRACTOR's travel policy and procedures? 2. Is the travel reimbursement policy in accordance with the terms of the notice of contract award? Does the manual provide for reimbursement by: ❑ Actual expense? ❑ What is your mileage reimbursement rate?				
FEDERAL BLOCK GRANT				
Federal Block Grant	**YES**	**NO**	**NA**	**Comments/ source documents**
1. Do you receive FBG funds from North Sound Mental Health Administration? 2. Did you have a single audit? 3. Did you have any question costs? How do you account for question costs? 4. Were FBG funds used for any of the following costs? • Services and programs that are covered under the capitation rate for Medicaid-covered services to Medicaid enrollees; • Inpatient services; • Cash payments to intended recipients of services; • Construction or renovation; • Capitol assets or the accumulation of operating reserve accounts; • Equipment costs over $5,000;				

• State match for other federal funds. 5. Did you have any administration costs included in the FBG services billing? What is the administration cost percentage? 6. Were services identified in the Scope of Work provided? 7. Has Contractor made progress on identified Performance Measures?				
Programs With Multiple Funding Sources 1. How do you insure that programs with multiple funding sources do not double bill for the same costs? 2. Show us how this is accomplished. 3. List RSN programs with multiple funding sources, excluding third party billing.				

REVIEWED BY: _____

DATE: _____

Routine Utilization Review Tool 2015

The following Interpretive Guidelines (IGs) detail the criteria used by NSMHA staff to determine a "Yes" (and conversely a "No") and "NA" response to the standards in the NSMHA Routine Utilization Review (UR) tool. For each standard, there is also a section that indicates the primary documentation reviewed. This a list of the most common documentation reviewed, but other documentation may be reviewed, if necessary, to score the standard. Review is primarily focused on documentation added since the last review (typically the last year) unless documentation from another time period is applicable.

NSMHA has adopted these guidelines in order to provide inter-rater reliability of NSMHA staff when reviewing charts at agencies and to assist agencies in meeting the standards.

The standards on the tool are organized into the following sections:

- Initial Assessment
- Risk and Crisis Planning
- Recovery/Resiliency Plan (RRP)
- Ongoing Assessment
- Treatment Provision
- Medication Services
- Miscellaneous

Scoring note for reviewers – When marking an item "No" which cannot be corrected (e.g., a RRP that was done past the due date), please indicate in the comments that no action/follow up is needed.

After the review standards/interpretive guidelines is an Addendum, which includes Core Elements, Recovery/Resiliency Plan examples, and Crisis Planning examples.

Initial Assessment

1. **The determination of initial eligibility is consistent with the NSMHA Clinical Eligibility and Care Standards (CECS)** [WAC 388-877A-0130(3); DSHS Contract Exhibit A, 5.1 & 5.2 (PIHP)/1.23, 9.1-9.3 (SMHC); NSMHA Policy 1556]
   - **YES**
     - Documentation supports that the individual qualifies for ongoing services per the Access to Care Standards, which includes
       - Diagnosis of a mental illness that is covered by Washington State;
       - The individual's impairment and corresponding need(s) is the result of the covered mental illness;
       - Requested service/intervention is deemed reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of the covered mental illness;
       - The individual is expected to benefit from the intervention;
       - The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.
       - GAF/CGAS 60 or below.
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation
     - Collateral records (e.g., hospitals, PCP, previous outpatient treatment)

2. **The intake evaluation contains sufficient clinical information to justify the diagnosis** [WAC 388-877-0610(2) & WAC 388-877A-0130(5)]
   - **YES**
     - Diagnosis uses criteria in the DSM-IV-TR (or DSM-5 once implemented) including differential diagnosis when appropriate.
     AND
     - Is supported by documentation of sufficient clinical information.
       - Sufficient clinical information includes, but may not be limited to:
         - ✓ Description of the presenting problem by the individual and others as applicable
         - ✓ Documentation of the mental health condition provided by the individual or another system/support
         - ✓ Documentation of inquiry into
           - Mental health history including any inpatient/outpatient services and medications
           - Trauma/abuse history
           - Substance use including treatment - current & historical and GAIN-SS
           - Pathological gambling including treatment – current & historical
           - Medical concerns

    - Current medications
- **NA**
  - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
- **Paperwork reviewed**
  - Intake evaluation
  - Collateral records (e.g., hospitals, PCP, previous outpatient treatment)

3. **The intake evaluation is age relevant** [WAC 388-877A-0130(6)(7)]
   - **YES**
     - The individual's age is identified in the intake.

     AND
     - If the individual is less than 18 years old, the intake addresses developmental history as evidenced by documentation of any developmental issues or documentation that there are no significant issues to note regarding developmental history. Developmental history does not require a separate document.

     AND
     - When applicable, age-related issues are incorporated into the assessment (e.g., diagnoses, eligibility, treatment recommendations).
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation
     - Behavior and Development form (if applicable)

4. **The intake evaluation is culturally relevant** [WAC 388-877A-0130(7)]
   - **YES**
     - The intake identifies the individual's culture/cultural history. Culture should be expanded beyond ethnicity.
       - Examples of cultural issues to consider include ethnic identification, family of origin, socioeconomic status, language, age, gender, housing status, family roles, religion, education, geographic, trauma, addictive behavior, general life style, etc. Please note that these are examples. It is NOT a review expectation that all of these issues are addressed for all individuals. Some will apply more than others for each individual.

     AND
     - As applicable, cultural issues are incorporated into the assessment (e.g., diagnoses, treatment recommendations).
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation

- CIV

5. **The intake evaluation includes a risk assessment** [WAC 388-877-0610(2i&j); NSMHA Clinical Guidelines]
   - **YES**
     - The intake identifies risk factors as well as protective factors.
       - Risk of harm to self or others, including suicide/homicide must be assessed.

     AND
     - There is a clinical assessment of risk, based upon existing risk and protective factors, that assigns a level of risk (e.g., none, low, medium, high).
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation

6. **The Level of Care assigned at intake appears consistent with the documentation** [NSMHA Policy 1565]
   - **YES**
     - The CA/LOCUS completed at intake appears to be accurately scored per the documentation provided at the time.

     AND
     - The identified Level of Care corresponds with CA/LOCUS scoring or there is a rationale for the recommended Level of Care if different from what the CA/LOCUS tool identifies.
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - CA/LOCUS
     - Intake evaluation

7. **The treatment recommendations from the intake evaluation appear appropriate based on the identified needs, severity of symptoms, and Level of Care** [WAC 388-877-0610(2l); DSHS Contract 5.1 & 5.4 (PIHP)/9.1 & 9.2 (SMHC); NSMHA Policy 1565]
   - **YES**
     - The treatment recommendations (type and frequency of services) correspond with the identified needs and NSMHA Utilization Guidelines for the identified/recommended Level of Care.
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - CA/LOCUS
     - Intake evaluation

8. **Individual's needs beyond mental health have been assessed (e.g., health care, substance use, legal, housing, daily activity needs appropriate to age and culture such as employment, education, socialization, etc)** [WAC 388-877A-0170(1b); DSHS Contract 10.2.3, 10.3.1(PIHP); NSMHA Policy 1551]
   - **YES**
     - Within the first 30 days following the first ongoing appointment, there is documentation that the individual has been asked if they have any additional needs beyond mental health and that any identified needs have been assessed (what is the individual's concern and desired outcome, what resources have been tried and/or are currently in place, etc). *Need for PCP reviewed in a separate standard.*
     - If "NO", reviewer shall identify which of the following needs have not been assessed (more than one may be identified) – health care, substance use, employment, education, legal, housing, developmental, socialization, other (identify specific need not assessed).
   - **NA**
     - The individual has not engaged past the intake assessment.

     OR
     - The chart has not been open for 30 days from the first ongoing outpatient appointment.
   - **Paperwork reviewed**
     - Intake evaluation
     - Recovery/Resiliency Plan (RRP)
     - Progress notes
     - Psychiatric notes

Risk and Crisis Planning

9. **Risk factors are continually monitored and addressed throughout the treatment episode** [WAC 388-877A-0135(4); NSMHA Clinical Guidelines & Policy 1551]
   - **YES**
     - Documentation in the chart indicates that risk factors (factors that put the individual at increased risk of harm to self or others or impaired functional status) for the individual are assessed throughout the course of treatment, (i.e., assessment of risk extends beyond the intake and assesses previously identified risks as well as any new risk factors).

     AND
     - The ongoing risk assessment is broader than risk of harm to self or others (e.g., substance dependence/abuse, trauma/victimization history, homelessness, criminal behavior/legal issues, not adhering to medications as prescribed, separation from family/natural supports, multiple residential placements, CPS/APS involvement).

     AND

- RRP and/or crisis plan includes a proposed plan of clinical intervention for dealing with any identified risk factors.

- **NA**
  - The individual has not received/engaged in ongoing treatment services.
- **Paperwork reviewed**
  - Intake evaluation
  - GAIN
  - Crisis plan, crisis alerts
  - Progress notes
  - Psychiatric service notes
  - Recovery and Resiliency Plan (RRP)
  - RRP review
  - LOCUS/CALOCUS
  - Extraordinary/Special Incident Reports Phone call logs
  - Previous treatment/hospitalization records

10. **When required (LOC 4 and above), requested or clinically indicated, a crisis plan exists** [NSMHA Policy 1551; WAC 388-877A-0170(1c)]
    - **YES**
      - A crisis plan is included in the individual's chart for individuals with a Level of Care (LOC) of 4 or above, if requested, or clinically indicated. Examples of when a plan is clinically indicated includes but is not limited to:
        - The individual is suicidal or has a history of suicide attempts
        - Individual engages in self-harm behaviors
        - Child engaging in behaviors with the likelihood of causing significant physical harm to self or others
        - Recent, increased use of crisis-oriented services (e.g., crisis line, crisis beds, emergency department)
        - Significant history of psychiatric inpatient admissions

    OR

      - The individual refused to complete a plan, but a plan was still required or clinically indicated AND the clinician completed the crisis plan addendum as thoroughly as possible based on the clinician's knowledge (i.e., the clinician should complete as much of the consumer part of the crisis plan as possible). At a minimum, the following information should be identified by the clinician:
        - Name and contact information for the mental health care provider
        - Crisis Line number
        - Clinician recommendations for proactive and progressive measures to prevent and intervene in a crisis

    AND

- If the individual refuses to participate in development of the plan, the clinician approaches the individual about input into the plan at a minimum of every 6 months until the individual participates.

- **NA**
  - Crisis plan is not required, requested or clinically indicated.

  OR
  - The chart has not been open for 30 days from the first ongoing outpatient appointment.

  OR
  - The individual has not received/engaged in ongoing outpatient services.
- **Paperwork reviewed**
  - Crisis plan
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Phone logs
  - Crisis system contact information

11. The crisis plan includes early warning signs of decompensation [NSMHA Policy 1551]

- **YES**
  - The crisis plan contains a section that describes clear signs (e.g., "triggers") by which the individual will recognize that they are experiencing a period of stress that either may lead to a crisis or has led to a crisis in their past.

  AND
  - The plan identifies how the individual will know the situation is escalating into a crisis (i.e., they are having difficulty diverting the crisis with early intervention strategies).
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has refused to participate in development of the plan and clinician does not have the information from another source).
- **Paperwork reviewed**
  - Crisis plan

12. **The crisis plan clearly defines a process by which to contact formal and/or informal supports including how to connect the individual/family directly to the emergency crisis intervention services** [NSMHA Policy 1551]
    - **YES**
        - The crisis plan includes the name and number of the mental health care provider (MHCP).

        AND
        - The crisis plan includes the telephone number of the Contractor's emergency crisis intervention services and that this service is available 24 hours a day.

        AND
        - The crisis plan includes names and telephone numbers of other formal and/or informal supports the individual has indicated they wish to contact during a crisis episode.

        AND
        - The crisis plan contains more than one listed contact (i.e., one more contact in addition to MHCP and crisis line) so that the individual has a back-up contact in the event that the first support they attempt to contact is unavailable.
    - **NA**
        - There is no crisis plan.

        OR
        - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).
    - **Paperwork reviewed**
        - Crisis plan

13. **The crisis plan focuses on individual health and safety** [NSMHA Policy 1551]
    - **YES**
        - The crisis plan identifies issues related to the individual's health and safety during times of crisis and includes recommendations for addressing identified issues. Examples of health and safety issues and potential recommendations:
            - Individual with a history of SA has access to weapons with a recommendation to ensure the weapons have been secured.
            - Individual has physical health issues requiring medication with a recommendation to ensure the individual has an adequate supply of needed medications.
            - The plan includes a list of places the individual can go to be safe and there is more than one safe place listed so that the individual has options.
    - **NA**
        - There is no crisis plan.

        OR
        - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

        OR

- Information for this section is not available (e.g., individual has declined to participate in development of the plan and clinician does not have the information from another source).

- **Paperwork reviewed**
  - Crisis plan

14. The crisis plan focuses on family/others health and safety [NSMHA Policy 1551]

- **YES**
  - The crisis plan identifies issues related to the individual's family members or other's health and safety during times of crisis for the individual and includes recommendations for addressing identified issues. Examples of health and safety issues and potential recommendations:
    - History of assaultive behavior with a recommendation not to see the individual alone during crisis or encourage individual to find a place to go where they can maintain safety.
    - Identification of issues that escalate the individual so that others know to stay away from those particular issues.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan or indicates no family/other safety considerations and clinician does not have the information from another source).
- **Paperwork reviewed**
  - Crisis plan

15. The crisis plan includes individual's roles, directives and responsibilities [NSMHA Policy 1551]

- **YES**
  - The crisis plan defines what the individual will do to prevent a crisis as well as what actions they will take during a crisis, including who they will contact.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan and clinician does not have the information from another source).

- **Paperwork reviewed**
- Crisis plan

16. The crisis plan includes family/other's roles, directives and responsibilities [NSMHA Policy 1551]

- **YES**
  - The crisis plan includes a plan defining what roles, responsibilities and actions the individual wishes family members and/or others (formal and informal supports) to take to prevent a crisis as well as during times of crisis for the individual.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan or indicates no family/other roles/directives/responsibilities for consideration and clinician does not have the information from another source).
- **Paperwork reviewed**
  - Crisis plan

17. The crisis plan includes proactive and progressive measures to divert or prevent crisis [NSMHA Policy 1551]

- **YES**
  - The crisis plan contains a section that details proactive steps identified as helpful to the individual in preventing a crisis and that will implemented if they feel that they are experiencing a situation that is causing them stress.

  AND
  - The plan addresses progressive measures that identify all viable less restrictive options for an individual/informal & formal supports to use once they perceive being in crisis. For example (in order from less to more restrictive), contact with informal supports, call clinician or office, call crisis line, consideration of crisis outreach, recommendation to use crisis beds before inpatient.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan and clinician does not have the information from another source).

- **Paperwork reviewed**
  - Crisis plan

18. The crisis plan includes the individual's voice [NSMHA Policy 1551]

- **YES**
  - The crisis plan contains evidence of the individual's voice as indicated by direct quotes from the individual regarding early warning signs, prevention and intervention strategies, and what people and systems they want involved.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - The individual has declined to participate in development of the crisis plan.
- **Paperwork reviewed**
  - Crisis plan

Recovery/Resiliency Plan

19. Goals/objectives for treatment are based upon identified mental health needs [WAC 388-877-0620(1i) & WAC 388-877A-0135(2)(4)]

- **YES**
  - Goals/objectives for treatment follow clearly from mental health needs identified either at intake or during the ongoing course of treatment.

  AND
  - The RRP is updated to reflect any changes (new needs and achievement of goals/objectives) in the individual's mental health treatment needs.

  AND
  - All identified mental health needs are addressed on the plan (i.e., need is addressed by identification of treatment goals/objectives/interventions, a documented referral or explanation of deferment).
- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Intake evaluation
  - Progress notes
  - Psychiatric notes

20. **The RRP addresses/supports the individual in meeting needs beyond their identified mental health needs (e.g., health care, substance use, daily activity needs appropriate to age and culture such as employment, education, etc)** [WAC 388-877A-0120(7) & WAC 388-877A-0170(1b); DSHS Contract 10.2.3 & 10.3.1 (PIHP) & NSMHA Policy 1551]
    - **YES**
      - Needs (other than mental health) identified either at intake or during the ongoing course of treatment are addressed on the plan (i.e., need is addressed by identification of treatment goals/objectives/interventions; and/or, a documented referral and, as appropriate, active assistance in linking to referral; or explanation of deferment). *Addressing need for a PCP reviewed in a separate standard, but goals/objectives/interventions related to ongoing care by PCP is addressed here.*

      AND
      - The RRP is updated to reflect any changes in the individual's needs (other than mental health).
      - If "NO", reviewer shall identify which of the following needs have not been addressed (more than one may be identified) – health care, substance use, developmental, employment, education, legal, housing, other (identify specific need not assessed).
    - **NA**
      - There is no RRP.

      OR
      - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

      OR
      - The individual indicates no identified needs beyond mental health needs.
    - **Paperwork reviewed**
      - Recovery/Resiliency Plan (RRP)
      - RRP Review
      - Intake evaluation
      - Progress notes
      - Psychiatric notes
      - Psychiatric notes

21. **If during the intake the individual reports having no PCP, a referral to a PCP is subsequently offered and facilitated** [WAC 388-877A-0120(7); DSHS Contract 10.3.1 (PIHP); Washington State Department of Health EPSDT; NSMHA per QMOC recommendation post Mortality Review]
    - **YES**
        - Documentation indicates that the individual either was asked or self-reported at intake that they currently do not have a PCP and was offered a list of PCPs/clinics within 30 days of the individual's first ongoing outpatient appointment.

        AND
        - For children/adolescents (20 and under) on Medicaid who have a PCP, but have not seen that PCP in the past two years, documentation in the clinical record indicates the provider has encouraged the individual/family to make an appointment with the PCP.

        AND
        - When clinically appropriate, active assistance with linking to the referral is provided.

        AND
        - Status of obtaining a PCP or, for individuals 20 and under, making an appointment is reviewed at a minimum of every 6 months until the individual has obtained a PCP or, for individuals 20 and under, made an appointment.
    - **NA**
        - Documentation indicates that the individual was either asked or self-reported that they currently have a PCP or, for children/adolescents 20 and under on Medicaid, have seen a PCP in the past two years.

        OR
        - The individual has not been in services for more than 30 days from the first ongoing outpatient appointment.

        OR
        - The individual has not received/engaged in ongoing services.

        OR
        - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
    - **Paperwork reviewed**
        - Intake evaluation
        - Health Screening Questionnaire
        - Recovery/Resiliency Plan (RRP)
        - Progress notes

22. **The RRP includes goals or objectives that allow the provider and individual to evaluate progress toward the individual's recovery goals/discharge from treatment** [WAC 388-877-0620(1h); NSMHA Policies 1540 &1551]
    - **YES**
        - The RRP identifies goals/objectives that, once achieved, indicate the end of the treatment episode.

        AND

- The goals or objectives listed in the RRP are measurable. They allow the individual and provider to evaluate & document progress towards the individual's recovery goals.

- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).
- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)

23. The RRP is individualized and developed collaboratively with the individual, the individual's parent/other legal representative as applicable, and significant others as requested by the individual [WAC 388-877-0620(1c-f) & WAC 388-877A-0135(3)(6)]

- **YES**
  - The RRP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with).

  AND
  - The RRP was developed collaboratively with the individual and/or their legal representative as evidenced by the individual's/legal representative's signature on the RRP and/or quotes from the individual and/or legal representative documented in the RRP.

  AND
  - Family or significant others are included in the development of the RRP as requested by the individual; or, the provider has inquired, but the individual is 13 years of age or older and declines to include family or significant others in development of their RRP.

  AND
  - The RRP is individualized and includes at least one goal/objective identified by the individual or their legal representative, if applicable.
- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).
- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)

24. With the individual's consent, or their parent or other legal representative if applicable, as allowed by confidentiality rules, or when required, the RRP includes coordination with any provider, system, or support the individual identifies as being relevant to their treatment [WAC 388-877A-0135(5)]

- **YES**
  - The names of other providers, systems, supports are documented in the individual's clinical record *OR* documentation that information was requested and not provided.

  AND
  - When needs beyond the scope of mental health services are identified (whether at initiation of treatment or later in the treatment episode), documented attempts are made to obtain a Release of Information (ROI) for the relevant provider, system, support.

  AND
  - Inclusion of coordination objectives/interventions with any provider, system, or support identified as being relevant to treatment when required, allowed by confidentiality rules, or to which the individual has consented.
    - Examples of coordination may include ***but are not limited to*** coordination with:
      - Individualized family service plan (IFSP) when serving children under three (3) years of age
      - Education system for children especially those who are on IEPs (Individualized Education Programs)
      - Children's Administration
      - Department of Corrections
      - PCP, other health care providers
      - Substance use treatment provider
      - Individual's church
      - Family, friends

  AND
  - Plan identifies the role of each relevant provider, system, support and the frequency of planned contact.
  - If "NO", reviewer shall identify which of the following categories of provider/system/support have not been included (more than one may be identified) – health care, substance use, employment, education, legal, housing, developmental, socialization, other (identify specific need not assessed). In addition to identifying the category, the reviewer shall identify the specific provider/system/support (e.g., Evergreen, Housing Authority, mom).
- **NA**
  - There is no indication that the individual or their parent or other legal representative, has consented to or requested coordination with any system or organization or identified any such system or organization as being relevant to their treatment and there is no indication that coordination is allowed by confidentiality rules or otherwise required.

  OR
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - Crisis plan
  - Collateral records
  - Intake evaluation
  - Progress notes

25. **The treatment proposed/provided is medically necessary and consistent with NSMHA clinical guidelines. (Note: In the absence of a NSMHA clinical guideline, generally accepted clinical practice for the individual's diagnosis)** [WAC 388-865-0280(2)(h); DSHS Contract 5.4.1.1 & 7.7 (PIHP)/9.1.1.3 (SMHC); NSMHA Clinical Guidelines]
    - **YES**
      - The RRP identifies state plan, medically necessary service modalities (i.e., the interventions are deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention and any other formal or informal system or support cannot address the individual's unmet needs).

      AND
      - Documentation reflects treatment consistent with generally accepted clinical practice as evidenced by provision of treatment that is consistent with either established NSMHA clinical guidelines or with generally accepted clinical practice guidelines such as those outlined by the American Psychiatric Association (APA) and the American Academy of Child & Adolescent Psychiatry (AACAP) *OR* there is a rationale why treatment is not consistent with NSMHA clinical guidelines or with generally accepted clinical practice.
        - See NSMHA Clinical Guidelines Core Elements (attached in addendum) for minimum expectations.
    - **NA**
      - There is no RRP OR the RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

      AND
      - The individual has not received/engaged in ongoing services.
    - **Paperwork reviewed**
      - Recovery/Resiliency Plan (RRP)
      - RRP Review
      - Intake evaluation
      - Progress notes
      - Psychiatric notes

26. The RRP is strengths-based [WAC 388-877-0620(1b) & WAC 388-877A-0135(2); NSMHA Clinical Guidelines – Guidelines to Person-Centered Recovery & Resiliency]

- **YES**
  - The clinical record documents specific strengths/resources/assets of the individual/family that can be used in the course of treatment/recovery.

  AND
  - The RRP focuses on what the individual will do and not what they won't do. Specific strengths/resources/assets (capacities, resiliencies, talents, coping abilities, supports) of the individual/family are incorporated into the objectives and interventions of the RRP to assist them in attaining their recovery goals (i.e., incorporation of strengths means more than listing the strengths on the RRP).
    - General examples of strengths that may be incorporated:
      - Interests, hobbies, talents (what types of prosocial activities/interests does the individual have, what does the individual do with leisure time; e.g., writing, music, fishing, bicycling, baseball, etc)
      - Capacities, resiliencies, coping abilities (what does the individual think they are good at naturally, what skills have they learned; e.g., good organizational skills, thinks positively, likes helping others, has knowledge about own mental health concerns, knows some strategies for managing mental health symptoms, etc)
      - Support systems (e.g., family, friends, school, church, AA, Big Brother/Big Sister, Girl/Boy Scouts, etc)
      - Life roles (what life roles does the individual have currently in life and feel that they are good at/enjoy; e.g., parent, spouse, son/daughter, friend, student, employee, etc.)
    - Strengths shall be incorporated in a way that demonstrates they are actively used to support the individual in treatment (i.e., the strengths and how they are used may be identified in various places on the RRP, but need to demonstrate their active use to support the individual's resiliency and recovery).
    - See addendum "Strength-Based Recovery/Resiliency Plan Examples" for specific examples of incorporating strengths into the RRP.
  - If "NO" due to no strengths to use in treatment were identified in the clinical record, reviewer shall:
    - Identify that strengths to use in treatment need to be identified and include possible strengths the reviewer may have noted in the chart.
  - If "NO" due to strengths identified not being actively incorporated into the RRP, reviewer shall:
    - Identify the strengths that were identified to use in treatment, but not actively incorporated.
- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Crisis plan
  - Intake evaluation
  - Progress notes
  - Psychiatric notes

27. **The RRP addresses age, cultural or disability issues identified by the individual or their parent or other legal representative, if applicable, as relevant to treatment** [WAC 388-877-0620(1b); NSMHA Clinical Guideline – Guidelines to Person-Centered Recovery and Resiliency]
    - **YES**
      - The RRP addresses age, cultural and/or disability issues relevant to treatment.
        - As defined in WAC 388-865-0150, a disability is defined as a developmental disability, serious physical handicap, or sensory impairment.
        - Culture should be expanded beyond ethnicity. Examples of cultural issues to consider beyond ethnicity include family of origin, socioeconomic status, language, gender, housing status, family roles, religion, education, geographic, trauma, addictive behavior, general life style, etc. Please note that these are examples. It is not a review expectation that all of these issues are addressed for all individuals.
        - Specific examples of age, cultural and disability issues that may be relevant to mental health treatment:
          - Single parent who feels the stress of parenting is exacerbating their depression.
          - Youth about to transition from middle school to high school says that their existing anxiety disorder is much worse as they get closer to starting at the new school.
          - Individual who, because of a developmental disability, has increased difficulty acknowledging or discussing mental health concerns.
          - Female, seeking treatment for a traumatic event, who is willing but wary of working with a male clinician due to the trauma history.
          - Individual with current co-morbid issue of substance abuse that is significantly impacting mental health issue and who is engaged with AA, but is unwilling to consider other substance treatment options.
          - Youth who indicates parent/caretaker's substance use/abuse and treatment is impacting his mental health.
    - **NA**
      - There are no identified age, cultural or disability issues relevant to treatment.

      OR
      - There is no RRP.

      OR

- The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan
  - RRP Review
  - Consultation notes
  - Intake evaluation
  - Progress notes
  - Psychiatric notes

Ongoing Assessment/Status Updates

28. The current Level of Care assigned appears consistent with the documentation [NSMHA Policy 1565]

- **YES**
  - There is a current CA/LOCUS.

  AND
  - The current CA/LOCUS appears to be accurately scored per the documentation provided at the time.

  AND
  - The identified Level of Care corresponds with CA/LOCUS scoring or there is a rationale for the recommended Level of Care if different from what the CA/LOCUS tool identifies.
- **NA**
  - CA/LOCUS from intake is still current (i.e., no clinically significant events or minimum period, at least annually for Level of Care 1 & 2 and minimum of every 6 months for Level of Care 3 and up, of time requiring completion of a new CA/LOCUS).

29. The determination of eligibility for continued stay is consistent with NSMHA Clinical Eligibility and Care Standards (CECS) [WAC 388-877; DSHS Contract 5.2.3 (PIHP)/9.1 & 9.2; NSMHA Policies 1539, 1540 &1556]

- **YES**
  - Documentation supports that the individual qualifies for ongoing services per NSMHA continued stay criteria and is not appropriate for discharge as evidenced by:
    - Individual continues to meet Access to Care Standards.
    - Services continue to meet medical necessity criteria:
      - The individual's impairment and corresponding need(s) are the result of a covered mental illness.
      - Intervention is deemed reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the covered mental illness.
      - The individual is expected to benefit from the intervention.

- The individual's unmet need(s) would not be more appropriately met by any other formal or informal system or support.
- The individual's documented RRP goals/objectives have not been substantially met.

AND/OR one or more of the following:

- Individual is engaged in a transition to discharge plan (i.e., the individual is expected to discharge within the next 90 days).
- Although the individual's functioning has improved to the point of appearing appropriate for discharge (per GAF/CGAS, CA/LOCUS, CANS, etc), continued treatment is deemed medically necessary to prevent deterioration as evidenced by previously documented, unsuccessful efforts at discharge.
- Although individual's functioning has improved, they have needs, which cannot be met by any other system or resource and, if unmet, would result in deterioration of functioning and likely re-admisstion.
- The individual has a current Conditional Release or Less Restrictive Court Order (CR/LR).

AND

- Rationale for continued stay includes an evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods and/or intensity of services as applicable.

- **NA**
  - Individual has not been in services long enough to be reviewed for continued stay.
- **Paperwork reviewed**
  - CA/LOCUS
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Crisis Plan
  - Phone logs
  - Progress notes
  - Psychiatric notes

30. **There is sufficient evidence to support the most recent diagnosis, including provisional diagnoses, identified in the clinical record** [WAC 388-877-0640 & WAC 388-877A-0120)
    - **YES**
      - The clinical record contains description of DSM-IV TR (or DSM-5 once implemented) criteria in sufficient detail to validate the most recent diagnosis, including any assigned provisional diagnoses.

      AND
      - Any diagnostic changes are clearly noted.

      AND
      - Any discrepancies in the documentation regarding diagnoses have been addressed.
    - **NA**
      - Not used with this standard.

- **Paperwork reviewed**
  - Intake evaluation
  - Collateral records
  - Diagnosis change forms
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - RRP Review

Treatment Provision

31. **The treatment (types of services and interventions) identified on the RRP has been implemented** [WAC 388-865-0225(2); 388-865-0320(4); 388-877A-0170(1)]
    - **YES**
      - Documentation in the chart indicates that treatment strategies identified on the RRP have been implemented during the course of treatment.

      OR
      - There is an adequate explanation, with noted individual agreement, describing why identified treatment strategies have not been implemented and are being deferred currently.
    - **NA**
      - There is no RRP.

      OR
      - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

      OR
      - The individual has not received/engaged in ongoing treatment services.
    - **Paperwork reviewed**
      - Progress notes
      - Recovery/Resiliency Plan (RRP)
      - RRP Review
      - Psychiatric notes
      - Consultation notes

32. The clinical record contains documentation of objective progress toward established goals on the RRP [WAC 388-877-0640(6)(b)]

- **YES**
  - Progress notes reflect that RRP goals are routinely addressed.

  AND
  - Progress notes document specific examples of the individual's response to treatment/objective progress toward goals established in their RRP (for example, the progress toward the goal as documented in the chart can be compared to the measurable goal on the RRP as evidenced by "x" to determine progress) *OR* if a particular goal in the individual's RRP is being deferred, there is an explanation as to why it is currently being deferred, including noted agreement by the individual for the goal to be deferred at present.

  AND
  - Progress notes identify immediate, next steps toward achievement of RRP goals/objectives.
- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - The individual has not received/engaged in ongoing treatment services.
- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Progress notes
  - Psychiatric notes
  - CA/LOCUS

33. The clinical record reflects intensity and frequency of interventions that correspond with the individual's needs, severity of symptoms, and Level of Care and vary over time as appropriate [WAC 388-865-0320; DSHS Contract 5.4.2 (PIHP)]

- **YES**
  - The clinical record documents that the frequency and intensity of interventions provided correspond with the individual's needs, severity of symptoms, and Level of Care over the course of treatment (i.e., individuals are not overserved or underserved). Examples of evidence that frequency and intensity of services is based on needs may include, but are not limited to:
    - In general, the hours of outpatient service the individual receives are within the ranges detailed in the NSMHA Utilization Guidelines for the individual's Level of Care (LOC)
      - LOC 1: 1-10 hours/year
      - LOC 2: 11-30 hours/year

- LOC 3: 31-60 hours/year
- LOC 4 & up: 60+ hours/year
- For more information on Utilization Guidelines see NSMHA Policy 1565.01 for child and adolescent guidelines & NSMHA Policy 1565.02 for adult and older adult guidelines. Please note that these are guidelines and that some individuals will fall outside the range of hours, above or below, for their identified LOC.

▪ Progress notes and RRP, as applicable, document changes to frequency and intensity of interventions when an individual's needs increase or decrease (this could be a short-term or longer-term change). Examples:
- Provision of more intense/frequent service hours to LOC 1 or 2 with plan to complete treatment & discharge in less than a year (e.g., LOC 1 seen 2x/month with completion of treatment in 4 months)
- Provision of more intense/frequent service hours when individual experiences decompensation
- Titration of med monitoring as individual demonstrates increased independence in taking meds
- Over the course of treatment, as goals are achieved, documentation addresses titration of services and increased use of natural supports and community resources to transition the individual to discharge.

- **NA**
  - The individual has not engaged in ongoing treatment services. Scoring of provider re-engagement efforts for individuals who cancel or no-show should be completed under #34. Individuals not receiving services due to provider reasons should be scored here.
- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Progress notes
  - Psychiatric notes
  - CA/LOCUS

34. If the individual has repeated cancellations and/or "No Shows", there is evidence that the intensity of the efforts to re-engage the individual were congruent with the individual's identified need/risk [NSMHA; WAC 388-865-0320; DSHS Contract 5.4.1.1]

- **YES**
  - There is documentation that the individual has repeated cancellations and/or "No Shows" and that the intensity of the efforts by the mental health staff to re-engage the individual were congruent with the individual's identified need/risk*.
    ▪ When considering risk and need, the following information may be helpful:
    - CA/LOCUS composite and dimension scores
    - Assessment of protective factors that mitigate the impact of the risk factors (e.g., other system involvement, strong natural supports, low stress environment)
    - Guidelines for re-engagement efforts based on need/risk. *These guidelines are meant to provide some direction when determining what type of re-engagement efforts to utilize and represent more of a minimum standard. These guidelines should not replace a clinician's clinical judgment in determining re-engagement efforts.*

  - Individuals at Level of Care 3 and above receive a re-engagement letter at minimum.
  - Individuals at Levels of Care below 3 with moderate risk or transition needs (e.g., transfer of medications, development of community supports) receive a re-engagement letter at minimum.
  - Individuals with more serious risk or transition needs receive more intensive re-engagement efforts such as attempts to contact the individual and/or natural supports, as allowable, by phone and/or in person.
  - If it appears that a home visit may have been warranted, but safety or privacy are potential issues, there is a documented rationale for not conducting a home visit and documentation that other types of re-engagement efforts have been utilized.
- **If appropriate re-engagement efforts have been made, but the episode of care has not yet closed, there should be a rationale for why the episode of care is still open. Otherwise, mark the standard as "No" with comment that the chart should be closed or rationale provided as to why the episode of care needs to remain open.* **NA**
  - There is no documentation that the individual has repeated cancellations and/or "No Shows".
- **Paperwork reviewed**
  - Progress notes
  - Phone logs
  - Re-engagement letters or other correspondence to the individual

35. **The clinical record contains documentation of coordination with the individual's current external health care provider(s)** [WAC 388-877-0640(12, 14-17); NSMHA Policy 1517]
- **YES**
  - As allowed (ROI, confidentiality rules, required), the mental health clinician has contacted the external health care provider(s), minimally, when:
    - The individual initiates care with the mental health agency.
    - The mental health agency begins prescribing medication for the individual.
    - There are changes in medication, prescribed by the mental health agency that may impact health care.
    - There are changes in the individual's clinical condition that potentially impact his/her external health care.
  - If the individual declines to provide information regarding external health care providers, indicates they do not have any external health care providers, refuses to sign an ROI for external health care providers and/or indicates they do not have any external health care needs, there is documentation that the clinician inquired again, at a minimum, every six months.
- **NA**
  - Information is unavailable as the individual has not received/engaged in ongoing services.

  OR
  - The individual indicates they do not have any external health care providers.

  OR
  - No external health care needs have been identified.

  OR

- The individual has refused to sign an ROI to facilitate care coordination.

- **Paperwork reviewed**
  - Health Screening Questionnaire
  - Intake evaluation
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Progress notes
  - Phone logs

36. **With the individual's consent, or their parent or other legal representative if applicable, as allowed by confidentiality rules, or when required, the clinical record documents ongoing coordination with any provider, system, or support the individual identifies as being relevant to their treatment** [WAC 388-877-0640(12, 16-17)]

- **YES** (coordination with healthcare providers reviewed separately)
  - As allowed (ROI, confidentiality rules, required), the mental health clinician has contacted the other provider/system/support minimally, when:
    - The individual initiates care with the mental health agency.
    - There are changes in the individual's clinical condition and/or care that potentially impact the individual.
  - If the individual declines to provide information regarding other involved provider/system/support, indicates they do not have any involved provider/system/support, refuses to sign an ROI, and/or indicates they do not have any needs other than mental health, there is documentation that the clinician inquired again, at a minimum, every six months.
  - If "NO", reviewer shall identify which of the following categories of provider/system/support that do not have documented coordination (more than one may be identified) – health care, substance use, employment, education, legal, housing, developmental, socialization, other (identify specific need not assessed). In addition to identifying the category, the reviewer shall identify the specific provider/system/support (e.g., Evergreen, Housing Authority, mom).
- **NA**
  - Information is unavailable as the individual has not received/engaged in ongoing services.

  OR
  - The individual indicates they do not have any other provider/system/support.

  OR
  - No related needs have been identified.

  OR
  - The individual has refused to sign an ROI to facilitate care coordination.

- **Paperwork reviewed**
  - Health Screening Questionnaire
  - Intake evaluation

- Recovery/Resiliency Plan (RRP)
- RRP Review
- Progress notes
- Phone logs

Medication Services

37. Referral for medication evaluation is provided when clinically indicated [WAC 388-877A-0135; DSHS Contract 13.3 (PIHP)]

- **YES**
  - Documentation indicates that referral for a medication evaluation is provided when clinically indicated for the individual. Clinically indicated is defined with the PIP Decision Tree and Target Symptoms list and NSMHA Clinical Guidelines Core Elements list.

  OR
  - There is an explanation regarding why the referral for medication evaluation is being deferred.
- **NA**
  - Documentation reviewed does not indicate any need for a medication evaluation.

  OR
  - The individual has not received/engaged in ongoing outpatient services.
- **Paperwork reviewed**
  - Intake evaluation
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Progress notes
  - Psychiatric notes
  - Referral form

38. If prescribed by agency staff, the intensity of medication monitoring is sufficient to meet the individual's need [WAC 388-877A-0180(5)]

- **YES**
  - Documentation indicates medications are monitored appropriately, either on a routine basis or on an "as needed" basis (i.e., the individual has had recent medication needs, such as readjustment, renewal, change, cancellation, expressed medications aren't working, etc).
- **NA**
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Psychiatric notes
  - Progress notes

- Recovery/Resiliency Plan (RRP)
- RRP Review (180-day Review
- Hospital discharge records
- Court documents such as LRO or CRO paperwork
- LRO Monitoring Report

39. The clinical record contains both the name and purpose of the medication prescribed [WAC 388-877A-0180(8cii)]

- **YES**
  - The clinical record contains both the name and purpose of the medication prescribed.
- **NA**
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Psychiatric notes
  - Medication log

40. The clinical record contains the prescribing authority's reason for changing or stopping the medication [WAC 388-877A-0180(8cv)]

- **YES**
  - The clinical record contains the prescribing authority's reasons for changing or stopping the medication.
- **NA**
  - The medications prescribed have not been changed or stopped.
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Psychiatric notes

41. The clinical record includes documentation of the medications' effects, interactions, and side effects staff observe or individual reports spontaneously or as a result of questions from staff [WAC 388-877A-0180(8b)]

- **YES**
  - Documentation includes information regarding the effects, interactions and side effects of each prescribed medication as observed by staff or reported by the individual OR as requested by staff when not observed by staff or reported by the individual.

AND

  - Documentation of effects, interactions and side effects of CMHA-prescribed medication occurs, at a minimum, at each medication management appointment with the prescriber. More frequent documentation may be warranted (e.g., newly prescribed medication or dosage, history of not adhering to the medication plan).

AND

- When negative effects, interactions and side effects are noted, there is documentation that the issue was reviewed by the prescriber and outcome of the review (e.g., continue/discontinue medication, change dosage).

- **NA**
  - The individual is not prescribed medication by agency staff.

  OR
  - The individual has only had the initial medication appointment and there have been no subsequent appointments (medication or otherwise) to note medication effects, interactions, side effects.
- **Paperwork reviewed**
  - Progress notes
  - Psychiatric notes

42. There is a delineation of psychiatric and non-psychiatric medications [WAC 388-877-0640(14); NSMHA per QMOC recommendation post Mortality Review]

- **YES**
  - The clinical record documents both the psychiatric and the non-psychiatric medication the individual is taking.
- **NA**
  - The individual is not taking both psychiatric and non-psychiatric medications.

  OR
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - Health Screening Questionnaire

43. The clinical record documents consideration/efforts of transfer of medication management responsibility to primary care providers when appropriate [NSMHA Policy 1546]

- **YES**
  - One of the following:
    - The individual is on a stable medication regimen and there is no longer medical necessity for the specialty care of mental health medication management services at a CMHA. A stable medication regimen includes:
      - No medication changes for a minimum of 6 months for individuals with a complex medication regimen (includes but is not limited to two or more psychiatric medications in the same class or three or more psychiatric medications total) or individuals who have multiple psychiatric diagnoses requiring mental health specialty medication expertise.
      - No medication changes for a minimum of 3 months for individuals without a complex medication regimen.

OR
- The PCP makes changes to medications currently prescribed by the CMHA and will not agree to stop making changes to those medications despite potential risk to the consumer.

OR
- The individual requests transfer of medication management services to the PCP.

AND
- There are documented efforts to facilitate transfer (i.e., work with existing PCP or locate a PCP willing to prescribe).

- **NA**
  - The individual is not prescribed medication by agency staff.

  OR
  - The individual is not on a stable medication regimen.

  OR
  - PCP is not making changes to medications prescribed by the CMHA.

  OR
  - The individual has not requested transfer.
- **Paperwork reviewed**
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - Health Screening Questionnaire

44. The clinical record documents a coordinated transfer of medication management responsibility to primary care providers
[NSMHA Policy 1546]

- **YES**
  - Documentation of the rationale for referring or transferring the individual to a PCP.

  AND
  - Documentation that the clinician and/or prescriber have discussed medication management transfer with the consumer.

  AND
  - With consent of the consumer, contacted the PCP regarding transfer OR, if the individual is not in agreement with a transfer, the clinician and/or prescriber have made efforts to locate a PCP willing to accept medication management responsibilities (i.e., PCPs have been contacted about the possibility of managing a particular medication regimen without specific information about the individual).

  AND
  - Documentation that PCP has agreed to referral/transfer of the individual for medication management.

  AND

- As allowed by confidentiality rules or an ROI, necessary psychiatric and medication records are sent to the PCP prior to transfer.

AND

- Individual's treatment episode at the CMHA remains open long enough after transfer to ensure successful transfer.

AND

- Written plan outlining what happens if the individual becomes unstable on medications and/or PCP believes it would be better for the mental health specialist prescriber to consult or resume medication management.

- **NA**
  - The individual is not prescribed medication by agency staff.

  OR
  - Medication management responsibility has not been transferred to a primary care provider.
- **Paperwork reviewed**
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - Health Screening Questionnaire

Miscellaneous

45. **If there is an indication that abuse, neglect or exploitation is suspected or evident, there is documentation in the chart that this was reported to the appropriate authorities** [WAC 388-877-0640(9)]
    - **YES**
      - Documentation in the chart that abuse, neglect or exploitation of the individual is suspected or evident and it has been reported to the appropriate authorities as required by mandatory reporting requirements.
    - **NA**
      - There is no documentation in the chart that abuse, neglect or exploitation of the individual is suspected or evident that would require a mandated report.
    - **Paperwork reviewed**
      - Access call sheet
      - Intake evaluation
      - Progress notes
      - Psychiatric notes
      - Phone logs

ADDENDUM

Core Elements

Recovery/Resiliency Planning Examples

Crisis Planning Examples

Core Elements

Adult Anxiety Disorders

- There is some form of cognitive behavioral therapy to address anxiety.
- There is an attempt at medication management. If the consumer has a history of substance abuse, then non-sedative medications should be tried first.

Adult ADHD

- Screen for co morbid substance abuse.
- Alternatives to stimulants are tried first such as Strattera, Wellbutrin, and Effexor.
- If Stimulants are used, then there are efforts to monitor for Substance Abuse and diversion of medication to family and peers.

Adult Bipolar Disorder

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania or depression

Adult Borderline Personality

- The treatment team has established a method to discourage self-injury.
- Use of DBT informed therapy or documentation that it was considered with rationale for not providing DBT informed therapy.

Adult Co-occurring Disorders

- The MH provider must coordinate care with substance abuse provider

Adult Dissociative Disorder

- There is a form of psychotherapy which is focused on integration of personality.

Adult Eating Disorders

- There is some form of cognitive behavioral therapy to address distorted body image.
- There is coordination with a medical provider who is monitoring weight and nutrition.
- Failure of intensive outpatient treatment is required before considering higher levels of care.

Adult Major Depressive Disorder

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Adult Neurocognitive Disorder (Dementia)

- *This group demonstrates behaviors that are aggressive, psychotic or depressed.* Care should be coordinated with primary care givers and PCP.
- Efforts should be made to establish a baseline of behaviors, exploring any environmental triggers and medications should be reviewed.

Adult Obsessive Compulsive Disorder

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors.
- Trial of medication has been attempted with SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

Adult Schizophrenia

- An anti-psychotic medication is being used or there is documentation that it was considered with the rationale for not prescribing
- The clinician/case manager is monitoring whether or not the consumer is agreeing to take prescribed psychiatric medications

Adult Trauma Disorders

- The focus of therapy (group or individual) is on resolving the trauma, through use of cognitive behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered.

Adult Suicidal Behaviors

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of risk (provides a clinical opinion), based on the risk & protective factors, and assigns a level of risk
- The RRP reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

Child & Youth Anxiety Disorders

- There is some form of cognitive behavioral therapy to address anxiety.
- There is an attempt at medication management. If the consumer has a history of substance abuse, then non-sedative medications should be tried first.

Child & Youth ADHD

- Patient management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered.
- There are documented efforts at school accommodations or there is documentation that it was considered with a rationale why it is not being offered.
- A psycho-stimulant has been tried or there is documentation that it was considered with a rationale for not prescribing.

Child & Youth Bipolar Disorder

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania or depression

Child & Youth Conduct Disorder

- Patient management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered.

- The treatment providers are not allowing or supporting efforts for the client to avoid consequences (legal or other consequences) for violating the rights of others.

Child & Youth Co-occurring Disorders

- The MH provider must coordinate care with substance abuse provider

Child & Youth Dissociative Disorder

- There is a form of psychotherapy which is focused on integration of personality.

Child & Youth Eating Disorders

- There is some form of cognitive behavioral therapy to address distorted body image.
- There is coordination with a medical provider who is monitoring weight and nutrition.
- Failure of intensive outpatient treatment is required before considering higher levels of care.

Child & Youth Major Depressive Disorder

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Child & Youth Obsessive Compulsive Disorder

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors.
- Trial of medication has been attempted with SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

Child & Youth Psychotic Disorders

- An anti-psychotic medication is being used or there is documentation that it was considered with rationale for not prescribing.
- There has been an exhaustive effort to rule out organic causes of the psychosis such as medical disorders, metabolic disorders, infection, brain injury & drug intoxication or withdrawal.
- If the child is 13 or younger, then there is documentation of consideration if psychotic symptoms related to malingering, attention seeking, misperception, suggestion from caregivers or cultural issues such as religion or other family beliefs.

Child & Youth Trauma Disorders

- The focus of therapy (group or individual) is on resolving the trauma, through use of cognitive behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered.

Child & Youth Suicidal Behaviors

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of risk (provides a clinical opinion), based on the risk & protective factors, and assigns a level of risk
- The RRP reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

RECOVERY/RESILIENCY PLAN EXAMPLES			
Goal	**Strength(s)**	**Objective**	**Intervention(s)**
"I want to understand what's going on with me."	"I like to write. I can write about what's going on with me to try and understand it."	By 2/1/11, Joe will be able to describe at least 5 signs of anxiety.	By 1/1/11 Joe will obtain a notebook and make a daily entry describing any anxiety he may have experienced that day. Clinician and Joe will discuss journal entries at individual psychotherapy once every 2 weeks.
"I want to feel less worried and tense all the time."	"Playing the guitar is one thing that helps me relax and de-stress."	By 2/1/11 Jane will be able to effectively use at least 3 coping skills to manage feelings of stress.	Jane will play her guitar for 30 minutes whenever she is feeling stressed. Clinician and Jane will identify 2 additional stress management strategies by 12/1/10.
"I want to be more comfortable around people and feel less lonely."	"I go to church regularly."	Joe will report increased comfort with socializing from 3 to 6 (1-10 scale).	Clinician and Joe will role play having conversations with acquaintances at church at weekly psychotherapy. Joe will initiate a conversation with at least two individuals at church each week by 2/1/11.
"I want to get sober."	"I used to go to AA and thought it was helpful."	"I think I should go to AA meetings three times a week starting next week (2/1/11)."	Clinician will assist Jane in locating an AA meeting near her home. Clinician and Jane will discuss the impact of these meetings on Jane's sobriety at weekly case management appointments.
"I've gained 20 lbs since I started this medication. I want to lose some weight."	"I know my medication helps me and I want to stay on it. Also, I'm a great cook and would like to start a vegetable garden."	Joe will create weekly healthy meal plan.	Joe will discuss concerns about weight gain caused by medication with prescriber at each prescriber appointment. Joe will meet with PCP to discuss weight loss goal and plan by 1/15/11. Clinician will assist Joe in developing meal plans & shopping lists at weekly case

"I want to have friends."	"I'm a good baseball player."	Joey will join Parks & Recreation T-Ball league.	Joey's mom will contact Parks & Recreation by 2/1/11 to sign Joey up for T-Ball. Clinician and Joey/family will talk about excitement and worries of joining baseball at twice monthly psychotherapy appointments.
"I want to feel happy."	"I feel happy when I have a good time with my mom and dad."	Janey and her parents will identify activities they like to do together.	Clinician and Janey/family will develop a family activity schedule by 5/1/11.

Crisis Planning Examples

As with Recovery/Resiliency Plans, each individual has different strengths, needs, interests and skills, and plans need to be tailored to the unique needs of each individual.

The following examples from charts we have recently reviewed within the region, demonstrate how the questions can be answered in a way that meets the intent of having a plan that is easy to follow and assists individuals to avert crises and assist in the event they face a crisis.

If an individual is having difficulty completing the crisis plan or is refusing to complete a plan when it is required or clinically indicated, the clinician should assist in completing as thorough a crisis plan as possible based on the clinician's knowledge of the individual (i.e., the clinician should complete as much of the consumer crisis plan as possible).

What are some day-to-day choices you can make to reduce your risk of having a crisis?

- "Go for a bike ride; spend time with friends and family; go to the YMCA; get enough sleep"
- "Make sure to take my meds; meet people and have social interactions; go for walks; don't isolate; stay active"
- "Listen to music and dance; read a book; take baths; check my mail"
- "Keep my appointments with my clinician; spend time with my cat; keep up a daily routine"

What are the early warning signs you need support from others?

- "When I get angry; lack of sleep; blackness under my eyes; when I yell"
- "If I stop doing things with my family; if I don't stay active; negative thoughts or not feeling well; feeling paranoid; not focusing on healthy relationships"
- "Asking lots of questions; running around barefoot outside; negative thoughts/bad feelings towards people"
- "I get grumpy, edgy; I don't want to leave the house; I stop answering the phone or the door"

If you are feeling stressed, what are some of the actions you can take to feel better?

- "First I'll try: Writing in my journal; if that doesn't work then I'll try listening to music. Then I'll try a TV show. Then I'll call my clinician at (xxx)xxx-xxxx"
- "First I'll try: talking to my parents; if that doesn't work then I'll try: focusing on something different, maybe a walk. Then I'll try calling my clinician at (xxx)xxx-xxxx"
- "First I'll try: Talking to my roommate; if that doesn't work then I'll try: going for a bike ride. Then I'll call my clinician at (xxx)xxx-xxxx"
- "First I'll try: calling my friend; if that doesn't work then I'll try: playing with my dog. Then I'll try breathing exercises. Then I'll call my clinician at (xxx)xxx-xxxx"

How could family members or friends best assist you during a time of crisis?

- "Just talking to my mom sometimes helps. She can help me keep my hopes up."
- "Offer suggestions of something to do. Involve me in a discussion. Visit or call me. They could call my clinician for me."
- "Call me and tell me it's going to be ok"
- "Take me out of the house to distract me. Go for a walk. Maybe watch a movie or something with me. It helps when I stay with a friend when I'm feeling down, or if they stay at my place with me."

What recommendations do you have about how mental health staff and crisis response professionals can best support you if you experience a crisis?

- "Help me get a quick appointment to get my meds checked. Talk calmly to me so that I'm not scared. They can help me contact my clinician who knows me."
- "Help me do breathing exercises and then help me call my family to come stay with me."
- "If I ask you, tell me I'm not evil. Help me list the things that are positive about me like I take good care of my animals and I'm a good friend."
- "Sometimes I forget to take my meds. You should check with me on that. I might need to stay at the crisis beds a couple of days while I get the meds back in my system."

What safety or health concerns do you want mental health staff to know about if you are in crisis?

- "Diabetes, insulin dependent"
- "I'm allergic to Prozac and have had a bad experience on Lithium and got sick"
- "I have a cat at home that needs to be taken care of. My mom will watch her if I need help."
- "My parents need to be notified if I go to the hospital so they don't worry about where I am"

Clinician Addendum to the Crisis Plan

The clinician addendum to the client's crisis plan is the place to identify additional issues and recommendations that may be helpful to other mental health staff/crisis response professionals if they have contact with the individual (i.e., provide information that is useful to other staff/professionals who do not know the individual so that they may intervene most effectively). It is helpful to note significant details of mental health history, signs/symptoms of decompensation, co-morbid and safety issues, activities/skills/supports the individual has utilized previously to divert a crisis, recommendations for several crisis intervention strategies from least to most restrictive.

Examples - Recommendations/Intervention strategies

"2 short-term hospitalizations, 1 voluntary, 1 involuntary. Hx of not taking meds due to disorganization, not refusal. Parents are good natural supports. Encourage contacting parents. Encourage activity such as walking. Encourage taking PRNs . Consult with Dr. X for possible med changes needed. Assess for need for crisis bed. Consult with MHP for possible DMHP evaluation."

"Individual has a history of multiple instances of self harm, some serious. Remind her to use mindfulness techniques and other skills she has learned in groups. Encourage crisis bed if she needs more support to be safe. If hospitalization is unavoidable, X hospital has worked with her in the past and is aware of her clinical plan."

"Multiple hospitalizations since 2000. Attempt to redirect in order to keep him goal focused. Encourage contact with clinical team. Consult with psychiatrist for medication issues. Encourage consistent use of medication and utilizing PRNs. Assess for possible need for crisis bed. May require a more restrictive setting while undergoing med changes, especially Clozaril. Consult with MHP for possible DMHP evaluation/detention if needed. "

"When delusional, believes she has been raped or assaulted. Hx of violating no-contact order. History of suicidal ideation. Has 2 children who live with their father who she has limited contact with. Supportive sisters and father live in the area. Encourage taking meds with assistance/monitoring by family. Offer time to discuss stressors/concerns. Discuss/educate regarding symptoms and redirect to coping skills (bath, journal, tv, music). Consult with psychiatrist for possible med changes needed. Assess for possible alcohol use, need for social detox. Assess for Crisis Respite. Consult with MHP for DMHP evaluation/detention if needed. "

Additional Notes:
24/7 programs (PACT, Residential, IOP, etc.) should have their after-hours phone number clearly printed on the crisis plan for clients to find easily if approaching/in crisis.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

ADMINISTRATIVE, FISCAL AND QUALITY ASSURANCE/IMPROVEMENT
MANAGEMENT SYSTEM
MONITORING REPORT

CONTRACTOR: Catholic Community Services NW **DATE:** August 17, 2015

CONTRACT NO(S): *NSMHA-CCSNW-MEDICAID-13-15; NSMHA-CCSNW-SMHC-13-15; NSMHA-CCSNW-WISe-13-15*

NSMHA MONITOR(S): Lisa Grosso, Margaret Rojas and Bill Whitlock

DBHR MONITORS: none

CONTRACTOR REPRESENTATIVE(S): Eric Love, Kathy McNaughton, Cindy Price and Sterling Chick

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SCOPE OF REVIEW

The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, quality assurance/improvement systems, compliance and policies and procedures. The review included an assessment of the agency's response to NSMHA Administrative, Fiscal and Quality Assurance/Improvement On-Site Monitoring Questionnaire, interviews with management and staff, and review of relevant personnel files, agency and department specific policies and procedures, and other organizational records.

SUMMARY OF REVIEW

The following areas were monitored through a review of the "Administrative, Fiscal and Management System Monitoring Questionnaire;" source documents; and interviews with the agency staff:

Financial Management	Internal Controls	Budgetary Controls
Petty Cash	Compensation Plan	Inventory
Purchasing	Regulatory Compliance	MIS
Personnel System	Travel	Consumer Rights
Access and Assessment	Care Management	Cultural Competence
Quality Management	Resource Management	Crisis Response

The responses to the "Administrative, Fiscal and Quality Assurance/Improvement Monitoring Questionnaire" and on-site review were discussed with staff during the review. Results of the Review follow.

INTRODUCTION

Catholic Community Services NW (CCSNW) is a community behavior health agency that contracts for the provision of mental health services with the North Sound Mental Health Administration (NSMHA).

CCSNW is certified by the DSHS Division of Behavior Health and Recovery to provide:

Family Therapy
Case management
Individual Treatment
Less Restrictive Alternate Support
Recovery Support Wraparound Facilitation
Recovery Peer Support
Psychiatric Medication

On CCSNW the NSMHA Administrative Audit Team conducted an administrative review. The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, and quality assurance/improvement management systems, processes, policies and procedures of CCSNW. NSMHA held interviews with management and staff and reviewed relevant personnel files.

The results of this review are included in this report.

STRENGTHS

- Leadership transition is complete for a leadership that is regionally focused
- Substance use treatment is established in Skagit County
- Priority is being place on developing a dually certified workforce
- School based services is growing Snohomish and Whatcom Counties
- Transition to WISe services is complete
- CCS Housing services in Whatcom County are expanding
- QM/QI processes have been enhanced to include risk management regional and statewide
- CCS continues to be a valued partner in providing children's mental health services in our region, we look forward to partnering with CCS on youth substance use services in 2016

FINDINGS AND RECOMMENDATIONS

A finding occurs when an agency fails to comply with Federal or State regulations and contract terms and conditions governing contract awards, and which could subject them to failed State Mental Health Licensing review, audit disallowances, debarment, or contract noncompliance. The NSMHA applies the 90% compliance rule established by the State of Washington Mental Health Division in reporting findings.

A recommendation occurs when an agency fails to follow generally accepted accounting principles, is close to, but does not meet the 90% compliance rule in a particular area and/or other areas in which the monitoring team feels improvement is needed in order to strengthen the agency's administrative, financial, management or quality management capabilities.

ADMINISTRATIVE

Personnel Records Review

18 personnel records were reviewed. All records were organized, complete with current documentation in accordance with the NSMHA audit tool. Training plans for employees were complete and provided an array of trainings with the spectrum ranging from Dignity and Respect to Medicaid Fraud and Abuse.

Policies and Procedures Review

CCS policies are up to date and tracked systematically to ensure revisions are incorporated within the timelines for implementation. CCS was placed in corrective action by DBHR in 2014 and has completed the updating of policies as outlined in their corrective action plan. Tracking the dissemination of policies is part the QI scorecard.

Quality Management (QM) Plan

CCS has implemented a System Wide Quality Improvement process that comprises of a quarterly QI Scorecard. The process is comprehensive and the results impressive. The scorecard grades each initiative with a "school type" grade, such as A-F with a findings/action section for each office in the Western Washington region. Areas of strength on the system wide QI plan:

- Reviewing QI functions that no longer need to be addressed
- Feedback loop to staff on QI issues
- Annual HIPAA compliance Checklist
- Board of Trustee involvement

NSMHA is impressed with the work and monitoring CCS has established with their vigorous QI processes.

FINDINGS

NONE

RECOMMENDATIONS

NONE

FISCAL

There were no concerns or issues identified during the review. CCSNW has well established policies, procedures and processes in their fiscal deparment.

FINDINGS

NONE

RECOMMENDATIONS

NONE

COMPLIANCE PLAN

The Catholic Community Service (CCS) Compliance Program, Policies and Plan were reviewed and found again, **exceptional**. The plan is current, thorough, specific, well laid out and easily read.

Particularly noteworthy are the following points:

1. Designation of the Compliance Officer by title vice name
2. Designation of the titles that constitute the Compliance Committee and the organizational reporting hierarchy

3. Separation of policy and plan into specific sections, which aids reasonable understanding within the organization
4. Outlining of unimpeded access to legal counsel
5. Specific mention of the contractual relationship with NSMHA with regard to overall compliance reporting
6. A detailed Compliance Plan that outlines proactive plans using many established internal audits to mitigate risks
7. Of particular note, Compliance Plan outlines the specific activities at CCS associated with each of the Office of Inspector General Seven Fundamental Elements of an Effective Compliance Program
8. Inclusion of the OIG HEAT training materials as an agency resource
9. Specific policy and direction for the compliance exclusion verification responsibilities of Human Resources in hiring practices, both contractor and employee
10. Whistleblower protection and non-retaliation are addressed in personnel policies

FINDINGS
NONE
RECOMMENDATIONS
NONE

CONSUMER RIGHTS ON-SITE REVIEW

All required postings were visible and accessible in the waiting area. Translations of the materials were available as well, specifically Spanish.

FINDINGS
NONE
RECOMMENDATIONS
NONE

COMPLAINT AND GRIEVANCE REVIEW

This review will take place at a later date.

CORRECTIVE ACTION PLAN

No corrective action is needed for this review.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

ADMINISTRATIVE, FISCAL AND QUALITY ASSURANCE/IMPROVEMENT MANAGEMENT SYSTEM MONITORING REPORT

CONTRACTOR: COMPASS HEALTH **DATE:** July 15, 2014

CONTRACT NO(S): *NSMHA-CH-PIHP-13-15, NSMHA-CH-SMHC-13-15, NSMHA-CH-MHBG-13-15 AND NSMHA-CH-PATH-13-15*

NSMHA MONITOR(S): Kurt Aemmer, Lisa Grosso, Margaret Rojas and Bill Whitlock

DBHR MONITORS: none

CONTRACTOR REPRESENTATIVE(S): Tom Sebastian, Kay Tillema, Marsh Kellegrew, Stacey Alles, Becky Olson-Hernandez, Chris Starets-Foote, Heather Fennell, Jill Henson, Judy Heinemann and Deana Gilpin

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SCOPE OF REVIEW

The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, quality assurance/improvement systems, compliance and policies and procedures. The review included an assessment of the agency's response to NSMHA Administrative, Fiscal and Quality Assurance/Improvement On-Site Monitoring Questionnaire, interviews with management and staff, and review of relevant personnel files, agency and department specific policies and procedures, and other organizational records.

SUMMARY OF REVIEW

The following areas were monitored through a review of the "Administrative, Fiscal and Management System Monitoring Questionnaire;" source documents; and interviews with the agency staff:

Financial Management	Internal Controls	Budgetary Controls
Petty Cash	Compensation Plan	Inventory
Purchasing	Regulatory Compliance	MIS
Personnel System	Travel	
Access and Assessment	Consumer Rights	
Quality Management	Cultural Competence	

The responses to the "Administrative, Fiscal and Quality Assurance/Improvement Monitoring Questionnaire" and on-site review were discussed with staff during the review. Results of the Review follow.

INTRODUCTION

Compass Health is a community mental health agency that contracts for the provision of mental health services with the North Sound Mental Health Administration (NSMHA).

Compass Health is certified by the DSHS Division of Behavior Health and Recovery to provide:

Emergency Crisis Intervention
Case management
Counseling and psychotherapy
Day treatment
Peer support services
Consumer employment; and
Psychiatric treatment, including medication management

On April 21-24, 2014 the NSMHA Administrative Audit Team conducted an administrative review. The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, and quality assurance/improvement management systems, processes, policies and procedures of Compass Health. NSMHA held interviews with management and staff and reviewed relevant personnel files.

The results of this review are included in this report.

STRENGTHS

- Compass is thriving amidst the constant change in the public mental health system
- Partnering with other agencies to provide a continuum of care
- Electronic Health Records are scheduled to be online agency wide in 6-9 months
- Triage has hired seven nurses and has MHP coverage 24/7
- Developed an Inpatient Transition Team in collaboration with NSMHA
- Implementing Evidence Based Practices
- Offering SA/SU services in San Juan County
- Co-location of mental health services in primary care
- 2nd annual art show in Skagit county
- SharePoint is being used as an effective communication tool throughout the agency
- Increasing open access opportunities throughout the region
- Peer Counselor employment is growing
- Peers are being promoted within the agency
- Collaborative documentation is provided throughout the agency
- Website is dynamic and easy to navigate
- Partnership with Bridgeways for Supported Employment Services

FINDINGS AND RECOMMENDATIONS

A finding occurs when an agency fails to comply with Federal or State regulations and contract terms and conditions governing contract awards, and which could subject them to failed State Mental Health Licensing review, audit disallowances, debarment, or contract noncompliance. The NSMHA applies the 90% compliance rule established by the State of Washington Mental Health Division in reporting findings.

A recommendation occurs when an agency fails to follow generally accepted accounting principles, is close to, but does not meet the 90% compliance rule in a particular area and/or other areas in which the monitoring team feels improvement is needed in order to strengthen the agency's administrative, financial, management or quality management capabilities.

ADMINISTRATIVE

Personnel Records Review

50 personnel records were reviewed. All files were well organized all required documentation was evident in the records reviewed. Compass has a well-established Human Resource department and is consistent in its policies and procedures.

Individual training plans and continuing education opportunities for staff are well developed and are consistently being reviewed and updated based on the employee's need.

Policies and Procedures Review

Access was given to review policies on the Compass Health intranet, most policies were up to date, however, there was a few that need updating. The policies that need revision are based on new contract requirements having to do with Medicaid Eligibility, Subcontracting and Access. NSMHA will be revising its policies, once those are updated, Compass will update their internal policies.

Quality Management (QM) Plan

Compass Health continues to have a dynamic quality management system. They clearly articulate their focus areas to staff through numerous communication venues. Surveys are conducted in a number of service areas, with the information being disseminated to the organization as a whole. Quality improvement initiatives are being implemented and measured in systematic processes.

Compliance Plan

The Compass Health policy for Business Ethics and Regulatory Program (AQ-230) and Notice of Privacy Practices (PR-200) were reviewed and found accurate and inclusive of all major points outlined in NSMHA policy.

Particular strengths include the following points:

1. AQ-230 states on page 1 Compass Health's commitment to "promote open and free communication regarding our ethical and compliance standards and provide a work environment free from retaliation."
2. Designation of a Compliance Committee, Chair and Members by title vice specific name.
3. Review of AQ-230 is documented as occurring every 1-3 years, which is excellent for keeping the information current to the changing health care and business environment.
4. Designation of the organizational reporting hierarchy.

5. Reporting termination of employees and contractors for Fraud & Abuse by written notification to the Washington State Department of Health as a step in the process. (This has been a special emphasis by the Centers for Medicare and Medicaid Services (CMS) to connect perpetrators of Medicaid fraud with a personnel action to ensure that confirmed violators are prevented from becoming re-employed with an unsuspecting employer through lack of inclusion on the List of Excluded Individuals and Entities (LEIE).)
6. Inclusion of the Code of Conduct and Compliance Policies and Procedures
7. Including Whistleblower information in the Compliance Program. Having it in both Compliance and Human Resource/Personnel policies is best.
   Education and training of employees within 90 days of hiring

Additional Recommendations:
Revision of the appropriate Compass Health policy (either the Business Ethics and Regulatory Compliance Program Personnel/Human Resource or other appropriate policy) to focus on areas in release of NSMHA update to Policy #2001, Business Ethics and Regulatory Compliance Program & Plan by Numbered Memorandum 2012-015 on October 10, 2011, and additional suggestions from this audit as follows (copies these annotate policies are included as a part of this report):

Audit:

1. It is not clear in policy AQ-230 what individual performs the duties as Compliance Officer. The title of Compliance Officer is initially mentioned on page 7, the first instance that the title is used. It is my understanding that the Chief Quality, Information & Privacy Officer.is the Compass Health Compliance Officer. Suggest Privacy Officer/Compliance Officer as the title in the definitions listing beginning on pages 1 and 2 and throughout policy AQ-230 for it to be clearer to the reader.
2. Throughout the document Privacy/Security Officer is used. These titles are defined separately in the definitions on page 2. If they are one and the same person, that is fine. If not, the Compliance Committee is currently to be chaired by the Privacy/Security Officer, which if separate individuals, the Compliance Officer needs to be included as a member of the Compliance Committee.
3. On page 3, the statement, "*You may not accept any money or gifts from any consumer (or consumer's family member), competitor, customer or anyone doing business with, or desiring to do business with, except that you may accept gifts of nominal value given as a sign of appreciation*" should also include a definition of "nominal," which may reference the definition if it is outlined in a fiscal or other current policy.
4. On page 7 of AQ-230, the statement: "*Notification to such law enforcement and regulatory authorities as legal Counsel advises, which at a minimum includes Medicaid Fraud, notification to the Washington State Medicaid Fraud Control Unit at PO Box 40116, Olympia, WA 98504 (360-586-8877)*", should also include that, at a minimum, a copy of the notification to the MFCU be provided immediately to the NSMHA Compliance Officer.
5. It appears that the last review of PR-200 was in 2006, 8 years ago. All reviews, even if there are no changes, should be recorded. Suggest this policy be reviewed and even if there is no change in information, a review date recorded.
6. Education and training of employees on hiring is addressed and method of training, though it would be best to included that a minimum of annual training thereafter is required to be documented

NSMHA Numbered Memorandum:

7. Inclusion of information for training modules as provided by HEAT at http://oig.hhs.gov/compliance/provider-compliance-training/index.asp to be utilized for new clinical staff and on an annual basis.
8. Strengthening of language, in particular with regard to:
    a. Validation of employee and contractors *prior to hiring*, annually and as directed by contract using the List of Excluded Individuals and Entities (LEIE) and Excluded Parties List System (EPLS). While policy AQ-230 outlines use of the LEIE on page 6, it is also a requirement to check and maintain documentation of the checks for the Excluded Parties List System (EPLS) found on the System for Award Management (SAM) website portal: https://www.sam.gov/portal/public/SAM/#1 for prospective employees, vendors and sub-contractors.
    b. Incorporating new compliance_officer@nsmha.org e-mail address for reporting suspected fraud & abuse.

FINDINGS
NONE
RECOMMENDATIONS
NONE

FISCAL

Darrell Heiner and I interviewed Marsh Kellegrew CFO, Deanna Gilpin and Katherine Adams. Compliance officer is Heather Fennell.

Started out with tool interviews after introduction meeting with Compass and NSMHA team. In their management letter no MHBG or PATH problems. No findings. Staff looks up clients in P1 for eligibility verification. Third billing policies are established.

Katherine stated the budget process was completed for the upcoming year and is going to the Board next month. Budgeting is a top down and bottom up process based on prior year actual and new contracts. Allocations, square footage occupancy costs, administration percentage is based on expenses, all programs get charged the same percentage based on actual cost, most employees are direct to the program based on actual time (employees fill out timesheet and code their own program) along with some multi program managers/directors are allocated on a percentage. Vacation is expensed when earned and sick is expensed when used. The managers propose changes and have a second meeting with fiscal. The budgets are adjusted and reviewed by CFO. A final meeting with CFO, COO and CEO in conducted and then it goes to the Board of Directors in June. Compass does not change budgets in mid-year they just monitor the variances and change in the following year. They are looking at changing their cost allocations to more FTE based instead of percentage of expense to better account for pass through funds.

Reviewed internal controls and purchasing/paying with CFO. Organizational chart looks like they have separate functions. Only one AP staff, two purchasing staff, which does the reconciliation of purchase orders and send the information to the AP staff. Expense reports go to payroll for review and payment (two people doing payroll). Physical inventory done every two years, IS department has inventory of all computers, cell phones and printers. Travel reimbursement is $.56 linked to IRS rate. No per-diem expenses, actual costs on all trips.

MHBG, spoke with Katherine about the MHBG. I asked her if they had any questioned costs. Peer Center only pays for wages and benefits no other costs. Recently updated policy on gift cards, not all costs paid for

by grant. There are no expenditures for inpatient, capital, equipment, cash or land/buildings. Received copies of January 2014 in detail. Darrell and I reviewed GL detail. No questioned costs in program. Asked about programs with multiple funding sources and how do they guarantee they do not double bill expenses. They use the GL program and episode codes to separate each program expense by revenue source. They gave examples using the MHBG Peer Center as an example showing the different codes used to account for various funding streams. No administration funds used and no money left over. Clinical personnel provide encounter reports and it's entered into the reports. No issues, looks good. Looked at MHBG payroll, only pays for payroll and benefits.

On the PATH program, Deanna stated the old match was interest income and the current match the RSN pays. They did not combine the Peer Center program with the PATH program. So I do not have to do a review to make sure the MHBG did not touch the PATH funds.

Asked the mandatory question, do you pay people not to work? The answer was no. All payments are for employees or contractors on a fee for service basis or hourly billing basis. Services from October 1, 2013 to March 31, 2014 can be adjusted through our normal six month reconciliation process. We will need to make a manual adjustment for services from July 1, 2013 to September 30, 2013, because the contract period has been closed out and we are no longer reviewing that period.

Darrel and I reviewed information on cost reimbursement programs; MHBG, PATH, PACT Skagit and Snohomish, flex funds, interpreter services and hospital transition. Seven day measure wages are manually put on billing, not broken out separately as a program. Discussed possible double billing in fee for service program, it was difficult tracing some items because of the large volume of transactions. Darrell and I were successful in tracing all of chosen charges to source documents (bills). After reviewing invoices we have no problems to report. Overall Compass does an excellent job.

FINDINGS
NONE
RECOMMENDATIONS
NONE

CONSUMER RIGHTS ON-SITE REVIEW

Three (3) sites were reviewed, Bailey Center, Building C & D on federal Campus. All posting were in order and accessible to individuals entering the facilities.

FINDINGS
NONE
RECOMMENDATIONS
NONE

COMPLAINT AND GRIEVANCE REVIEW

The Grievance system is currently going under policy revisions, this area will be reviewed at a later date.

FINDINGS
NONE
RECOMMENDATIONS
NONE

FEDERAL BLOCK GRANT REVIEW

Bailey Peer Center
The Peer Center has moved to a membership only program. Peers are involved in engaging individuals from the moment they walk in the center. The Center is bringing in outside presenters for workshops related to job readiness, health conditions and WRAP facilitation. Surveys are conducted on a regular basis to check in with participants on the effectiveness of the center, whether by attending they are feeling supported, life improvement and goal attainment. The responses are positive overall.

Strides have been made to move the Bailey Center from a "drop-in" center to a "recovery center", however with the provision of food service, it continues to be perceived as a drop in center, with a number of individuals whose only intent is eat and watch television. We would encourage Compass Health to move away from the activities that are best suited for a homeless shelter.

San Juan County Non-Medicaid Program
The program was found to be in 100% compliance with only one of the requirements.

- Receiving brief solution focused therapy

In two of the three cases at least two of the three requirements pertaining to Needs Assessment, Needs Assessment identification of services goals, & self-directed, strength based service plans were not met. The combination Needs Assessment/Services Plan form does not allow for these requirements to be met. In the one case where the Needs Assessment met the requirements, the PATH intake assessment form was used.*

Documentation of the MI utilization requirement could not be substantiated. There was no indication that it was occurring.

Documentation of the "location of service provision" requirement could not be substantiated. There was no indication that the individual was given a choice, nor were any chosen locations identified in the record. It appeared that only one of the three records reflected services were being provided to a member of the target population.

The only one of the three cases receiving eight or fewer service encounters was the case that reflected an early transition when the individual was found to be ineligible for the program.

Conclusions
As the documentation requirements are generally not being met (or minimally met) it appears that the staff is not familiar with the contract requirements. As there were only three individuals served, & two of those did not appear to be members of the target population there is little evidence that this program is needed in the catchment area.

FINDINGS
NONE
RECOMMENDATIONS

1. Develop & implement an intake assessment form which includes a final section that cues the clinician to identify & record achievable & focused service goals.*
2. Develop & implement a separate self-directed & strength based Service Plan form

PATH GRANT

Ten open and five closed records were reviewed against ten requirements from the current Scope of Work section of the NSMHA/Compass Health PATH contract.

1. The program was found to be in 100% compliance with five of the requirements
2. The program was found to be in 93% compliance with four of the requirements
3. The program was found to be in 73% compliance with one of the requirements

The "context of the referral" (to PATH) was not clearly identified/described in 3 three of the fifteen cases. The overall compliance rate (all requirements, all cases) was 94%

Though 100% of the cases had Service Plans, as required, very few contained measurable objectives against which progress can be determined, and in no cases were all objectives measurable.*

In general, these clinical records looked very good.
Major Improvements Noted

- DBHR scope of diagnostic impressions
- Implementation of individual PATH referral logs

FINDINGS
NONE
RECOMMENDATIONS
NONE

CRISIS SERVICES

Compass Health Crisis chart review for 2014:
Emergency Services crisis charts (voluntary and involuntary services) were reviewed April, 2014. Charts pulled for this review was from 2013 and early 2014 charts. Charts were reviewed for completeness of documentation.

Compass Health 048 (this includes 5 charts from Island and San Juan)
28 charts were reviewed. All 28 were reviewed for contact sheet completeness, 15 charts were reviewed as a voluntary contact. 13 were reviewed as involuntary investigations which resulted in a detention. The score for ICRS contact completeness which included the voluntary services was 97.6%. This was down from 97.7% from 2013.

Strengths (100%):

- Source of referral

- Reason for call is clearly documented
- Inclusion of natural supports and other relevant treatment providers
- Documentation of voluntary and involuntary services performed
- Documentation that crisis staff stabilized the person in crisis to resolution of the crisis or referred to another appropriate service

Areas that fell below 90%:

- Evidence of documentation for referring consumers to an E and T (81.8%)
- Disposition called into VOA (88.5%)

Comments:

- The charts reviewed continued to have consistent and complete documentation.
- Documentation in charts has continued to improve on the contact sheets. Referral reasons, evaluation of the problem, and clinical impressions are more thorough.

Compass Health 048 ITA

13 charts were then reviewed as involuntary investigations that resulted in a detention. These were detentions that needed to involve a single bed certification due to a lack of a bed as a resource. The overall score for ITA charts was 95.4%, down from 96.5% in 2013.

Strengths on ITA charts (100%):

- Documentation of the evaluation of a mental disorder
- Evidence that the person presents a likelihood of DS/DO/GD
- Documentation of the attempt to perform the face to face evaluation
- Assessing the person's behavior and judgment in the evaluation
- Documentation of using their professional judgment in the evaluation
- Using available history
- Consistency with statutes

These areas fell below 90% on the ITA chart documentation:

- Evidence that consideration is given to a person using Etoh or drugs (60.0%)
- Identification of the DMHP by name and position, informing of rights, purpose of investigation and informing of remaining silent and speaking to an attorney (84.6%)

Comments on the ITA chart documentation:

- Single bed certifications, in the majority of the charts, appears to be utilized after a receiving bed was not available.
- The charts reviewed continued to be consistent in the completeness of documentation.
- Involuntary evaluations remain very detailed with the presenting issues, symptoms, and clinical assessments well documented in the body of the detention paperwork.
- Consideration needs to be given to the results of medical screenings and needs to be included in the documentation. This was hard to find in some charting.
- Consideration needs to be given to persons using etoh or drugs in the documentation of the evaluation.
- Informing the person of the role, purpose of the evaluation, remaining silent, speaking to an attorney is still absent in detention paperwork and remains an area needing improvement.

RECOMMENDATIONS:

- Informing the person of the role, purpose of the evaluation, remaining silent, speaking to an attorney is still absent in detention paperwork continues to need improvement (San Juan charts).
- Medical screening results and inclusion or etoh and drug results need to be better documented in the evaluation (the impact, if any on the detention).
- There needs to be a discussion with San Juan DMHPs of the need to advise an individual of their rights at the beginning of the evaluation.
- Medical screening information had improved but also continues to need better documentation.
- Etoh and drug results continue to need to be addressed in the documentation.

The recommendations will be reviewed in 2015.

FINDINGS:
NONE

CORRECTIVE ACTION PLAN

No Corrective Action is needed.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

ADMINISTRATIVE, FISCAL AND QUALITY ASSURANCE/IMPROVEMENT MANAGEMENT SYSTEM MONITORING REPORT

CONTRACTOR: Sunrise Services **DATE:** January 23, 2015

CONTRACT NO(S): *NSMHA-SUNRISE SERVICES-MEDICAID-13-15; NSMHA-SUNRISE SERVICES-SMHC-13-15; NSMHA-SUNRISE SERVICES-MHBG-13-15*

NSMHA MONITOR(S): Lisa Grosso, Margaret Rojas and Bill Whitlock

DBHR MONITORS: none

CONTRACTOR REPRESENTATIVE(S): Sue Closser, Mike Manley, Kim Eldred, Randy Polidan, Lisa Pinkerton, Lisa Hanks and Camilla Prince.

SCOPE OF REVIEW

The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, quality assurance/improvement systems, compliance and policies and procedures. The review included an assessment of the agency's response to NSMHA Administrative, Fiscal and Quality Assurance/Improvement On-Site Monitoring Questionnaire, interviews with management and staff, and review of relevant personnel files, agency and department specific policies and procedures, and other organizational records.

SUMMARY OF REVIEW

The following areas were monitored through a review of the "Administrative, Fiscal and Management System Monitoring Questionnaire;" source documents; and interviews with the agency staff:

Financial Management	Internal Controls	Budgetary Controls
Petty Cash	Compensation Plan	Inventory
Purchasing	Regulatory Compliance	MIS
Personnel System	Travel	Consumer Rights
Access and Assessment	Care Management	Cultural Competence
Quality Management	Resource Management	Crisis Response

The responses to the "Administrative, Fiscal and Quality Assurance/Improvement Monitoring Questionnaire" and on-site review were discussed with staff during the review. Results of the Review follow.

INTRODUCTION

Sunrise Services is a community mental health agency that contracts for the provision of mental health services with the North Sound Mental Health Administration (NSMHA).

Sunrise Services is certified by the DSHS Division of Behavior Health and Recovery to provide:

Emergency Crisis Intervention
Case management
Counseling and psychotherapy
Peer support services
Consumer employment; and
Psychiatric treatment, including medication management

On Sunrise Services the NSMHA Administrative Audit Team conducted a review of direct service programs. The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, and quality assurance/improvement management systems, processes, policies and procedures of Sunrise Services. NSMHA held interviews with management and staff, reviewed relevant personnel files, complaint & grievance policies and procedures, complaint and grievance files.

The results of this review are included in this report.

STRENGTHS

- Sunrise is expanding services in ten (10) different geographic locations, including rural areas in Snohomish, Skagit and Island counties;
- Implementation of IDDT in Snohomish County;
- Providing needed mental health services to eastern Snohomish County, with continued emphasis on the Darrington/Oso areas;
- Sunrise is developing housing options throughout the region;
- Sunrise continues to increase the number of Certified Peer Counselors within their organization;
- Implementation of the regional Geriatric Transition Team;
- Electronic Health Record is currently being implemented;
- Sunrise has instituted a marketing campaign that provides positive exposure for Sunrise and mental illness;

FINDINGS AND RECOMMENDATIONS

A finding occurs when an agency fails to comply with Federal or State regulations and contract terms and conditions governing contract awards, and which could subject them to failed State Mental Health Licensing review, audit disallowances, debarment, or contract noncompliance. The NSMHA applies the 90% compliance rule established by the State of Washington Mental Health Division in reporting findings.

A recommendation occurs when an agency fails to follow generally accepted accounting principles, is close to, but does not meet the 90% compliance rule in a particular area and/or other areas in which the monitoring team feels improvement is needed in order to strengthen the agency's administrative, financial, management or quality management capabilities.

ADMINISTRATIVE

Personnel Records Review

Sixteen (16) personnel records were reviewed, all of which were new hires since the last review. All records were well organized and compliant with WAC and NSMHA requirements. Sunrise conducts a background check on applicants that have lived less than three years in the State of Washington, this is a best practice in preventing debarred and/or sanctioned individuals from being hired.

Policies and Procedures Review

Policies were current and are in a constant state of updates. NSMHA recommends the following additions to Sunrise Service's policies; the reviewer was unable to determine whether they were currently in policy:

- Cultural Competency
  - Provide the inclusion of the LBGTQ community
  - Keep a log of interpreter use within the organization
- Access
  - Add the following language "Not discriminate against enrolled individuals who are considered difficult to serve. Examples include: refusal to treat an individual because the individual is deemed too dangerous, because housing is not available in the community, or a particular type of residential placement is not currently available"
  - Add the following language "Not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition"
  - Add the following language "Maintain the ability to provide an intake evaluation in the individual's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to individuals being discharged from a state hospital or E&T facilities to such placements when the individual requires an on-site service due to medical needs or lack of transportation."
- Care Coordination
  - Add the following language "Maintain the ability to provide an intake evaluation in the individual's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to individuals being discharged from a state hospital or E&T facilities to such placements when the individual requires an on-site service due to medical needs or lack of transportation."
- Eligibility
  - Add the following language "Contractor shall verify an individual's Medicaid eligibility at each appointment. For individuals not currently enrolled in Medicaid, Contractor shall refer individuals to the designated in-person assistor agency in their catchment area. Contractor shall act in accordance with NSMHA's policy on eligibility verification herein incorporated by reference"
- Inpatient Coordination
  - Add the following language "Provision of most recent psychiatric assessment/intake assessment, prescriber notes, medication sheet, advanced directive, progress notes and/or other information requested by the inpatient unit."
  - Add the following language "Procedure for offering covered MH services for follow-up & aftercare as needed when an enrolled individual has been treated in an emergency room for a psychiatric condition."

Quality Management (QM) Plan

Sunrise continues to track measures and initiatives that are either implemented or completed. Communication of status on QI measures is evident in agency committees and meetings. Goals, objectives and action steps were clearly outlined in the plan and tracked for progress and completion.

FINDINGS

NONE

RECOMMENDATIONS

Policy and Procedures: Update policies to include the information above and communicate to staff the requirements, if not provided at an earlier date.

COMPLIANCE PLAN

The Sunrise Services, Inc., MH 1 – 10.23, Regulatory Compliance-Fraud Prevention Policy was reviewed and found accurate and inclusive of all points outlined in the NSMHA policy with exceptions as follows:

- **FINDING:** As identified as an exception in the 2012 Audit Report, while the SCMH Administrator, serving as the SCMH Compliance Officer, generally reports to the Sunrise CEO, when circumstances warrant as determined by the SCMH Compliance Officer, the policy should outline that the SCMH Compliance Officer may meet directly with an authority in the chain of command above the Sunrise CEO and/or independently with the agency legal counsel.

- **FINDING:** The SCMH compliance policy page 3, B., Training and Education, reads, "*SCMH Administrator share with staff notification from NSMHA of applicable fraud and abuse training opportunities offered through CMS, Washington State Attorney General's Medicaid Fraud Unit, Washington State Auditor's Office, MHD, NSMHA or any other relevant entity.*"
    a. By Numbered Memorandum 2012-004 of March 30, 2012, NSMHA required that OIG Health Care Fraud Prevention Enforcement Action Team (HEAT) training audio/videos be made available by providers to their healthcare professionals and included as a training resource as a part of each provider agency Compliance Plan. As outlined in the Numbered Memorandum, beginning in May 2012, NSMHA audit of provider agencies includes a review of the Compliance Program, Plan, and Policy for inclusion of this resource and internal communication of this information to their healthcare professionals.
    b. Annual training outlined in policy should specify training in the following areas:
        i. False Claims Act,
        ii. Deficit Reduction Act
        iii. Whistle Blower reporting of improper governmental action and protections against retaliation
    c. Training resources may also be listed in a separate attachment, which would make it easier to update over time.

- **FINDING**: SCMH compliance policy document page 4, E, 1.reads "*If the initial investigation reveals possible criminal activity, the corrective action plan includes: c. Notification to such law enforcement and regulatory authorities such as NSMHA.*"
    a. This should more clearly outline that if after initial investigation by the SCMH Administrator as the SCMH Compliance Officer and consultation with the SCMH CEO and legal counsel, it is determined that there are genuine compliance concerns, the SCMH Compliance Officer will

notify the NSMHA Compliance Officer (360.416.7013 compliance_officer@nsmha.org), and, if applicable, notifies all appropriate governmental organizations, which should include the list outlined in the NSMHA Policy 2001.00. This could be a list included as an attachment, which would make it easier to update over time. This list of governmental organizations should include:

i. Refer potential fraud to one or more of the appropriate authorities including but not limited to:
   1. North Sound Mental Health Administration (NSMHA)
   2. DSHS/DBHR;
   3. DSHS/Medical Assistance Administration (MAA) Payment Review and Audit Section;
   4. WA State Auditor's Office;
   5. WA State Medicaid Fraud Control Unit (MFCU)/Office of Attorney General;
   6. Office of Civil Rights

- **FINDING**: SCMH compliance policy document, page 5, G, 3. reads, "*Implement procedures to screen its employees and contractors to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation as verified through the United States Health and Human Services website at http://exclusions.oig.hhs.gov., and the Excluded Parties Listing System at http://www.epls.gov. Employees or subcontractors found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with NSMHA funded services.*
  a. For Medicaid exclusions, at a minimum, a validation check of each employee, including vendor employees, against the current U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), List of Excluded Individuals and Entities (LEIE) database shall occur ***prior to hiring and at least annually or as designated by contract*** thereafter by the anniversary of the hire date. The periodicity of the exclusion review in the SCMH policy is not designated.
  b. In addition, the LEIE website has 2 web portals, the one mentioned above and https://www.oig.hhs.gov/exclusions/index.asp.
  c. Also, the Excluded Parties List System (EPLS) was moved under the System for Awards Management (SAM) website and an additional link is https://www.sam.gov/index.html/#1.
  d. All of the web links could be a list included as an attachment, which would make it easier to update over time.

- **FINDING:** SCMH compliance policy document, page 6, H. 3.reads, "*SCMH will comply with specific reporting procedures developed by DSHS/DBHR.*"
  a. As a contracted provider agency in NSMHA's regional network, "SCMH will implement processes that comply with specific reporting procedures developed by NSMHA and with processes establishing and administering penalties and sanctions for fraud and abuse."

- **FINDING:** As identified as an exception in the 2012 Audit Report, on page 6, I, of the SCMH compliance policy, titled "NSMHA Definitions," this title should be changed to Definitions and the "Ethics and Compliance Committee" definition should be revised to reflect the definition of the Compliance Committee for SCMH, to fulfill this role in compliance with a Federal program integrity requirement, State contractual requirement (42 CFR 438.608(b) (2), and reference SCMH contract with NSMHA). This designation can be the titles that constitute the Compliance Committee or an existing

leadership/management group and include the organizational reporting hierarchy. This also necessitates a change on page 7, J, 2. "...the duties of a compliance officer AND a compliance committee," vice "or a compliance committee."

The Compliance Plan is thorough and easily read.
Particular strengths including the following points:

- Designation of the Compliance Officer by title, as the SCMH Administrator, vice name
- Statements of Compliance and Assurance
- Specific mention of the contractual relationship with NSMHA with regard to overall compliance reporting
- Specific direction for the compliance exclusion verification responsibilities
- Special emphasis on prevention of double billing

Additional Recommendations:

- As recommended in the 2012 Audit, while the "Sunrise Community Mental Health (SCMH) Administrator is designated to fulfill the duties of a compliance officer or a compliance committee that is accountable to the Sunrise CEO" is addressed on page 7, J, 2. of the Sunrise Services, Inc., Regulatory Compliance-Fraud Prevention Policy, it is recommended that this designation occur earlier on in page 1 of the document, for example, under:
    a. Page 1, Procedure, A. At a minimum, the SCMH administrator as the designated Compliance Officer will carefully review all documentation...."

- As recommended in the 2012 Audit, Sunrise Services Policy MH1-10.23, Regulatory Compliance-Fraud Prevention, section F, reads *"SCMH will initiate appropriate disciplinary action against employees who fail to comply with the applicable laws, regulations, and policies."* It is recommended that additional language be included in the agency policy, specifically to address that in resolving Medicaid fraud, written notification to the Washington State Department of Health will be made as a step in the process in the case of employee termination. This was recently made a special emphasis by Centers for Medicare and Medicaid (CMS) – to connect perpetrators of Medicaid fraud with a personnel action to ensure that confirmed violators are prevented from becoming re-employed with an unsuspecting employer through lack of inclusion on the List of Excluded Individuals and Entities (LEIE).

A suggested emphasis in formatting the compliance policy is a separation in the establishment of the Compliance Program (outline of objectives and definitions) from the details of the Compliance Plan (the procedures to accomplish the program objectives). In addition, it is helpful to reference other sources materials, such as the Employee Personnel Handbook as a resource for the Code of Ethics and other information regarding the enforcement of standards.

FISCAL

Financial Statements, Client Audit monitoring questionnaire organizational chart and interviews were conducted on 11/19/14.

1) Met with Kim Eldred controller and committee Sue Closser, Mike Manley, Camilla Prince and Randy Polidan.
2) The compliance officer is Sue Closser, their Audit was clean, management letter minor issues, no single audit requested Sunrise to send the Mental Health Block Grant (MHBG) reporting form to us at period end. Reviewed organizational chart for separation of duties. Separate AR, AP and receipting. Two people on the cash receipting. Write offs reviewed by management. Budget process done by Sue Closser and Mike

Manley, Kim Eldred looks at the actuals. RSN cap issues are part of the process. Annual inventory of computers and major equipment. Purchasing after the fact authorization. Managers have authorization and credit cards. Kim Eldred purchases supplies. Sue C reviews all expenses. Capital amount $1,000.Travel expense reimbursement $48.5 for mileage. Cost reimbursement for all other travel expenses. Training requires pre approval. Other business travel is approved by managers.

3) MHBG rural east county Snohomish County and OSO outreach. No single audit. Questioned costs, none. Do not pay cash to clients, gave food instead. Reconciled March 2014 MHBG billing. Reconciled February 2014 EHR billing. Reconciled September 2014 IDDT billing. Reconciled June 2014 flex funds billing. Billing matched.
4) Multiple funders for same program. Most programs are separate by program revenue and expense. Only one revenue source. They separate clinician time and have separate departments for the two FBG programs. Snohomish IDDT funded by RSN and county. County pays a bed rate and a daily outreach date. Balance of costs billed to RSN. Reviewed June 2014 interim financial statements.

Overall excellent job at expanding in a changing market. It took a lot of work from the administration to plan, implement and monitor the Snohomish, Skagit and Island expansion without the negative agency impact. They said it was tough and they had some growing pains, but got the job done.

FINDINGS
NONE
RECOMMENDATIONS
NONE

CONSUMER RIGHTS ON-SITE REVIEW

Facility on Broadway was compliant with WAC and NSMHA required postings. All were accessible to customers. Facility 1509 Broadway was deficient in posting BHA license/Certification certificates.

FINDINGS
NONE
RECOMMENDATIONS
1509 Broadway: Post the license and certification document in public view.

COMPLAINT AND GRIEVANCE REVIEW

The review of Complaint and Grievance Policies and Procedures will be forthcoming.

FINDINGS
NONE
RECOMMENDATIONS
NONE

CORRECTIVE ACTION PLAN

A Corrective Action Plan is required for the findings identified above in the following section: Compliance Review.

The corrective action plan shall comply with Section F.2 of your PIHP/SMHC Contract. At a minimum your plan should address the following:

i. A brief description of the finding.
ii. Specific actions to be taken, a timetable, a description of the monitoring to be performed, the steps taken and responsible individuals that will reflect the resolution of the situation.

Corrective Action Plan must be submitted to NSMHA no later than COB (close of business) on February 23, 2015.

NORTH SOUND MENTAL HEALTH ADMINISTRATION

ADMINISTRATIVE, FISCAL AND QUALITY ASSURANCE/IMPROVEMENT MANAGEMENT SYSTEM MONITORING REPORT

CONTRACTOR: Volunteers of America (VOA) **DATE:** March 9, 2015

CONTRACT NO(S): *NSMHA-VOA-MEDICAID-13-15; NSMHA-VOA-SMHC-13-15; NSMHA-VOA-DCC-14-15*

NSMHA MONITOR(S): Sandy Whitcutt, Charissa Fuller, Lisa Grosso, Margaret Rojas and Bill Whitlock

DBHR MONITORS: none

CONTRACTOR REPRESENTATIVE(S): Marci Bloomquist, Elisa Delgado, Pat Morris, Gail Selander and Kevin Anderson

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SCOPE OF REVIEW

The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, quality assurance/improvement systems, compliance and policies and procedures. The review included an assessment of the agency's response to NSMHA Administrative, Fiscal and Quality Assurance/Improvement On-Site Monitoring Questionnaire, interviews with management and staff, and review of relevant personnel files, agency and department specific policies and procedures, and other organizational records.

SUMMARY OF REVIEW

The following areas were monitored through a review of the "Administrative, Fiscal and Management System Monitoring Questionnaire;" source documents; and interviews with the agency staff:

Financial Management	Internal Controls	Budgetary Controls
Petty Cash	Compensation Plan	Inventory
Purchasing	Regulatory Compliance	MIS
Personnel System	Travel	Consumer Rights
Access and Assessment	Care Management	Cultural Competence
Quality Management	Resource Management	Crisis Response

The responses to the "Administrative, Fiscal and Quality Assurance/Improvement Monitoring Questionnaire" and on-site review were discussed with staff during the review. Results of the Review follow.

INTRODUCTION

VOA contracts for the provision of Crisis Hotline, Triage, Access and Inpatient utilization services with the North Sound Mental Health Administration (NSMHA).

VOA is certified by the DSHS Division of Behavior Health and Recovery to provide:

- Crisis Telephone Support

On November 7, 2014 the NSMHA Administrative Audit Team conducted an administrative review. The purpose of this monitoring visit was to conduct a limited assessment, for contract compliance purposes, of the administrative, fiscal, and quality assurance/improvement management systems, processes, policies and procedures. NSMHA held interviews with management and staff, reviewed relevant materials.

The results of this review are included in this report.

STRENGTHS

- VOA has merged the 211 service with Behavior Health Division of the organization
- Community partnerships have grown over the past year
- VOA has established an internal strategy to reinvest in their workforce, by instituting a cultural change to encourage positive attitudes and commitment to co-workers
- An Advisory Committee was formed for a period of time to gather feedback from the community on VOA's role in community awareness
- Services are trending upward with an increase in calls in access, triage and utilization management of inpatient authorizations
- VOA has initiated a plan to explore the role of social media in their service offerings, including texting as a medium
- Outreach to the inpatient psychiatric units continues to be an effective communication tool
- Chat is two (2) years old and receiving national recognition
- VOA has begun shadowing/cross training of staff for a more effective and efficient workforce
- A Certified Peer Counselor has been added to the workforce
- ***VOA did an outstanding job on the Disaster Crisis Counseling FEMA Grant, they worked diligently to ensure service was provided to those affected by the Oso landslide, an admirable job in a very difficult situation. NSMHA is extreme**ly proud of their work and pleased we could partner with them on this important work.*

FINDINGS AND RECOMMENDATIONS

A finding occurs when an agency fails to comply with Federal or State regulations and contract terms and conditions governing contract awards, and which could subject them to failed State Mental

Health Licensing review, audit disallowances, debarment, or contract noncompliance. The NSMHA applies the 90% compliance rule established by the State of Washington Mental Health Division in reporting findings.

A recommendation occurs when an agency fails to follow generally accepted accounting principles, is close to, but does not meet the 90% compliance rule in a particular area and/or other areas in which the monitoring team feels improvement is needed in order to strengthen the agency's administrative, financial, management or quality management capabilities.

ADMINISTRATIVE

Personnel Records Review

A random sample of eight (8) personnel files were reviewed. All files were complete and contained all of the WAC/contract required documents. VOA has a strong supervision program, to include their silent monitoring for continuous quality improvement.

Policies and Procedures Review

VOA has a systematic process for updating and revising policies. Policies reviewed for this time period were up to date and were found to have no deficiencies. VOA has detailed contingency plans and procedures for phone service, if or when an outage takes place.

Quality Management (QM) Plan

The QM/QI plan that VOA has instituted is systematic, organization wide and an ongoing improvement process that is reviewed on a frequent basis and is reported to the Board of Directors at regular intervals. Areas of concern from staff, stakeholders and callers are incorporated into the plan.

FINDINGS

NONE

RECOMMENDATIONS

NONE

FISCAL

Financial Statements, Audit, Client Audit monitoring questionnaire and interview were conducted on 10/7/14.

1) Interviewed Bruce Keller new CFO, he has been with the agency less than a year. Paul Fishler (accountant) who has been with VOA 20+ years retired last year. Reviewed agency organizational chart and changes. Accounting separation of AP, AR and payroll, no internal control issue was found.

2) Reviewed time sheets filled out by individual and individual codes what program they work on. Most of the crisis work is done by specific people due to education issues. Individuals code time sheets to program. Supervisor reviews and signs time sheets. This is important for the staff working on the FEMA grant.
3) Budget process the same. Five month before budget sent to program managers along with seven month history. Accounting does the FTE's and benefits calculations. Budgets are done by program and line item by the program staff and revenues are estimated for each program. Accounting does a contract review to try and help determine revenue. Then taken to the director for final management review then fiscal committee and then the board for approval.
4) Travel is paid at 75% of federal rate at $.42. Allocation system. Rent and building insurance utilities, janitorial and all occupancy costs are done on square footage, number of phones, staff by program and individual usage. Administration 12% allocated to programs based on expenses, plus 2.25% goes to national organization for a 14.25% overall administration cost. They have a current approved federal indirect cost allocation rate approved at 15.73% for their federal programs. Costs are only broken down once into billing areas.
5) Asked about multiple funding sources for the same program. Programs costs are broken down by cost center, program code and revenue source code. Revenues are broken down by department, then revenue source. Reviewed new billings for one month to include the FEMA Grant.

Overall VOA is a very professional agency. CFO did not know some of the policy questions due to being new to the organization.

FINDINGS

NONE

RECOMMENDATIONS

NONE

COMPLIANCE REVIEW

The Volunteers of America of Western Washington (VOAWW), policies for 2001-Business Ethics and Regulatory Compliance Program and Plan, 380-Fraud and Abuse Compliance Plan, 2002-Prohibition on Certain Physician Relationships, Strategic Plan and Risk Management Plan were reviewed and found to be both accurate and inclusive of all points outlined in the NSMHA policy with exceptions as follows:

RECOMMENDATIONS ***(policies attached with insertions)***

1. VOAWW Policy 2001: See attached copy of policy with comments inserted.
    a. Page 4, 6.0 B. 1. f., If any referral is made outside the organization for any fraud involving NSMHA funded services or enrollees, a notification must also be made to the NSMHA Compliance Officer at the same time as any other external notifications are made.
    b. Page 5, 9.0 d., Recommend a generic E-mail account be used so that if the Compliance Officer changes, the E-mail would not have to be updated in the policy. Also, it allows

the generic E-mail addressed to be redirected to others in the organization in the absence of the Compliance Officer for any reason.

c. Page 6, 10.0 B., Suggest to also use the term "Whistleblower" in addition to No Retaliation policy as the most commonly accepted and known term.

2. VOAWW Policy 380: See attached copy of policy with comments inserted.
   a. Page 1, 3.0, All allegations of fraud and abuse should first be reported to VOA's Compliance Officer for initial/preliminary investigation, after which the VOA Compliance Officer makes the determination to make external notifications, at a minimum, to the NSMHA Compliance Officer.
   b. Page 1-3, 3.0, Suggest that this information be identified as a separate attachment, which, when update is needed, will require only the information on the attachment to be updated rather than the entire policy.

3. VOAWW Strategic Plan – Target dates, many were not met.
   a. Recommend addition of comments section in the plan to allow documentation as to why target dates were not met or to allow modification/adjustment of target dates with explanation.

4. VOAWW Risk Management Plan – meeting minutes.
   a. It was not apparent whether meetings were being held. In addition, the last Risk Assessment appeared to be in 2006. Recommend new Risk Assessment with a process in place, at a minimum, with designation of an annual review and update with report to the Board of Directors.

The VOAWW policy documents were easily read.

<u>Particular strengths include the following points:</u>

1. Addressing each of the Office of Inspector General (OIG) 7 Elements of an Effective Compliance Program as an integral part of the policy document.
2. Designation of the VOAWW Compliance Officer by title vice name
3. Designation VOAWW Board of Directors with ultimate responsibility for VOAWW's Compliance Program and Plan.
4. Designation of the organizational reporting hierarchy and a Compliance Committee.
5. Designation that the VOAWW Compliance Officer may meet directly with an authority in the chain of command above the Volunteers of America's CEO, Board of Directors, senior management and independently with the legal counsel.
6. Specific process, procedure and on-line training modules for Compliance
7. Reference to a written Code of Ethics.

<u>Additional Comments:</u>

1. The 2012 VOAWW policy documents were compared to the 2014 documents with comments as follows:
   a. The latter were found to be a more thorough and well laid out documents, ***laudably*** taking into account recommendations made as a result NSMHA's 2012 Administrative

Audit report. In particular, in separating the establishment of a Compliance Program (outline of objectives and definitions) from the details of the Compliance Plan (the procedures to accomplish the program objectives).

b. In addition, the latter also referenced the organization's Code of Ethics and other information regarding the enforcement of standards.

FINDINGS
NONE

CONSUMER RIGHTS ON-SITE REVIEW

Individual rights are posted by each staff member's call station; this will help the staff and caller when individual rights are being discussed. Because VOA does not have the public coming in for services, the usual posting are not required in "public" areas.

FINDINGS
NONE

RECOMMENDATIONS
NONE

COMPLAINT AND GRIEVANCE REVIEW

The review for the Grievance system will occur at a later date.

FINDINGS
NONE

RECOMMENDATIONS
NONE

INPATIENT UTILIZATION MANAGEMENT

North Sound Mental Health Administration (NSMHA) is responsible for responding to certification/authorization requests (Inpatient Utilization Management) for psychiatric hospitalization for residents of the North Sound region who have Medicaid, may be Medicaid-eligible or have been psychiatrically hospitalized involuntarily.

NSMHA delegates the Inpatient UM function to Volunteers of America (VOA) who conducts utilization management for voluntary psychiatric inpatient stays. Involuntary stays are based on the individual's involuntary treatment status (i.e., as long as the individual is determined to meet criteria for detention by the Designated Mental Health Professionals/Courts/Inpatient Facility, the inpatient stay is authorized by VOA) and are not subject to UM. Following is a look at inpatient data that provides a picture of inpatient utilization and the UM process.

In 2014, VOA received 1,903 requests for hospitalization. Of these, 1,046 (60% of requests) were requests for authorization of involuntary stays and the remaining 688 (40% of requests) were requests for voluntary hospitalization. The total number of requests for hospitalization in 2014 increased by about 14% from 2013 with total hospitalizations increasing by about 10%. In the context of total hospitalizations, the percentage of involuntary hospitalizations decreased by approximately 7% and voluntary hospitalizations increased by about 6%. This shift to voluntary from involuntary continues a downward trend in involuntary hospitalizations and may be due to such factors as the

implementation of Parent-Initiated Treatment statutes and focus on increasing regional consistency in applying ITA criteria in DMHP investigations.

Only voluntary hospitalization requests are subject to the Inpatient UM process. Of the 857 requests for voluntary hospitalization, 164 (19%) were denied either at the initial request or at a request for an extension. While the total number of denials has increased by 100% from 2013, likely due to more requests being subject to the UM process, denials as a percentage of the total number of voluntary requests has increased by about 6%, which is a change from previous years. This may be attributed to more people actively seeking a variety of treatment options as they now have Medicaid coverage as a result of the Affordable Care Act. This increase in requests for inpatient treatment would mirror what is occurring in outpatient services.

The quality of the Inpatient UM program is of utmost importance as inpatient psychiatric care is the most restrictive and most expensive service available. As NSMHA has delegated this function, NSMHA conducts a review of VOA's Inpatient UM process on a routine basis. Up until 2013 this review was conducted annually. However, due to VOA's consistently good performance on the review, the decision was made to conduct the review bi-annually. Therefore, no review was conducted in 2013 and the 2014 review occurred in November.

The results of the 2014 Inpatient UM chart review confirmed results of previous reviews with VOA meeting all but one review standard with at least 90% compliance. Eighteen charts were reviewed and the only standard that fell below 90% was related to documentation of discharge planning (88.9%). The two charts that were marked as not meeting this standard had the same issue, which was that discharge options for individuals without Washington Apple Health were not accurately identified (i.e., they were offered options for which individuals must have Washington Apple Health to qualify). The full data report of the VOA Inpatient UM review is attached to this summary. NSMHA's Medical Director has also reviewed a sample (16) of inpatient requests, both initial and extension requests, which were denied. Of these 16, NSMHA's Medical Director indicated that two (13%) of the denial determinations were not supported by the documentation. Review of additional 2014 denials will be conducted by NSMHA's Medical Director to determine if this is a pattern in the denials or an artifact of the small sample size.

VOA handles a large volume of inpatient authorization requests and has developed and maintains a quality Inpatient Utilization Management program to manage these requests.

FINDINGS
NONE
RECOMMENDATIONS
NONE

ACCESS

NSMHA contracts with Volunteers of America (VOA) to run a centralized access line to respond to all requests for mental health services in our five-county region. In 2014, VOA received 20,320 calls which is a 25% increase in call volume from 2013. This is very likely due to the increase in individuals with Medicaid from the Affordable Care Act who may now be more likely to seek services because

they have coverage. It should be noted that not all of these calls are a request for mental health services, but the total volume of calls do have an impact on the access process. NSMHA is currently working on its data for requests for service. As a result, that information will not be a part of this report.

The increased call volume appears to have had an impact on the average wait time, which has increased from about one and a half minutes or less in 2013 to 2-3 minutes in 2014. While wait time has increased, the abandonment rate remains low at 1.1% (224); the same as 2013. The abandonment rate is limited to individuals who call and hang up without speaking to an Access clinician or leaving a voicemail. What is not discernable from the data is how many callers have to leave a voicemail and are not able to be reached when VOA calls them back.

FINDINGS

NONE

RECOMMENDATIONS

It is recommended that VOA explore options of reducing wait time. However, this is not will not require corrective action at this point as NSMHA is in the process of exploring a "no wrong door" approach for individuals seeking services (i.e., individuals seeking services would not have to use the centralized access line, but could contact agencies directly). It seems likely that this will have an impact on the call volume at the centralized access line and may resolve some of the wait time issue. It should be noted that NSMHA believes the centralized access line is an essential component of this "no wrong door" approach and plans to maintain the centralized access option.

CORRECTIVE ACTION PLAN

No corrective action plan is required for this audit cycle.

Effective Date: 11/21/2005
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 1000 – Administrative: Delegation of NSMHA Functions and Responsibilities

Authorizing Source: 42 CFR§438.230, MHD contract; NSMHA
Cancels: 1548.00
See Also:
Providers are required to 'comply with' this policy — Approved by: Executive Director — Date: 9/3/2008
Responsible Staff: Quality Manager — Signature:

POLICY #1018.00

SUBJECT: DELEGATION OF NORTH SOUND MENTAL HEALTH ADMINISTRATION (NSMHA) FUNCTIONS AND RESPONSIBILITIES

PURPOSE

To establish a mechanism to provide for the delegation of specific functions and responsibilities required of a Pre-paid inpatient health plan (PIHP).

POLICY

NSMHA contracts with the Mental Health Division (MHD)as a mental health prepaid health plan and as such complies with all applicable federal, state and local statutes and regulations for mental health prepaid health plans as well as all applicable federal and state statutes and regulations for a regional support network (RSN).

As a PIHP, NSMHA is required to meet minimum standards, including the assurance that specific functions are addressed either through delegation or through direct performance. Any functions which NSMHA proposes to delegate to a sub-contractor will be evaluated through a formal delegation plan, consistent with the requirements of 42 CFR§438.230, to ensure the contractor's ability to performed the delegated activities. All formal delegation plans are submitted to MHD for approval according to required timelines.

PROCEDURE

Delegation plans include:

1. An evaluation of the contractor's ability to perform delegated activities,
2. A detailed description of the proposed subcontracting arrangements, including:
3. Name, address, and telephone number of the sub-contractor(s),
4. Specific contracted services,
5. Compensation arrangement, and
6. Monitoring plan.

A copy of the existing or draft subcontract that specifies the activities and reporting responsibilities delegated and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is not adequate. The Care Management functions cannot be delegated to a subcontracted community mental health agency (CMHA) within the NSMHA service area. No delegation or subcontract will replace the legal obligation of NSMHA to perform its responsibilities. NSMHA is fully responsible for all services provided whether those services are rendered by subcontractors or non-contracted providers.

NSMHA will develop and maintain written contracts that clearly recognize that legal responsibility for administration of service delivery system remains with NSMHA.

1. NSMHA retains responsibility to ensure that applicable standards of state and federal statutes and regulations and WACs are met, even when it delegates duties to providers.
2. NSMHA will monitor contracts and notify MHD of observations and information indicating that providers may not be in compliance with licensing or certification requirements. This monitoring will be addressed as part of the NSMHA annual administrative audit process. Additional reviews can also be performed and/or corrective action required based on concerns raised during the annual audit or as indicated.

NSMHA will terminate its contract with a provider if MHD notifies NSMHA of a provider's failure to attain or maintain licensure or certification, if applicable.

ATTACHMENTS

1018.01 – Sample Delegation Plan Form

Effective Date:
Revised Date:
Review Date:

North Sound Mental Health Administration

Section 5000 – Contracts/Audit: Subcontractual Relationships and Delegation

Authorizing Source:
Cancels: New
See Also:
Responsible Staff: Contracts Manager

Approved by: Executive Director
Motion#:

Date: 6-24-04

POLICY#5002.00

SUBJECT: SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION

PURPOSE

To define the requirements for oversight of delegated functions

POLICY

NSMHA will ensure that subcontractors performing delegated functions receive proper oversight and are accountable for these responsibilities.

PROCEDURES

1. Prior to delegation, NSMHA will evaluate the prospective subcontractor's ability to perform the activities to be delegated.
2. There will be a written agreement that specifies the activities and report responsibilities designated to the subcontractor, which provides for revoking the delegation or imposing other sanctions if the subcontractor's performance is inadequate.
3. NSMHA will monitor the subcontractor's performance on an ongoing basis and subject it to formal annual review.
4. If any deficiencies or areas for improvement are noted NSMHA will require the subcontractor to take corrective action.

ATTACHMENTS

None

Form: Sample Delegation Plan

Pre-Contract Evaluation and Readiness Review

Performance Requirements-Evaluation of Prospective Sub-Contractor's ability to perform delegated activities

Contractor can provide _____to the NSMHA service area in accordance with contract _____. Contractor is not a CMHA providing state plan services within the NSMHA region. (Please include a detailed description of the proposed subcontracting arrangements, including (1) name, address, and telephone number of the sub-contractor(s), (2) specific contracted services, (3) compensation arrangement, and (4) monitoring plan)

Contractor has the necessary number and type of qualified staff to perform the delegated function.

Contractor compensation is not structured so as to provide incentives for the contractor to deny, limit or discontinue medically necessary services to any enrollee and is in accordance with BBA and MHD requirements.

Contractor has the necessary policies, procedures and forms in place for effective operations.

Contractor has a quality management plan, process and mechanisms to collect data and report to NSMHA so that the PIHP can monitor and be accountable all functions and responsibilities delegated.

Contractor has a quality management plan, process and mechanisms that assess the quality and appropriateness of activities in this program

Contractor has an information system that is adequate to meet NSMHA data collection, transmittal, and quality requirements.

Contractor staff has appropriate training to provide the services as described.

Contractor staff has access to ongoing regular documented supervision with qualified supervisor(s).

Contractor personnel records and systems meet MHD and NSMHA requirements, including credentialing.

Contractor can demonstrate that they have a grievance system that meets NSMHA, MHD and BBA requirements.

Contractor can demonstrate the ability to comply and verbalize understanding of consumer rights in this area, including the right to a Notice of Action per BBA, NSMHA and MHD requirements.

Contractor can demonstrate the ability to comply with all applicable state and federal privacy and confidentiality requirements.

Contractor has access to all needed resources.

Other requirements to be evaluated

Monitoring Plan:

Attach Copy of existing or draft contract

Routine Utilization Review Tool 2015

The following Interpretive Guidelines (IGs) detail the criteria used by NSMHA staff to determine a "Yes" (and conversely a "No") and "NA" response to the standards in the NSMHA Routine Utilization Review (UR) tool. For each standard, there is also a section that indicates the primary documentation reviewed. This a list of the most common documentation reviewed, but other documentation may be reviewed, if necessary, to score the standard. Review is primarily focused on documentation added since the last review (typically the last year) unless documentation from another time period is applicable.

NSMHA has adopted these guidelines in order to provide inter-rater reliability of NSMHA staff when reviewing charts at agencies and to assist agencies in meeting the standards.

The standards on the tool are organized into the following sections:

- Initial Assessment
- Risk and Crisis Planning
- Recovery/Resiliency Plan (RRP)
- Ongoing Assessment
- Treatment Provision
- Medication Services
- Miscellaneous

Scoring note for reviewers – When marking an item "No" which cannot be corrected (e.g., a RRP that was done past the due date), please indicate in the comments that no action/follow up is needed.

After the review standards/interpretive guidelines is an Addendum, which includes Core Elements, Recovery/Resiliency Plan examples, and Crisis Planning examples.

Initial Assessment

1. **The determination of initial eligibility is consistent with the NSMHA Clinical Eligibility and Care Standards (CECS)** [WAC 388-877A-0130(3); DSHS Contract Exhibit A, 5.1 & 5.2 (PIHP)/1.23, 9.1-9.3 (SMHC); NSMHA Policy 1556]
   - **YES**
     - Documentation supports that the individual qualifies for ongoing services per the Access to Care Standards, which includes
       - Diagnosis of a mental illness that is covered by Washington State;
       - The individual's impairment and corresponding need(s) is the result of the covered mental illness;
       - Requested service/intervention is deemed reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of the covered mental illness;
       - The individual is expected to benefit from the intervention;
       - The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.
       - GAF/CGAS 60 or below.
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation
     - Collateral records (e.g., hospitals, PCP, previous outpatient treatment)

2. **The intake evaluation contains sufficient clinical information to justify the diagnosis** [WAC 388-877-0610(2) & WAC 388-877A-0130(5)]
   - **YES**
     - Diagnosis uses criteria in the DSM-IV-TR (or DSM-5 once implemented) including differential diagnosis when appropriate.

     AND
     - Is supported by documentation of sufficient clinical information.
       - Sufficient clinical information includes, but may not be limited to:
         - ✓ Description of the presenting problem by the individual and others as applicable
         - ✓ Documentation of the mental health condition provided by the individual or another system/support
         - ✓ Documentation of inquiry into
           - Mental health history including any inpatient/outpatient services and medications
           - Trauma/abuse history
           - Substance use including treatment - current & historical and GAIN-SS
           - Pathological gambling including treatment – current & historical
           - Medical concerns

- Current medications

- **NA**
  - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
- **Paperwork reviewed**
  - Intake evaluation
  - Collateral records (e.g., hospitals, PCP, previous outpatient treatment)

3. **The intake evaluation is age relevant** [WAC 388-877A-0130(6)(7)]
   - **YES**
     - The individual's age is identified in the intake.

     AND
     - If the individual is less than 18 years old, the intake addresses developmental history as evidenced by documentation of any developmental issues or documentation that there are no significant issues to note regarding developmental history. Developmental history does not require a separate document.

     AND
     - When applicable, age-related issues are incorporated into the assessment (e.g., diagnoses, eligibility, treatment recommendations).
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation
     - Behavior and Development form (if applicable)

4. **The intake evaluation is culturally relevant** [WAC 388-877A-0130(7)]
   - **YES**
     - The intake identifies the individual's culture/cultural history. Culture should be expanded beyond ethnicity.
       - Examples of cultural issues to consider include ethnic identification, family of origin, socioeconomic status, language, age, gender, housing status, family roles, religion, education, geographic, trauma, addictive behavior, general life style, etc. Please note that these are examples. It is NOT a review expectation that all of these issues are addressed for all individuals. Some will apply more than others for each individual.

     AND
     - As applicable, cultural issues are incorporated into the assessment (e.g., diagnoses, treatment recommendations).
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation

- CIV

5. **The intake evaluation includes a risk assessment** [WAC 388-877-0610(2i&j); NSMHA Clinical Guidelines]
   - **YES**
     - The intake identifies risk factors as well as protective factors.
       - Risk of harm to self or others, including suicide/homicide must be assessed.

     AND
     - There is a clinical assessment of risk, based upon existing risk and protective factors, that assigns a level of risk (e.g., none, low, medium, high).
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - Intake evaluation

6. **The Level of Care assigned at intake appears consistent with the documentation** [NSMHA Policy 1565]
   - **YES**
     - The CA/LOCUS completed at intake appears to be accurately scored per the documentation provided at the time.

     AND
     - The identified Level of Care corresponds with CA/LOCUS scoring or there is a rationale for the recommended Level of Care if different from what the CA/LOCUS tool identifies.
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - CA/LOCUS
     - Intake evaluation

7. **The treatment recommendations from the intake evaluation appear appropriate based on the identified needs, severity of symptoms, and Level of Care** [WAC 388-877-0610(2l); DSHS Contract 5.1 & 5.4 (PIHP)/9.1 & 9.2 (SMHC); NSMHA Policy 1565]
   - **YES**
     - The treatment recommendations (type and frequency of services) correspond with the identified needs and NSMHA Utilization Guidelines for the identified/recommended Level of Care.
   - **NA**
     - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
   - **Paperwork reviewed**
     - CA/LOCUS
     - Intake evaluation

8. **Individual's needs beyond mental health have been assessed (e.g., health care, substance use, legal, housing, daily activity needs appropriate to age and culture such as employment, education, socialization, etc)** [WAC 388-877A-0170(1b); DSHS Contract 10.2.3, 10.3.1(PIHP); NSMHA Policy 1551]
   - **YES**
     - Within the first 30 days following the first ongoing appointment, there is documentation that the individual has been asked if they have any additional needs beyond mental health and that any identified needs have been assessed (what is the individual's concern and desired outcome, what resources have been tried and/or are currently in place, etc). *Need for PCP reviewed in a separate standard.*
     - If "NO", reviewer shall identify which of the following needs have not been assessed (more than one may be identified) – health care, substance use, employment, education, legal, housing, developmental, socialization, other (identify specific need not assessed).
   - **NA**
     - The individual has not engaged past the intake assessment.

     OR
     - The chart has not been open for 30 days from the first ongoing outpatient appointment.
   - **Paperwork reviewed**
     - Intake evaluation
     - Recovery/Resiliency Plan (RRP)
     - Progress notes
     - Psychiatric notes

Risk and Crisis Planning

9. **Risk factors are continually monitored and addressed throughout the treatment episode** [WAC 388-877A-0135(4); NSMHA Clinical Guidelines & Policy 1551]
   - **YES**
     - Documentation in the chart indicates that risk factors (factors that put the individual at increased risk of harm to self or others or impaired functional status) for the individual are assessed throughout the course of treatment, (i.e., assessment of risk extends beyond the intake and assesses previously identified risks as well as any new risk factors).

     AND
     - The ongoing risk assessment is broader than risk of harm to self or others (e.g., substance dependence/abuse, trauma/victimization history, homelessness, criminal behavior/legal issues, not adhering to medications as prescribed, separation from family/natural supports, multiple residential placements, CPS/APS involvement).

     AND

- RRP and/or crisis plan includes a proposed plan of clinical intervention for dealing with any identified risk factors.

- **NA**
  - The individual has not received/engaged in ongoing treatment services.
- **Paperwork reviewed**
  - Intake evaluation
  - GAIN
  - Crisis plan, crisis alerts
  - Progress notes
  - Psychiatric service notes
  - Recovery and Resiliency Plan (RRP)
  - RRP review
  - LOCUS/CALOCUS
  - Extraordinary/Special Incident Reports Phone call logs
  - Previous treatment/hospitalization records

10. **When required (LOC 4 and above), requested or clinically indicated, a crisis plan exists** [NSMHA Policy 1551; WAC 388-877A-0170(1c)]
    - **YES**
      - A crisis plan is included in the individual's chart for individuals with a Level of Care (LOC) of 4 or above, if requested, or clinically indicated. Examples of when a plan is clinically indicated includes but is not limited to:
        - The individual is suicidal or has a history of suicide attempts
        - Individual engages in self-harm behaviors
        - Child engaging in behaviors with the likelihood of causing significant physical harm to self or others
        - Recent, increased use of crisis-oriented services (e.g., crisis line, crisis beds, emergency department)
        - Significant history of psychiatric inpatient admissions

    OR

      - The individual refused to complete a plan, but a plan was still required or clinically indicated AND the clinician completed the crisis plan addendum as thoroughly as possible based on the clinician's knowledge (i.e., the clinician should complete as much of the consumer part of the crisis plan as possible). At a minimum, the following information should be identified by the clinician:
        - Name and contact information for the mental health care provider
        - Crisis Line number
        - Clinician recommendations for proactive and progressive measures to prevent and intervene in a crisis

    AND

- If the individual refuses to participate in development of the plan, the clinician approaches the individual about input into the plan at a minimum of every 6 months until the individual participates.

- **NA**
  - Crisis plan is not required, requested or clinically indicated.

  OR
  - The chart has not been open for 30 days from the first ongoing outpatient appointment.

  OR
  - The individual has not received/engaged in ongoing outpatient services.
- **Paperwork reviewed**
  - Crisis plan
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Phone logs
  - Crisis system contact information

11. The crisis plan includes early warning signs of decompensation [NSMHA Policy 1551]

- **YES**
  - The crisis plan contains a section that describes clear signs (e.g., "triggers") by which the individual will recognize that they are experiencing a period of stress that either may lead to a crisis or has led to a crisis in their past.

  AND
  - The plan identifies how the individual will know the situation is escalating into a crisis (i.e., they are having difficulty diverting the crisis with early intervention strategies).
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has refused to participate in development of the plan and clinician does not have the information from another source).
- **Paperwork reviewed**
  - Crisis plan

12. **The crisis plan clearly defines a process by which to contact formal and/or informal supports including how to connect the individual/family directly to the emergency crisis intervention services** [NSMHA Policy 1551]
    - **YES**
        - The crisis plan includes the name and number of the mental health care provider (MHCP).

        AND
        - The crisis plan includes the telephone number of the Contractor's emergency crisis intervention services and that this service is available 24 hours a day.

        AND
        - The crisis plan includes names and telephone numbers of other formal and/or informal supports the individual has indicated they wish to contact during a crisis episode.

        AND
        - The crisis plan contains more than one listed contact (i.e., one more contact in addition to MHCP and crisis line) so that the individual has a back-up contact in the event that the first support they attempt to contact is unavailable.
    - **NA**
        - There is no crisis plan.

        OR
        - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).
    - **Paperwork reviewed**
        - Crisis plan

13. **The crisis plan focuses on individual health and safety** [NSMHA Policy 1551]
    - **YES**
        - The crisis plan identifies issues related to the individual's health and safety during times of crisis and includes recommendations for addressing identified issues. Examples of health and safety issues and potential recommendations:
            - Individual with a history of SA has access to weapons with a recommendation to ensure the weapons have been secured.
            - Individual has physical health issues requiring medication with a recommendation to ensure the individual has an adequate supply of needed medications.
            - The plan includes a list of places the individual can go to be safe and there is more than one safe place listed so that the individual has options.
    - **NA**
        - There is no crisis plan.

        OR
        - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

        OR

- Information for this section is not available (e.g., individual has declined to participate in development of the plan and clinician does not have the information from another source).

- **Paperwork reviewed**
  - Crisis plan

14. The crisis plan focuses on family/others health and safety [NSMHA Policy 1551]

- **YES**
  - The crisis plan identifies issues related to the individual's family members or other's health and safety during times of crisis for the individual and includes recommendations for addressing identified issues. Examples of health and safety issues and potential recommendations:
    - History of assaultive behavior with a recommendation not to see the individual alone during crisis or encourage individual to find a place to go where they can maintain safety.
    - Identification of issues that escalate the individual so that others know to stay away from those particular issues.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan or indicates no family/other safety considerations and clinician does not have the information from another source).
- **Paperwork reviewed**
  - Crisis plan

15. The crisis plan includes individual's roles, directives and responsibilities [NSMHA Policy 1551]

- **YES**
  - The crisis plan defines what the individual will do to prevent a crisis as well as what actions they will take during a crisis, including who they will contact.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan and clinician does not have the information from another source).

- **Paperwork reviewed**
- Crisis plan

16. The crisis plan includes family/other's roles, directives and responsibilities [NSMHA Policy 1551]

- **YES**
  - The crisis plan includes a plan defining what roles, responsibilities and actions the individual wishes family members and/or others (formal and informal supports) to take to prevent a crisis as well as during times of crisis for the individual.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan or indicates no family/other roles/directives/responsibilities for consideration and clinician does not have the information from another source).
- **Paperwork reviewed**
  - Crisis plan

17. The crisis plan includes proactive and progressive measures to divert or prevent crisis [NSMHA Policy 1551]

- **YES**
  - The crisis plan contains a section that details proactive steps identified as helpful to the individual in preventing a crisis and that will implemented if they feel that they are experiencing a situation that is causing them stress.

  AND
  - The plan addresses progressive measures that identify all viable less restrictive options for an individual/informal & formal supports to use once they perceive being in crisis. For example (in order from less to more restrictive), contact with informal supports, call clinician or office, call crisis line, consideration of crisis outreach, recommendation to use crisis beds before inpatient.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - Information for this section is not available (e.g., individual has declined to participate in development of the plan and clinician does not have the information from another source).

- **Paperwork reviewed**
  - Crisis plan

18. The crisis plan includes the individual's voice [NSMHA Policy 1551]

- **YES**
  - The crisis plan contains evidence of the individual's voice as indicated by direct quotes from the individual regarding early warning signs, prevention and intervention strategies, and what people and systems they want involved.
- **NA**
  - There is no crisis plan.

  OR
  - The crisis plan does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

  OR
  - The individual has declined to participate in development of the crisis plan.
- **Paperwork reviewed**
  - Crisis plan

Recovery/Resiliency Plan

19. Goals/objectives for treatment are based upon identified mental health needs [WAC 388-877-0620(1i) & WAC 388-877A-0135(2)(4)]

- **YES**
  - Goals/objectives for treatment follow clearly from mental health needs identified either at intake or during the ongoing course of treatment.

  AND
  - The RRP is updated to reflect any changes (new needs and achievement of goals/objectives) in the individual's mental health treatment needs.

  AND
  - All identified mental health needs are addressed on the plan (i.e., need is addressed by identification of treatment goals/objectives/interventions, a documented referral or explanation of deferment).
- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Intake evaluation
  - Progress notes
  - Psychiatric notes

20. **The RRP addresses/supports the individual in meeting needs beyond their identified mental health needs (e.g., health care, substance use, daily activity needs appropriate to age and culture such as employment, education, etc)** [WAC 388-877A-0120(7) & WAC 388-877A-0170(1b); DSHS Contract 10.2.3 & 10.3.1 (PIHP) & NSMHA Policy 1551]
    - **YES**
      - Needs (other than mental health) identified either at intake or during the ongoing course of treatment are addressed on the plan (i.e., need is addressed by identification of treatment goals/objectives/interventions; and/or, a documented referral and, as appropriate, active assistance in linking to referral; or explanation of deferment). *Addressing need for a PCP reviewed in a separate standard, but goals/objectives/interventions related to ongoing care by PCP is addressed here.*

      AND
      - The RRP is updated to reflect any changes in the individual's needs (other than mental health).
      - If "NO", reviewer shall identify which of the following needs have not been addressed (more than one may be identified) – health care, substance use, developmental, employment, education, legal, housing, other (identify specific need not assessed).
    - **NA**
      - There is no RRP.

      OR
      - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

      OR
      - The individual indicates no identified needs beyond mental health needs.
    - **Paperwork reviewed**
      - Recovery/Resiliency Plan (RRP)
      - RRP Review
      - Intake evaluation
      - Progress notes
      - Psychiatric notes
      - Psychiatric notes

21. **If during the intake the individual reports having no PCP, a referral to a PCP is subsequently offered and facilitated** [WAC 388-877A-0120(7); DSHS Contract 10.3.1 (PIHP); Washington State Department of Health EPSDT; NSMHA per QMOC recommendation post Mortality Review]
    - **YES**
        - Documentation indicates that the individual either was asked or self-reported at intake that they currently do not have a PCP and was offered a list of PCPs/clinics within 30 days of the individual's first ongoing outpatient appointment.

        AND
        - For children/adolescents (20 and under) on Medicaid who have a PCP, but have not seen that PCP in the past two years, documentation in the clinical record indicates the provider has encouraged the individual/family to make an appointment with the PCP.

        AND
        - When clinically appropriate, active assistance with linking to the referral is provided.

        AND
        - Status of obtaining a PCP or, for individuals 20 and under, making an appointment is reviewed at a minimum of every 6 months until the individual has obtained a PCP or, for individuals 20 and under, made an appointment.
    - **NA**
        - Documentation indicates that the individual was either asked or self-reported that they currently have a PCP or, for children/adolescents 20 and under on Medicaid, have seen a PCP in the past two years.

        OR
        - The individual has not been in services for more than 30 days from the first ongoing outpatient appointment.

        OR
        - The individual has not received/engaged in ongoing services.

        OR
        - Intake evaluation was completed prior to completion of the previous Routine UR (currently May of the previous year).
    - **Paperwork reviewed**
        - Intake evaluation
        - Health Screening Questionnaire
        - Recovery/Resiliency Plan (RRP)
        - Progress notes

22. **The RRP includes goals or objectives that allow the provider and individual to evaluate progress toward the individual's recovery goals/discharge from treatment** [WAC 388-877-0620(1h); NSMHA Policies 1540 &1551]
    - **YES**
        - The RRP identifies goals/objectives that, once achieved, indicate the end of the treatment episode.

        AND

- The goals or objectives listed in the RRP are measurable. They allow the individual and provider to evaluate & document progress towards the individual's recovery goals.

- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).
- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)

23. The RRP is individualized and developed collaboratively with the individual, the individual's parent/other legal representative as applicable, and significant others as requested by the individual [WAC 388-877-0620(1c-f) & WAC 388-877A-0135(3)(6)]

- **YES**
  - The RRP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with).

  AND
  - The RRP was developed collaboratively with the individual and/or their legal representative as evidenced by the individual's/legal representative's signature on the RRP and/or quotes from the individual and/or legal representative documented in the RRP.

  AND
  - Family or significant others are included in the development of the RRP as requested by the individual; or, the provider has inquired, but the individual is 13 years of age or older and declines to include family or significant others in development of their RRP.

  AND
  - The RRP is individualized and includes at least one goal/objective identified by the individual or their legal representative, if applicable.
- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).
- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)

24. With the individual's consent, or their parent or other legal representative if applicable, as allowed by confidentiality rules, or when required, the RRP includes coordination with any provider, system, or support the individual identifies as being relevant to their treatment [WAC 388-877A-0135(5)]

- **YES**
  - The names of other providers, systems, supports are documented in the individual's clinical record *OR* documentation that information was requested and not provided.

  AND
  - When needs beyond the scope of mental health services are identified (whether at initiation of treatment or later in the treatment episode), documented attempts are made to obtain a Release of Information (ROI) for the relevant provider, system, support.

  AND
  - Inclusion of coordination objectives/interventions with any provider, system, or support identified as being relevant to treatment when required, allowed by confidentiality rules, or to which the individual has consented.
    - Examples of coordination may include ***but are not limited to*** coordination with:
      - Individualized family service plan (IFSP) when serving children under three (3) years of age
      - Education system for children especially those who are on IEPs (Individualized Education Programs)
      - Children's Administration
      - Department of Corrections
      - PCP, other health care providers
      - Substance use treatment provider
      - Individual's church
      - Family, friends

  AND
  - Plan identifies the role of each relevant provider, system, support and the frequency of planned contact.
  - If "NO", reviewer shall identify which of the following categories of provider/system/support have not been included (more than one may be identified) – health care, substance use, employment, education, legal, housing, developmental, socialization, other (identify specific need not assessed). In addition to identifying the category, the reviewer shall identify the specific provider/system/support (e.g., Evergreen, Housing Authority, mom).
- **NA**
  - There is no indication that the individual or their parent or other legal representative, has consented to or requested coordination with any system or organization or identified any such system or organization as being relevant to their treatment and there is no indication that coordination is allowed by confidentiality rules or otherwise required.

  OR
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - Crisis plan
  - Collateral records
  - Intake evaluation
  - Progress notes

25. **The treatment proposed/provided is medically necessary and consistent with NSMHA clinical guidelines. (Note: In the absence of a NSMHA clinical guideline, generally accepted clinical practice for the individual's diagnosis)** [WAC 388-865-0280(2)(h); DSHS Contract 5.4.1.1 & 7.7 (PIHP)/9.1.1.3 (SMHC); NSMHA Clinical Guidelines]
    - **YES**
      - The RRP identifies state plan, medically necessary service modalities (i.e., the interventions are deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention and any other formal or informal system or support cannot address the individual's unmet needs).

      AND
      - Documentation reflects treatment consistent with generally accepted clinical practice as evidenced by provision of treatment that is consistent with either established NSMHA clinical guidelines or with generally accepted clinical practice guidelines such as those outlined by the American Psychiatric Association (APA) and the American Academy of Child & Adolescent Psychiatry (AACAP) *OR* there is a rationale why treatment is not consistent with NSMHA clinical guidelines or with generally accepted clinical practice.
        - See NSMHA Clinical Guidelines Core Elements (attached in addendum) for minimum expectations.
    - **NA**
      - There is no RRP OR the RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

      AND
      - The individual has not received/engaged in ongoing services.
    - **Paperwork reviewed**
      - Recovery/Resiliency Plan (RRP)
      - RRP Review
      - Intake evaluation
      - Progress notes
      - Psychiatric notes

26. The RRP is strengths-based [WAC 388-877-0620(1b) & WAC 388-877A-0135(2); NSMHA Clinical Guidelines – Guidelines to Person-Centered Recovery & Resiliency]

- **YES**
  - The clinical record documents specific strengths/resources/assets of the individual/family that can be used in the course of treatment/recovery.

  AND
  - The RRP focuses on what the individual will do and not what they won't do. Specific strengths/resources/assets (capacities, resiliencies, talents, coping abilities, supports) of the individual/family are incorporated into the objectives and interventions of the RRP to assist them in attaining their recovery goals (i.e., incorporation of strengths means more than listing the strengths on the RRP).
    - General examples of strengths that may be incorporated:
      - Interests, hobbies, talents (what types of prosocial activities/interests does the individual have, what does the individual do with leisure time; e.g., writing, music, fishing, bicycling, baseball, etc)
      - Capacities, resiliencies, coping abilities (what does the individual think they are good at naturally, what skills have they learned; e.g., good organizational skills, thinks positively, likes helping others, has knowledge about own mental health concerns, knows some strategies for managing mental health symptoms, etc)
      - Support systems (e.g., family, friends, school, church, AA, Big Brother/Big Sister, Girl/Boy Scouts, etc)
      - Life roles (what life roles does the individual have currently in life and feel that they are good at/enjoy; e.g., parent, spouse, son/daughter, friend, student, employee, etc.)
    - Strengths shall be incorporated in a way that demonstrates they are actively used to support the individual in treatment (i.e., the strengths and how they are used may be identified in various places on the RRP, but need to demonstrate their active use to support the individual's resiliency and recovery).
    - See addendum "Strength-Based Recovery/Resiliency Plan Examples" for specific examples of incorporating strengths into the RRP.
  - If "NO" due to no strengths to use in treatment were identified in the clinical record, reviewer shall:
    - Identify that strengths to use in treatment need to be identified and include possible strengths the reviewer may have noted in the chart.
  - If "NO" due to strengths identified not being actively incorporated into the RRP, reviewer shall:
    - Identify the strengths that were identified to use in treatment, but not actively incorporated.
- **NA**
  - There is no RRP.

  OR
  - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Crisis plan
  - Intake evaluation
  - Progress notes
  - Psychiatric notes

27. **The RRP addresses age, cultural or disability issues identified by the individual or their parent or other legal representative, if applicable, as relevant to treatment** [WAC 388-877-0620(1b); NSMHA Clinical Guideline – Guidelines to Person-Centered Recovery and Resiliency]
    - **YES**
      - The RRP addresses age, cultural and/or disability issues relevant to treatment.
        - As defined in WAC 388-865-0150, a disability is defined as a developmental disability, serious physical handicap, or sensory impairment.
        - Culture should be expanded beyond ethnicity. Examples of cultural issues to consider beyond ethnicity include family of origin, socioeconomic status, language, gender, housing status, family roles, religion, education, geographic, trauma, addictive behavior, general life style, etc. Please note that these are examples. It is not a review expectation that all of these issues are addressed for all individuals.
        - Specific examples of age, cultural and disability issues that may be relevant to mental health treatment:
          - Single parent who feels the stress of parenting is exacerbating their depression.
          - Youth about to transition from middle school to high school says that their existing anxiety disorder is much worse as they get closer to starting at the new school.
          - Individual who, because of a developmental disability, has increased difficulty acknowledging or discussing mental health concerns.
          - Female, seeking treatment for a traumatic event, who is willing but wary of working with a male clinician due to the trauma history.
          - Individual with current co-morbid issue of substance abuse that is significantly impacting mental health issue and who is engaged with AA, but is unwilling to consider other substance treatment options.
          - Youth who indicates parent/caretaker's substance use/abuse and treatment is impacting his mental health.
    - **NA**
      - There are no identified age, cultural or disability issues relevant to treatment.

      OR
      - There is no RRP.

      OR

- The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

- **Paperwork reviewed**
  - Recovery/Resiliency Plan
  - RRP Review
  - Consultation notes
  - Intake evaluation
  - Progress notes
  - Psychiatric notes

Ongoing Assessment/Status Updates

28. The current Level of Care assigned appears consistent with the documentation [NSMHA Policy 1565]

- **YES**
  - There is a current CA/LOCUS.

  AND
  - The current CA/LOCUS appears to be accurately scored per the documentation provided at the time.

  AND
  - The identified Level of Care corresponds with CA/LOCUS scoring or there is a rationale for the recommended Level of Care if different from what the CA/LOCUS tool identifies.
- **NA**
  - CA/LOCUS from intake is still current (i.e., no clinically significant events or minimum period, at least annually for Level of Care 1 & 2 and minimum of every 6 months for Level of Care 3 and up, of time requiring completion of a new CA/LOCUS).

29. The determination of eligibility for continued stay is consistent with NSMHA Clinical Eligibility and Care Standards (CECS) [WAC 388-877; DSHS Contract 5.2.3 (PIHP)/9.1 & 9.2; NSMHA Policies 1539, 1540 &1556]

- **YES**
  - Documentation supports that the individual qualifies for ongoing services per NSMHA continued stay criteria and is not appropriate for discharge as evidenced by:
    - Individual continues to meet Access to Care Standards.
    - Services continue to meet medical necessity criteria:
      - The individual's impairment and corresponding need(s) are the result of a covered mental illness.
      - Intervention is deemed reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the covered mental illness.
      - The individual is expected to benefit from the intervention.

- The individual's unmet need(s) would not be more appropriately met by any other formal or informal system or support.
- The individual's documented RRP goals/objectives have not been substantially met.

AND/OR one or more of the following:

- Individual is engaged in a transition to discharge plan (i.e., the individual is expected to discharge within the next 90 days).
- Although the individual's functioning has improved to the point of appearing appropriate for discharge (per GAF/CGAS, CA/LOCUS, CANS, etc), continued treatment is deemed medically necessary to prevent deterioration as evidenced by previously documented, unsuccessful efforts at discharge.
- Although individual's functioning has improved, they have needs, which cannot be met by any other system or resource and, if unmet, would result in deterioration of functioning and likely re-admisstion.
- The individual has a current Conditional Release or Less Restrictive Court Order (CR/LR).

AND

- Rationale for continued stay includes an evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods and/or intensity of services as applicable.

- **NA**
  - Individual has not been in services long enough to be reviewed for continued stay.
- **Paperwork reviewed**
  - CA/LOCUS
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Crisis Plan
  - Phone logs
  - Progress notes
  - Psychiatric notes

30. **There is sufficient evidence to support the most recent diagnosis, including provisional diagnoses, identified in the clinical record** [WAC 388-877-0640 & WAC 388-877A-0120)
    - **YES**
      - The clinical record contains description of DSM-IV TR (or DSM-5 once implemented) criteria in sufficient detail to validate the most recent diagnosis, including any assigned provisional diagnoses.

      AND
      - Any diagnostic changes are clearly noted.

      AND
      - Any discrepancies in the documentation regarding diagnoses have been addressed.
    - **NA**
      - Not used with this standard.

- **Paperwork reviewed**
  - Intake evaluation
  - Collateral records
  - Diagnosis change forms
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - RRP Review

Treatment Provision

31. **The treatment (types of services and interventions) identified on the RRP has been implemented** [WAC 388-865-0225(2); 388-865-0320(4); 388-877A-0170(1)]
    - **YES**
      - Documentation in the chart indicates that treatment strategies identified on the RRP have been implemented during the course of treatment.

      OR
      - There is an adequate explanation, with noted individual agreement, describing why identified treatment strategies have not been implemented and are being deferred currently.
    - **NA**
      - There is no RRP.

      OR
      - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

      OR
      - The individual has not received/engaged in ongoing treatment services.
    - **Paperwork reviewed**
      - Progress notes
      - Recovery/Resiliency Plan (RRP)
      - RRP Review
      - Psychiatric notes
      - Consultation notes

32. **The clinical record contains documentation of objective progress toward established goals on the RRP** [WAC 388-877-0640(6)(b)]
    - **YES**
        - Progress notes reflect that RRP goals are routinely addressed.

        AND
        - Progress notes document specific examples of the individual's response to treatment/objective progress toward goals established in their RRP (for example, the progress toward the goal as documented in the chart can be compared to the measurable goal on the RRP as evidenced by "x" to determine progress) *OR* if a particular goal in the individual's RRP is being deferred, there is an explanation as to why it is currently being deferred, including noted agreement by the individual for the goal to be deferred at present.

        AND
        - Progress notes identify immediate, next steps toward achievement of RRP goals/objectives.
    - **NA**
        - There is no RRP.

        OR
        - The RRP does not yet reflect this information as the plan is still in development (i.e., the chart has not been open for 30 days from the first ongoing outpatient appointment).

        OR
        - The individual has not received/engaged in ongoing treatment services.
    - **Paperwork reviewed**
        - Recovery/Resiliency Plan (RRP)
        - RRP Review
        - Progress notes
        - Psychiatric notes
        - CA/LOCUS

33. **The clinical record reflects intensity and frequency of interventions that correspond with the individual's needs, severity of symptoms, and Level of Care and vary over time as appropriate** [WAC 388-865-0320; DSHS Contract 5.4.2 (PIHP)]
    - **YES**
        - The clinical record documents that the frequency and intensity of interventions provided correspond with the individual's needs, severity of symptoms, and Level of Care over the course of treatment (i.e., individuals are not overserved or underserved). Examples of evidence that frequency and intensity of services is based on needs may include, but are not limited to:
            - In general, the hours of outpatient service the individual receives are within the ranges detailed in the NSMHA Utilization Guidelines for the individual's Level of Care (LOC)
                - LOC 1: 1-10 hours/year
                - LOC 2: 11-30 hours/year

- LOC 3: 31-60 hours/year
- LOC 4 & up: 60+ hours/year
- For more information on Utilization Guidelines see NSMHA Policy 1565.01 for child and adolescent guidelines & NSMHA Policy 1565.02 for adult and older adult guidelines. Please note that these are guidelines and that some individuals will fall outside the range of hours, above or below, for their identified LOC.

▪ Progress notes and RRP, as applicable, document changes to frequency and intensity of interventions when an individual's needs increase or decrease (this could be a short-term or longer-term change). Examples:
- Provision of more intense/frequent service hours to LOC 1 or 2 with plan to complete treatment & discharge in less than a year (e.g., LOC 1 seen 2x/month with completion of treatment in 4 months)
- Provision of more intense/frequent service hours when individual experiences decompensation
- Titration of med monitoring as individual demonstrates increased independence in taking meds
- Over the course of treatment, as goals are achieved, documentation addresses titration of services and increased use of natural supports and community resources to transition the individual to discharge.

- **NA**
  - The individual has not engaged in ongoing treatment services. Scoring of provider re-engagement efforts for individuals who cancel or no-show should be completed under #34. Individuals not receiving services due to provider reasons should be scored here.
- **Paperwork reviewed**
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Progress notes
  - Psychiatric notes
  - CA/LOCUS

34. If the individual has repeated cancellations and/or "No Shows", there is evidence that the intensity of the efforts to re-engage the individual were congruent with the individual's identified need/risk [NSMHA; WAC 388-865-0320; DSHS Contract 5.4.1.1]

- **YES**
  - There is documentation that the individual has repeated cancellations and/or "No Shows" and that the intensity of the efforts by the mental health staff to re-engage the individual were congruent with the individual's identified need/risk*.
    - When considering risk and need, the following information may be helpful:
      - CA/LOCUS composite and dimension scores
      - Assessment of protective factors that mitigate the impact of the risk factors (e.g., other system involvement, strong natural supports, low stress environment)
      - Guidelines for re-engagement efforts based on need/risk. *These guidelines are meant to provide some direction when determining what type of re-engagement efforts to utilize and represent more of a minimum standard. These guidelines should not replace a clinician's clinical judgment in determining re-engagement efforts.*

  - Individuals at Level of Care 3 and above receive a re-engagement letter at minimum.
  - Individuals at Levels of Care below 3 with moderate risk or transition needs (e.g., transfer of medications, development of community supports) receive a re-engagement letter at minimum.
  - Individuals with more serious risk or transition needs receive more intensive re-engagement efforts such as attempts to contact the individual and/or natural supports, as allowable, by phone and/or in person.
  - If it appears that a home visit may have been warranted, but safety or privacy are potential issues, there is a documented rationale for not conducting a home visit and documentation that other types of re-engagement efforts have been utilized.
- **If appropriate re-engagement efforts have been made, but the episode of care has not yet closed, there should be a rationale for why the episode of care is still open. Otherwise, mark the standard as "No" with comment that the chart should be closed or rationale provided as to why the episode of care needs to remain open.*__NA__
  - There is no documentation that the individual has repeated cancellations and/or "No Shows".
- __Paperwork reviewed__
  - Progress notes
  - Phone logs
  - Re-engagement letters or other correspondence to the individual

35. The clinical record contains documentation of coordination with the individual's current external health care provider(s) [WAC 388-877-0640(12, 14-17); NSMHA Policy 1517]

- __YES__
  - As allowed (ROI, confidentiality rules, required), the mental health clinician has contacted the external health care provider(s), minimally, when:
    - The individual initiates care with the mental health agency.
    - The mental health agency begins prescribing medication for the individual.
    - There are changes in medication, prescribed by the mental health agency that may impact health care.
    - There are changes in the individual's clinical condition that potentially impact his/her external health care.
  - If the individual declines to provide information regarding external health care providers, indicates they do not have any external health care providers, refuses to sign an ROI for external health care providers and/or indicates they do not have any external health care needs, there is documentation that the clinician inquired again, at a minimum, every six months.
- __NA__
  - Information is unavailable as the individual has not received/engaged in ongoing services.

  OR
  - The individual indicates they do not have any external health care providers.

  OR
  - No external health care needs have been identified.

  OR

- The individual has refused to sign an ROI to facilitate care coordination.

- **Paperwork reviewed**
  - Health Screening Questionnaire
  - Intake evaluation
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Progress notes
  - Phone logs

36. **With the individual's consent, or their parent or other legal representative if applicable, as allowed by confidentiality rules, or when required, the clinical record documents ongoing coordination with any provider, system, or support the individual identifies as being relevant to their treatment** [WAC 388-877-0640(12, 16-17)]

- **YES** (coordination with healthcare providers reviewed separately)
  - As allowed (ROI, confidentiality rules, required), the mental health clinician has contacted the other provider/system/support minimally, when:
    - The individual initiates care with the mental health agency.
    - There are changes in the individual's clinical condition and/or care that potentially impact the individual.
  - If the individual declines to provide information regarding other involved provider/system/support, indicates they do not have any involved provider/system/support, refuses to sign an ROI, and/or indicates they do not have any needs other than mental health, there is documentation that the clinician inquired again, at a minimum, every six months.
  - If "NO", reviewer shall identify which of the following categories of provider/system/support that do not have documented coordination (more than one may be identified) – health care, substance use, employment, education, legal, housing, developmental, socialization, other (identify specific need not assessed). In addition to identifying the category, the reviewer shall identify the specific provider/system/support (e.g., Evergreen, Housing Authority, mom).

- **NA**
  - Information is unavailable as the individual has not received/engaged in ongoing services.

  OR
  - The individual indicates they do not have any other provider/system/support.

  OR
  - No related needs have been identified.

  OR
  - The individual has refused to sign an ROI to facilitate care coordination.

- **Paperwork reviewed**
  - Health Screening Questionnaire
  - Intake evaluation

- Recovery/Resiliency Plan (RRP)
- RRP Review
- Progress notes
- Phone logs

Medication Services

37. Referral for medication evaluation is provided when clinically indicated [WAC 388-877A-0135; DSHS Contract 13.3 (PIHP)]

- **YES**
  - Documentation indicates that referral for a medication evaluation is provided when clinically indicated for the individual. Clinically indicated is defined with the PIP Decision Tree and Target Symptoms list and NSMHA Clinical Guidelines Core Elements list.

  OR
  - There is an explanation regarding why the referral for medication evaluation is being deferred.
- **NA**
  - Documentation reviewed does not indicate any need for a medication evaluation.

  OR
  - The individual has not received/engaged in ongoing outpatient services.
- **Paperwork reviewed**
  - Intake evaluation
  - Recovery/Resiliency Plan (RRP)
  - RRP Review
  - Progress notes
  - Psychiatric notes
  - Referral form

38. If prescribed by agency staff, the intensity of medication monitoring is sufficient to meet the individual's need [WAC 388-877A-0180(5)]

- **YES**
  - Documentation indicates medications are monitored appropriately, either on a routine basis or on an "as needed" basis (i.e., the individual has had recent medication needs, such as readjustment, renewal, change, cancellation, expressed medications aren't working, etc).
- **NA**
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Psychiatric notes
  - Progress notes

- Recovery/Resiliency Plan (RRP)
- RRP Review (180-day Review
- Hospital discharge records
- Court documents such as LRO or CRO paperwork
- LRO Monitoring Report

39. The clinical record contains both the name and purpose of the medication prescribed [WAC 388-877A-0180(8cii)]

- **YES**
  - The clinical record contains both the name and purpose of the medication prescribed.
- **NA**
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Psychiatric notes
  - Medication log

40. The clinical record contains the prescribing authority's reason for changing or stopping the medication [WAC 388-877A-0180(8cv)]

- **YES**
  - The clinical record contains the prescribing authority's reasons for changing or stopping the medication.
- **NA**
  - The medications prescribed have not been changed or stopped.
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Psychiatric notes

41. The clinical record includes documentation of the medications' effects, interactions, and side effects staff observe or individual reports spontaneously or as a result of questions from staff [WAC 388-877A-0180(8b)]

- **YES**
  - Documentation includes information regarding the effects, interactions and side effects of each prescribed medication as observed by staff or reported by the individual OR as requested by staff when not observed by staff or reported by the individual.

AND

- Documentation of effects, interactions and side effects of CMHA-prescribed medication occurs, at a minimum, at each medication management appointment with the prescriber. More frequent documentation may be warranted (e.g., newly prescribed medication or dosage, history of not adhering to the medication plan).

AND

- When negative effects, interactions and side effects are noted, there is documentation that the issue was reviewed by the prescriber and outcome of the review (e.g., continue/discontinue medication, change dosage).

- **NA**
  - The individual is not prescribed medication by agency staff.

  OR
  - The individual has only had the initial medication appointment and there have been no subsequent appointments (medication or otherwise) to note medication effects, interactions, side effects.
- **Paperwork reviewed**
  - Progress notes
  - Psychiatric notes

42. **There is a delineation of psychiatric and non-psychiatric medications** [WAC 388-877-0640(14); NSMHA per QMOC recommendation post Mortality Review]
- **YES**
  - The clinical record documents both the psychiatric and the non-psychiatric medication the individual is taking.
- **NA**
  - The individual is not taking both psychiatric and non-psychiatric medications.

  OR
  - The individual is not prescribed medication by agency staff.
- **Paperwork reviewed**
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - Health Screening Questionnaire

43. **The clinical record documents consideration/efforts of transfer of medication management responsibility to primary care providers when appropriate** [NSMHA Policy 1546]
- **YES**
  - One of the following:
    - The individual is on a stable medication regimen and there is no longer medical necessity for the specialty care of mental health medication management services at a CMHA. A stable medication regimen includes:
      - No medication changes for a minimum of 6 months for individuals with a complex medication regimen (includes but is not limited to two or more psychiatric medications in the same class or three or more psychiatric medications total) or individuals who have multiple psychiatric diagnoses requiring mental health specialty medication expertise.
      - No medication changes for a minimum of 3 months for individuals without a complex medication regimen.

OR
- The PCP makes changes to medications currently prescribed by the CMHA and will not agree to stop making changes to those medications despite potential risk to the consumer.

OR
- The individual requests transfer of medication management services to the PCP.

AND
- There are documented efforts to facilitate transfer (i.e., work with existing PCP or locate a PCP willing to prescribe).

- **NA**
  - The individual is not prescribed medication by agency staff.

  OR
  - The individual is not on a stable medication regimen.

  OR
  - PCP is not making changes to medications prescribed by the CMHA.

  OR
  - The individual has not requested transfer.
- **Paperwork reviewed**
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - Health Screening Questionnaire

44. The clinical record documents a coordinated transfer of medication management responsibility to primary care providers
[NSMHA Policy 1546]

- **YES**
  - Documentation of the rationale for referring or transferring the individual to a PCP.

  AND
  - Documentation that the clinician and/or prescriber have discussed medication management transfer with the consumer.

  AND
  - With consent of the consumer, contacted the PCP regarding transfer OR, if the individual is not in agreement with a transfer, the clinician and/or prescriber have made efforts to locate a PCP willing to accept medication management responsibilities (i.e., PCPs have been contacted about the possibility of managing a particular medication regimen without specific information about the individual).

  AND
  - Documentation that PCP has agreed to referral/transfer of the individual for medication management.

  AND

- As allowed by confidentiality rules or an ROI, necessary psychiatric and medication records are sent to the PCP prior to transfer.
AND
- Individual's treatment episode at the CMHA remains open long enough after transfer to ensure successful transfer.
AND
- Written plan outlining what happens if the individual becomes unstable on medications and/or PCP believes it would be better for the mental health specialist prescriber to consult or resume medication management.

- **NA**
  - The individual is not prescribed medication by agency staff.
  OR
  - Medication management responsibility has not been transferred to a primary care provider.
- **Paperwork reviewed**
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Recovery/Resiliency Plan (RRP)
  - Health Screening Questionnaire

Miscellaneous

45. If there is an indication that abuse, neglect or exploitation is suspected or evident, there is documentation in the chart that this was reported to the appropriate authorities [WAC 388-877-0640(9)]

- **YES**
  - Documentation in the chart that abuse, neglect or exploitation of the individual is suspected or evident and it has been reported to the appropriate authorities as required by mandatory reporting requirements.
- **NA**
  - There is no documentation in the chart that abuse, neglect or exploitation of the individual is suspected or evident that would require a mandated report.
- **Paperwork reviewed**
  - Access call sheet
  - Intake evaluation
  - Progress notes
  - Psychiatric notes
  - Phone logs

ADDENDUM

Core Elements

Recovery/Resiliency Planning Examples

Crisis Planning Examples

Core Elements

Adult Anxiety Disorders

- There is some form of cognitive behavioral therapy to address anxiety.
- There is an attempt at medication management. If the consumer has a history of substance abuse, then non-sedative medications should be tried first.

Adult ADHD

- Screen for co morbid substance abuse.
- Alternatives to stimulants are tried first such as Strattera, Wellbutrin, and Effexor.
- If Stimulants are used, then there are efforts to monitor for Substance Abuse and diversion of medication to family and peers.

Adult Bipolar Disorder

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania or depression

Adult Borderline Personality

- The treatment team has established a method to discourage self-injury.
- Use of DBT informed therapy or documentation that it was considered with rationale for not providing DBT informed therapy.

Adult Co-occurring Disorders

- The MH provider must coordinate care with substance abuse provider

Adult Dissociative Disorder

- There is a form of psychotherapy which is focused on integration of personality.

Adult Eating Disorders

- There is some form of cognitive behavioral therapy to address distorted body image.
- There is coordination with a medical provider who is monitoring weight and nutrition.
- Failure of intensive outpatient treatment is required before considering higher levels of care.

Adult Major Depressive Disorder

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Adult Neurocognitive Disorder (Dementia)

- *This group demonstrates behaviors that are aggressive, psychotic or depressed.* Care should be coordinated with primary care givers and PCP.
- Efforts should be made to establish a baseline of behaviors, exploring any environmental triggers and medications should be reviewed.

Adult Obsessive Compulsive Disorder

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors.
- Trial of medication has been attempted with SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

Adult Schizophrenia

- An anti-psychotic medication is being used or there is documentation that it was considered with the rationale for not prescribing
- The clinician/case manager is monitoring whether or not the consumer is agreeing to take prescribed psychiatric medications

Adult Trauma Disorders

- The focus of therapy (group or individual) is on resolving the trauma, through use of cognitive behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered.

Adult Suicidal Behaviors

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of risk (provides a clinical opinion), based on the risk & protective factors, and assigns a level of risk
- The RRP reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

Child & Youth Anxiety Disorders

- There is some form of cognitive behavioral therapy to address anxiety.
- There is an attempt at medication management. If the consumer has a history of substance abuse, then non-sedative medications should be tried first.

Child & Youth ADHD

- Patient management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered.
- There are documented efforts at school accommodations or there is documentation that it was considered with a rationale why it is not being offered.
- A psycho-stimulant has been tried or there is documentation that it was considered with a rationale for not prescribing.

Child & Youth Bipolar Disorder

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania or depression

Child & Youth Conduct Disorder

- Patient management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered.

- The treatment providers are not allowing or supporting efforts for the client to avoid consequences (legal or other consequences) for violating the rights of others.

Child & Youth Co-occurring Disorders

- The MH provider must coordinate care with substance abuse provider

Child & Youth Dissociative Disorder

- There is a form of psychotherapy which is focused on integration of personality.

Child & Youth Eating Disorders

- There is some form of cognitive behavioral therapy to address distorted body image.
- There is coordination with a medical provider who is monitoring weight and nutrition.
- Failure of intensive outpatient treatment is required before considering higher levels of care.

Child & Youth Major Depressive Disorder

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Child & Youth Obsessive Compulsive Disorder

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors.
- Trial of medication has been attempted with SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

Child & Youth Psychotic Disorders

- An anti-psychotic medication is being used or there is documentation that it was considered with rationale for not prescribing.
- There has been an exhaustive effort to rule out organic causes of the psychosis such as medical disorders, metabolic disorders, infection, brain injury & drug intoxication or withdrawal.
- If the child is 13 or younger, then there is documentation of consideration if psychotic symptoms related to malingering, attention seeking, misperception, suggestion from caregivers or cultural issues such as religion or other family beliefs.

Child & Youth Trauma Disorders

- The focus of therapy (group or individual) is on resolving the trauma, through use of cognitive behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered.

Child & Youth Suicidal Behaviors

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of risk (provides a clinical opinion), based on the risk & protective factors, and assigns a level of risk
- The RRP reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

RECOVERY/RESILIENCY PLAN EXAMPLES			
Goal	**Strength(s)**	**Objective**	**Intervention(s)**
"I want to understand what's going on with me."	"I like to write. I can write about what's going on with me to try and understand it."	By 2/1/11, Joe will be able to describe at least 5 signs of anxiety.	By 1/1/11 Joe will obtain a notebook and make a daily entry describing any anxiety he may have experienced that day. Clinician and Joe will discuss journal entries at individual psychotherapy once every 2 weeks.
"I want to feel less worried and tense all the time."	"Playing the guitar is one thing that helps me relax and de-stress."	By 2/1/11 Jane will be able to effectively use at least 3 coping skills to manage feelings of stress.	Jane will play her guitar for 30 minutes whenever she is feeling stressed. Clinician and Jane will identify 2 additional stress management strategies by 12/1/10.
"I want to be more comfortable around people and feel less lonely."	"I go to church regularly."	Joe will report increased comfort with socializing from 3 to 6 (1-10 scale).	Clinician and Joe will role play having conversations with acquaintances at church at weekly psychotherapy. Joe will initiate a conversation with at least two individuals at church each week by 2/1/11.
"I want to get sober."	"I used to go to AA and thought it was helpful."	"I think I should go to AA meetings three times a week starting next week (2/1/11)."	Clinician will assist Jane in locating an AA meeting near her home. Clinician and Jane will discuss the impact of these meetings on Jane's sobriety at weekly case management appointments.
"I've gained 20 lbs since I started this medication. I want to lose some weight."	"I know my medication helps me and I want to stay on it. Also, I'm a great cook and would like to start a vegetable garden."	Joe will create weekly healthy meal plan.	Joe will discuss concerns about weight gain caused by medication with prescriber at each prescriber appointment. Joe will meet with PCP to discuss weight loss goal and plan by 1/15/11. Clinician will assist Joe in developing meal plans & shopping lists at weekly case

"I want to have friends."	"I'm a good baseball player."	Joey will join Parks & Recreation T-Ball league.	Joey's mom will contact Parks & Recreation by 2/1/11 to sign Joey up for T-Ball. Clinician and Joey/family will talk about excitement and worries of joining baseball at twice monthly psychotherapy appointments.
"I want to feel happy."	"I feel happy when I have a good time with my mom and dad."	Janey and her parents will identify activities they like to do together.	Clinician and Janey/family will develop a family activity schedule by 5/1/11.

Crisis Planning Examples

As with Recovery/Resiliency Plans, each individual has different strengths, needs, interests and skills, and plans need to be tailored to the unique needs of each individual.

The following examples from charts we have recently reviewed within the region, demonstrate how the questions can be answered in a way that meets the intent of having a plan that is easy to follow and assists individuals to avert crises and assist in the event they face a crisis.

If an individual is having difficulty completing the crisis plan or is refusing to complete a plan when it is required or clinically indicated, the clinician should assist in completing as thorough a crisis plan as possible based on the clinician's knowledge of the individual (i.e., the clinician should complete as much of the consumer crisis plan as possible).

What are some day-to-day choices you can make to reduce your risk of having a crisis?

- "Go for a bike ride; spend time with friends and family; go to the YMCA; get enough sleep"
- "Make sure to take my meds; meet people and have social interactions; go for walks; don't isolate; stay active"
- "Listen to music and dance; read a book; take baths; check my mail"
- "Keep my appointments with my clinician; spend time with my cat; keep up a daily routine"

What are the early warning signs you need support from others?

- "When I get angry; lack of sleep; blackness under my eyes; when I yell"
- "If I stop doing things with my family; if I don't stay active; negative thoughts or not feeling well; feeling paranoid; not focusing on healthy relationships"
- "Asking lots of questions; running around barefoot outside; negative thoughts/bad feelings towards people"
- "I get grumpy, edgy; I don't want to leave the house; I stop answering the phone or the door"

If you are feeling stressed, what are some of the actions you can take to feel better?

- "First I'll try: Writing in my journal; if that doesn't work then I'll try listening to music. Then I'll try a TV show. Then I'll call my clinician at (xxx)xxx-xxxx"
- "First I'll try: talking to my parents; if that doesn't work then I'll try: focusing on something different, maybe a walk. Then I'll try calling my clinician at (xxx)xxx-xxxx"
- "First I'll try: Talking to my roommate; if that doesn't work then I'll try: going for a bike ride. Then I'll call my clinician at (xxx)xxx-xxxx"
- "First I'll try: calling my friend; if that doesn't work then I'll try: playing with my dog. Then I'll try breathing exercises. Then I'll call my clinician at (xxx)xxx-xxxx"

How could family members or friends best assist you during a time of crisis?

- "Just talking to my mom sometimes helps. She can help me keep my hopes up."
- "Offer suggestions of something to do. Involve me in a discussion. Visit or call me. They could call my clinician for me."
- "Call me and tell me it's going to be ok"
- "Take me out of the house to distract me. Go for a walk. Maybe watch a movie or something with me. It helps when I stay with a friend when I'm feeling down, or if they stay at my place with me."

What recommendations do you have about how mental health staff and crisis response professionals can best support you if you experience a crisis?

- "Help me get a quick appointment to get my meds checked. Talk calmly to me so that I'm not scared. They can help me contact my clinician who knows me."
- "Help me do breathing exercises and then help me call my family to come stay with me."
- "If I ask you, tell me I'm not evil. Help me list the things that are positive about me like I take good care of my animals and I'm a good friend."
- "Sometimes I forget to take my meds. You should check with me on that. I might need to stay at the crisis beds a couple of days while I get the meds back in my system."

What safety or health concerns do you want mental health staff to know about if you are in crisis?

- "Diabetes, insulin dependent"
- "I'm allergic to Prozac and have had a bad experience on Lithium and got sick"
- "I have a cat at home that needs to be taken care of. My mom will watch her if I need help."
- "My parents need to be notified if I go to the hospital so they don't worry about where I am"

Clinician Addendum to the Crisis Plan

The clinician addendum to the client's crisis plan is the place to identify additional issues and recommendations that may be helpful to other mental health staff/crisis response professionals if they have contact with the individual (i.e., provide information that is useful to other staff/professionals who do not know the individual so that they may intervene most effectively). It is helpful to note significant details of mental health history, signs/symptoms of decompensation, co-morbid and safety issues, activities/skills/supports the individual has utilized previously to divert a crisis, recommendations for several crisis intervention strategies from least to most restrictive.

Examples - Recommendations/Intervention strategies

"2 short-term hospitalizations, 1 voluntary, 1 involuntary. Hx of not taking meds due to disorganization, not refusal. Parents are good natural supports. Encourage contacting parents. Encourage activity such as walking. Encourage taking PRNs . Consult with Dr. X for possible med changes needed. Assess for need for crisis bed. Consult with MHP for possible DMHP evaluation."

"Individual has a history of multiple instances of self harm, some serious. Remind her to use mindfulness techniques and other skills she has learned in groups. Encourage crisis bed if she needs more support to be safe. If hospitalization is unavoidable, X hospital has worked with her in the past and is aware of her clinical plan."

"Multiple hospitalizations since 2000. Attempt to redirect in order to keep him goal focused. Encourage contact with clinical team. Consult with psychiatrist for medication issues. Encourage consistent use of medication and utilizing PRNs. Assess for possible need for crisis bed. May require a more restrictive setting while undergoing med changes, especially Clozaril. Consult with MHP for possible DMHP evaluation/detention if needed. "

"When delusional, believes she has been raped or assaulted. Hx of violating no-contact order. History of suicidal ideation. Has 2 children who live with their father who she has limited contact with. Supportive sisters and father live in the area. Encourage taking meds with assistance/monitoring by family. Offer time to discuss stressors/concerns. Discuss/educate regarding symptoms and redirect to coping skills (bath, journal, tv, music). Consult with psychiatrist for possible med changes needed. Assess for possible alcohol use, need for social detox. Assess for Crisis Respite. Consult with MHP for DMHP evaluation/detention if needed. "

Additional Notes:
24/7 programs (PACT, Residential, IOP, etc.) should have their after-hours phone number clearly printed on the crisis plan for clients to find easily if approaching/in crisis.

Evidence Based, Research Based, Promising Practices Listing

NSMHA Current Provider Network and Proposed Future SUD OP Providers (N=12)

EBP/RB/PP NAME	Population of Implementation	# Providers that have Implemented
A-CRA	youth	1
CBT	adult; youth	7
CBT +	adult; youth	1
Collabortive Problem Solving	adult; youth	2
CRAFFT	youth	1
Dialectical Behavior Therapy	adult	8
Eye Movement Desensitization and Response (EMDR)	adult	2
Family Functional Therapy (FFT)	adult; youth	1
Family Psychoeducation	adult; youth	12
Fidelity Supported Employment	adult; youth	1
GAIN-I	youth	3
GAIN-SS	adult; youth	12
Illness Management Recovery	adult	3
IMPACT		1
Integrated Dual Disorder Treatment (IDDT)	adult	3
Living in Balance	adults	4
Matrix Model	adult; youth	3
Mental Health First Aid -Adult	community	1
Mental Health First Aid- Youth	community	1
Moral Reconation Therapy	adult	5
Motivational Interviewing	adult; youth	12
Motvational Ennhancement Therapy	adult	1
Multi-Systemic Therapy	youth; family	1
PACT	adult	2
Parent Child Interaction Training (PCIT)	adult; youth	1
Parent Management Training	adult; youth	1
Pathways to Self Discovery and Change	youth	1
Project SafeCare	youth; family	1
Relapse Prevention Therapy	adult	5
Seeking Safety	adult	3
Seven Challenges	youth	4
Solution Focused Brief Therapy	adults	1
Strengthening Families	youth; family	1
Supported Employment	adult; youth	2
Trauma Focused CBT	adult; youth	4
Wraparound		2

IX. Appendix: Program Integrity Plan

DELETED BY THE DIVISION OF BEHAVIORAL HEALTH AND RECOVERY (DBHR)

North Sound Mental Health Administration (NSMHA) Complaint, Grievance, Notices of Action, Appeal, and Fair Hearing Reporting **6 Month Narrative Report**
Date:
Agency or Reporting Source:
Agency Contact: Phone #:
6 Month Report Period: ***April 2015 through September 2015***
1. Summary and analysis of the implications of the data
(Please summarize and analyze all data including complaints, grievances, notices of action, and fair hearings for the 6 month period of April 2015 through September 2015. (Please include all complaint and grievance data regardless of Ombuds involvement. Please include analysis of complaints from others even though this information is not included in Web portal system for grievance reporting)
2. Identification of system implications
(Please note any system implications).
3. Identification of areas for further study, analysis, and review or quality improvement
(Please note any areas identified for further study, analysis and review or quality improvement).
4. Was information related to complaints, grievances, notices of action, appeals or fair hearings used on your quality management plan? If yes please summarize. ***(Providers, designees, and counties).***
5. Measures that may be taken to address quality improvement or undesirable patterns ***(all reporters).***
(Please outline any measures you have identified to address identified quality improvements).

NORTH SOUND MENTAL HEALTH ADMINISTRATION
GRIEVANCE, FAIR HEARING, NOTICE of ACTION and APPEAL SUMMARY
October, 2014 through March, 2015

INTRODUCTION

NSMHA is working to report grievances, appeals, notices, and fair hearings to meet DBHR intentions. NSMHA revised our Grievance system policies, including our notice policy in 2014. We continue to be in the process of reviewing and revising our policies to be in line with changing DBHR expectations.

GRIEVANCE, APPEAL, NOTICE of ACTION, and FAIR HEARING DATA

As outlined in previous reports NSMHA anticipated increases in grievance reporting and Notice of Actions for outpatient services this period due to changes in policy and data collection and the impact of the expansion of the Medicaid eligible population as a result of the Affordable Care Act.

The grievance reporting this period reflects these anticipated changes. Many concerns processed as complaints in the past are now processed and reported as grievances. There were 110 new grievances reported for this period. We reported each level as a grievance at the top of the forms. NSMHA is reporting Ombuds cases as the number of level 1 or 2 grievances with which Ombuds was involved. For this period Ombuds was involved in 49 of the 110 grievances. NSMHA is using provider reports of Ombuds involvement for level 1 grievance reporting this period.

For the 110 grievances there were 144 categories of issues reported across level 1 and level 2 grievances. We will continue to work to have a common understanding with the providers in our network and Ombuds of these categories. NSMHA may also contact DBHR as indicated to clarify their requirements. NSMHA is developing reporting mechanisms to capture resolutions as outstanding if written responses were not yet provided by the end of the reporting period.

Ombuds have been involved in assisting us to understand their past reporting including resolution codes. As outlined previously, NSMHA Ombuds are able to assist individuals in the level 1 grievance process, level 2 grievance process, appeal process, and fair hearing process.

Notices of Action this period (for outpatient services) also reflect policy change. There were 338 Notices of Action for this period. There were 215 for outpatient services and 123 for inpatient services. Inpatient Notices of Action increased from 90 to 123 this period.

There was 1 appeal by an enrollee reported and no new fair hearings (See Attachments (1) PIHP Grievances (2) SMHC Grievances and (3) Notice of Action appeals report.

QUALITY MANAGEMENT PROCESSES and RECOMMENDATIONS

NSMHA continues to fine-tune our quality management processes and has continued to maintain an Internal Grievance System Committee and our Leadership Team (LT)/Internal Quality Management Committee (IQMC). System recommendations related to the grievance system can be are reviewed by NSMHA LT/IQMC and then taken to the NSMHA Quality Management Oversight Committee (QMOC).

North Sound Regional Ombuds continue to provide quarterly reports and a semiannual summary of their recommendations for quality improvement or further study and review to Leadership Team/IQMC. Once approved by LT/IQMC, select recommendations may also be taken to QMOC. In addition, Ombuds also reports to our QMOC and Advisory Board.

NSMHA has also continued monthly meetings with Ombuds services. NSMHA continues to discuss integration of Ombuds recommendations with other grievance system recommendations and continues to review for system recommendations and opportunities for continuous quality improvement.

We have continued to focus on policy change and implementation, as well as a focus on collecting data in a consistent method for quality management purposes. NSMHA providers and designees also use information in their internal quality management processes and plans and provide a semiannual summary of information to the NSMHA.

NSMHA Leadership Team (LT/IQMC) will review this summary report, identify any new recommendations, and review status of previous system recommendations summarized and reviewed below. The report will then be taken to NSMHA QMOC.

Ongoing System Recommendations through the QMOC processes that are related to the grievance system are summarized below:

1. **Expertise for Specialty Areas** Recommendation concerned contracting for assessments and/or second opinions in specialty areas (Dissociative Identity Disorder (DID), Post-Traumatic Stress Disorder (PTSD), Eating Disorders. The recommendation and discussion was to look for expertise in these areas within the network but not restrict ourselves to the network. NSMHA has also had broader discussions about trauma informed care.

   NSMHA has been reviewing expertise within our network. Our Medical Director has also contacted resources outside of our network. The original discussion and recommendation was revised to exclude the term complex PTSD as this will not be a diagnosis in the DSM V.

   NSMHA continues discussing this area. A NSMHA Care Coordinator was hired and has been reviewing this area and has developed a resource spreadsheet for eating disorder providers. NSMHA Medical Director has contacted University of Washington as well.

   We are continuing to work with Relias Learning (http://www.reliaslearning.com/) a web based training and tracking platform, which was procured by NSMHA for use by all providers in the network, both mental health and chemical dependency professionals. Part of the product functionality may allow RSN/providers to identify specialized training.

   NSMHA has been reviewing trauma resources. NSMHA has also been discussing trauma informed care in our QMOC.

Updates: *As outlined above A NSMHA Care Coordinator had been developing a resource spreadsheet about eating disorder providers and has a list of resources for eating disorders. In addition, a need was identified for specialists with expertise for individuals with a covered mental health issue and co-occurring Autism Spectrum Disorder, and as a result a list was developed for this specialty area. Lists of resources for PTSD and DID are in development.*

2. **Dignity and Respect** (Recommendation for further study and review of dignity and respect in the region).

   As outlined in previous reports, the NSMHA plan was to develop a system-wide partnership with consumers, Ombuds, advocates, providers and other stakeholders to explore how dignity and respect is experienced and perceived within our system of care. This plan was reviewed and approved by QMOC.

   The following recommendations were made to the NSMHA Planning Committee:

   1. Develop a Dignity and Respect Campaign

2. Develop a Dignity and Respect Toolkit. The toolkit would include training resources, organizational self -assessments, etc.

EQRO highlighted dignity and respect workgroup as a NSMHA strength in the 2010 EQRO Annual Report.

The Dignity and Respect site page had been added to the NSMHA website and the dignity and respect pledge, part of the dignity and respect campaign, was initiated. Work was also done to begin an organizational self-assessment tool.

NSMHA also had contracted with the University of Pittsburgh Medical Center (UPMC) to assist us with developing and maintaining our dignity and respect campaign. The UPMC Campaign includes 3 toolkits to be implemented over a 3 year period. UPMC launched a national dignity and respect campaign in 2010. Linda Kehoe was hired as a consultant to assist with our Dignity and Respect Initiative.

NSMHA continued with the Dignity and Respect initiative and campaign, Linda Kehoe continued as the NSMHA Dignity and Respect Consultant. Multiple NSMHA providers have also continued their own dignity and respect campaigns.

Most recently NSMHA had a region wide Dignity and Respect Conference, Celebrating Workplace Diversity. NSMHA will review next steps for the Dignity and Respect Campaign and related efforts in this area. It had been noted in QMOC that it would be beneficial to have more Peers involved in this process as it moves forward.

Update: *NSMHA through its administrative audit process is reviewing for inclusion of dignity and respect in policies and in training plans for orientation of new staff.*

3. **Database for DBHR Reporting including Notices, Grievances, Appeals and Fair Hearings** (Recommendation had been to develop a regional database for grievance system to track monitor and analyze data related to grievances and fair hearings.

NSMHA has been developing a database to align with the new DBHR reporting requirements. This recommendation has been adjusted to reflect the revised DBHR reporting requirements regarding the grievance system including grievances and Notice of Action.

Update: NSMHA developed and implemented a web based portal for provider reporting of initiation and resolution of grievances to assist with current and future data collection. NSMHA will continue to review and revise systems for reporting.

RSN Grievance Report-- Medicaid Funded Services

RSN Name NSMHA **Contact Name:** Diana Striplin **Contact Number:** (360) 416-7013 **Reporting Period** Oct 2014 through March 2015

Total Unduplicated Number of Adult Grievances 65

Category Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access	7		2	
Dignity and Respect	14	2	1	
Quality/ Appropriateness	8			
Phone calls not returned	3			
Service -- Intensity, Not Available, Coordination	11	1	3	
Violation of Confidentiality	1			
Physicians and ARNPs	15		1	
Financial & Admin Svs	4			
Residential	2			
Housing	3			
Transportation	0			
Emergency Services	2			
Participation in Treatment	1			
Other Rights Violations	6	1	1	
Other	5	1	2	
Total	**82**	**5**	**10**	**0**

Total Unduplicated Number of Children's Grievances 35

Category Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access	3			
Dignity and Respect	9			
Quality/ Appropriateness	21			
Phone calls not returned	2			
Service -- Intensity, Not Available, Coordination	5			
Violation of Confidentiality	1			
Physicians and ARNPs	2			
Financial & Admin Svs	0			
Residential	0			
Housing	0			
Transportation	0			
Emergency Services	0			
Participation in Treatment	1			
Other Rights Violations	0			
Other	0			
Total	**44**	**0**	**0**	**0**

Resolutions Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Information/Referral	34		
Conciliation/Mediation	34		
Not Pursued	0		
Other	7	2	
Total	**75**	**2**	**0**

Resolutions Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Information/Referral	13		
Conciliation/Mediation	28		
Not Pursued	3		
Other			
Total	**44**	**0**	**0**

Ombuds Cases	
Level 1 Grievances	Level 2 Grievances
43	1

DBHR Grievance Report Medicaid 7-31--13

RSN Grievance Report-- State Funded Services Only

Reporting Period Oct 2014 through March 2015

RSN Name NSMHA **Contact Name:** Diana Striplin **Contact Number:** 360 416 7013

Total Unduplicated Number of Adult Grievances 8

Total Unduplicated Number of Children's Grievances 2

Category Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access	1			
Dignity and Respect	2			
Quality/ Appropriateness	2			
Phone calls not returned				
Service -- Intensity, Not Available, Coordination	1		1	
Participation in Treatment	0			
Physicians and ARNPs	3			
Financial & Admin Svs				
Residential				
Housing	1			
Transportation				
Emergency Services				
Violation of Confidentiality	1			
Other Rights Violations				
Other				
Total	**11**	**0**	**1**	**0**

Category Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access	1			
Dignity and Respect				
Quality/ Appropriateness	1			
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Participation in Treatment				
Physicians and ARNPs				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Other Rights Violations				
Other				
Total	**2**	**0**	**0**	**0**

Resolutions Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Info/Referral	7		
Conciliation/Mediation	3		
Not Pursued			
Other			
Total	**10**	**0**	**0**

Resolutions Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Info/Referral			
Conciliation/Mediation	1		
Not Pursued			
Other	1		
Total	**2**	**0**	**0**

Ombuds Cases	
Level 1 Grievances	Level 2 Grievances
5	0

RSN Notice of Action and Appeals Report

PIHP: NSMHA

Report Period: October 2014 through March 2015

APPEALS FILED			Type of Appeal				Resolutions			
	Adults	Children	Expedited Appeal (3 Days)	Standard Appeal (45 Days)	Extended Appeal (59 Days)	Ombuds Cases	In Favor of Enrollee	Partially in Favor of Enrollee	Appeal Denied	Pending
Denials	1			1		1			1	
Reductions										
Suspensions										
Terminations										
Disagreement with Treatment Plan										
Total	1	0	0	1	0	1	0	0	1	0

NOTICE OF ACTIONS	Adults		Children	
	Medicaid Outpatient	Medicaid Inpatient	Medicaid Outpatient	Medicaid Inpatient
Denials	134	77	81	46
Reductions				
Suspensions				
Terminations				
Disagreement with Treatment Plan				
Total	134	77	81	46

JOINT COUNTY AUTHORITY BHO OPERATING AGREEMENT

OF

NORTH SOUND BEHAVIORAL HEALTH ORGANIZATION, LLC,

a Washington Behavioral Health Organization and Limited Liability Company (LLC)

Dated and Effective

as of

_____, 2016

JOINT COUNTY AUTHORITY BHO OPERATING AGREEMENT OF NORTH SOUND MENTAL HEALTH ORGANIZATION, LLC

THIS JOINT COUNTY AUTHORITY BHO OPERATING AGREEMENT (this "Agreement") is made and entered into effective as of _____ 2016, by and among the following County Authorities: Island County, San Juan County, Skagit County, Snohomish County and Whatcom County (collectively "County Authorities").

RECITALS

A. The County Authorities, as defined below and as provided for in RCW 71.24.025 (12), are entering into this Agreement to jointly provide a community health program and regional system of care, with the collective goal of consolidating administration, reducing administrative layering and reducing administrative costs, consistent with the State of Washington's legislative policy as set forth in RCW 71.24.015.

B. This Agreement is a joint operating agreement entered into by a group of County Authorities responding to a request for a detailed plan and contract with the State of Washington to operate as a regional support network until April 1, 2016, and as a behavioral health administration as of April 1, 2016, as provided for in RCW 71.24.100.

C. This Agreement provides a means for each County Authority to share in the cost of mental and behavioral health services and further provides the means for both payment of services and audit of funds, as provided for in RCW 71.24.100. In addition, this Agreement provides for the joint supervision and operation of services and facilities, as provided for in RCW 71.24.110.

D. This Agreement also serves as an Operating Agreement as provided for in the LLC Act, as defined below.

ARTICLE 1 -- DEFINITIONS

The following terms used in this Agreement shall have the following meanings (unless otherwise expressly provided herein):

1.1 "**BHO Act**" means Chapter 225, Laws of 2014 and those portions of Chapter 71.24 in effect on and after April 1, 2016.

1.2 "**BHO**" means North Sound Behavioral Health Organization, LLC, a joint operating agreement of the five County Authorities. The BHO is a "company" as that term is used in the LLC Act.

1.3 "**Capital Account**" means the capital account determined and maintained for each County Authority pursuant to Section 8.3.

1.4 "**Capital Contribution**" means any contribution to the capital of the BHO in cash or property by a County Authority whenever made.

1.5 "**Certificate of Formation**" means the certificate of formation pursuant to which the BHO was formed as an LLC, as originally filed with the office of the Secretary of State on _____, 2016, and as amended from time to time.

1.6 "**Code**" means the Internal Revenue Code of 1986, as amended, or corresponding provisions of subsequent superseding federal revenue laws.

1.7 "**County Authority**" or "**County Authorities**" shall have the same meaning as used in RCW 71.24.025 (12), as amended and shall include only Island, San Juan, Snohomish Skagit and Whatcom Counties. Each County Authority that signs a counterpart of this Agreement shall be a "member" of the LLC formed hereby as that term is defined in RCW 25.15.005 (8) and as that term is used in RCW 25.15.115, as amended. Each County Authority of the BHO must be a public agency as provided for in RCW 39.34.030(3)(b).

1.8 "**County Authorities Interest**" means all of a County Authority's share in the BHO's assets pursuant to this Agreement and the LLC Act and includes a County Authority's rights to participate in the management and affairs of the BHO, including the right to vote on, consent to or otherwise participate in any decision of the County Authorities.

1.9 "**LLC**" means limited liability company.

1.10 "**LLC Act**" means the Washington Limited Liability Act, RCW Ch. 25.15, as amended.

1.11 "**Majority Interest**" means, at any time, more than fifty percent (50%) of the then outstanding Units held by the County Authorities.

1.12 "**Executive Committee**" means the governing body of the BHO as further specified in Article 5 of the Agreement. On behalf of the County Authorities, the Executive Committee shall govern the BHO. The Executive Committee shall be comprised of individual representatives from the following County Authorities with each County Authority having the number of representatives noted:

County	Representatives
Island	One
San Juan	One
Skagit	One
Snohomish	Four
Whatcom	Two

1.13 "**Percentage Interest**" means with respect to any County Authority, the percentage determined based upon the ratio that the number of Units held by such County Authority bears to the total number of outstanding Units.

1.14 "**Regulations**" includes proposed, temporary and final Treasury regulations promulgated under the Code and the corresponding sections of any regulations subsequently issued that amend or supersede such regulations.

1.15 "**Reserves**" means, with respect to any fiscal period, funds set aside or amounts allocated during such period to reserves which shall be maintained in amounts deemed sufficient by the Executive Committee for working capital and to pay obligations, expenses and other costs or expenses incident to the ownership or operation of the services provided by the BHO and the BHO's business.

1.16 "**Tribal Authority**" means the federally recognized Indian tribes and the major Indian organizations recognized by the Secretary of the Washington Department of Social and Health Services ("DSHS") that fall within the boundaries of the County Authorities insofar as those tribal organizations do not have a financial relationship with the BHO that would present a conflict of interest.

1.18 "**Tribal Member**" means a Tribal Authority that executes an agreement to become a Tribal Member as set forth in Article 4 below.

1.19 "**Units**" means the Units issued to any County Authority under this Agreement as reflected in attached **Exhibit A**, as amended from time to time.

ARTICLE 2 -- FORMATION OF BHO AS AN LLC

2.1 Formation. The BHO as an LLC was formed on _____, 2016, when the LLC Certificate of Formation was executed and filed with the office of the State of Washington Secretary of State in accordance with and pursuant to the LLC Act. The County Authorities shall promptly execute all amendments to the Certificate of Formation and all other documents needed to enable the County Authorities or Executive Committee, or their respective agents, to accomplish all filing, recording, and other acts necessary and appropriate to comply with all requirements for the formation and operation of the BHO as an LLC under the LLC Act.

2.2 Name. The name of the BHO is North Sound Behavioral Health Organization, LLC.

2.3 Principal Place of Business. The principal place of business of the BHO shall be 301 Valley Mall Way, Suite ____, Mount Vernon, WA 98273. The BHO may locate its places of business at any other place or places as the Executive Committee may from time to time deem advisable.

2.4 Registered Office and Registered Agent. The BHO's initial registered agent and the address of its initial registered office in the State of Washington are as follows:

Name	Address
Bradford E. Furlong	825 Cleveland Avenue, Mount Vernon, WA 98273

The registered office and registered agent may be changed by the County Authorities from time to time by filing an amendment to the Certificate of Formation.

2.5 Term. The term of the BHO shall be perpetual unless the BHO is dissolved in accordance with either Article 11 or the LLC Act.

ARTICLE 3 – AUTHORITY, BUSINESS AND PURPOSE OF BHO

3.1 Authority. As provided for in RCW 71.24.015, it is the policy of the State of Washington to encourage the development of regional mental health services and the availability of treatment components. To this end, RCW 71.24.015 provides for counties to enter into joint operating agreements with one another to form regional systems of care, integrating planning, administration and service delivery duties under RCW Chapters 71.05 and 71.24 in order to consolidate administration and reduce administrative layering and costs. This Agreement is a joint operating agreement between the County Authorities to initially operate as a regional support network. Pursuant to Chapter 225, Laws of 2014 ("BHO Act"), effective April 1, 2016, the BHO, and through the BHO, the County Authorities jointly, will undertake the responsibilities of a behavioral health organization.

The purpose of the County Authorities, in entering into this Agreement, is to present a plan to the Secretary of DSHS to contract for the provision of behavioral health services and upon approval of such plan undertake to contract for the provision of such services within the boundaries of the County Authorities and to take such other and further actions as are required and and/or authorized by the BHO Act. The mutual goal of the County Authorities, in entering into this Agreement, is to work together to provide mental health and behavioral health services to the citizens of each of the County Authorities in an efficient and stream-lined manner.

The State of Washington Interlocal Corporation Act, specifically RCW 39.34.030, provides, in part, that any two or more public agencies may enter into agreements with one another for joint cooperative action. RCW 39.34.030(3)(b) specifically provides that the County Authorities may form a limited liability company under which each County Authority is a public agency, as provided for in Section 1.9, and further provides the BHO's funds are subject to audit, as provided for in Section 9.4. The County Authorities have exercised the authority granted to them under the BHO Act, the LLC Act and the Interlocal Cooperation Act to form this BHO as an LLC to achieve maximum efficiency in the delivery of mental health and behavioral health services and so that their rights and liabilities as to each other and third parties are firmly established and clearly understood.

This Agreement serves as such a joint operating agreement between the County Authorities to operate as a regional support network, as provided for in RCW 71.24.100 and 71.24.110, until April 1, 2016 with:

(a) Each County Authority bearing a share of the cost of mental health services;

(b) The Treasurer of Skagit County serving as the custodian of funds made available for the purposes of such behavioral health services and that the Treasurer may make payments from such funds upon audit by the appropriate auditing officer of Skagit County and shall be responsible to Washington State Department of Social and Health Services ("DSHS") for all debts, obligations, and liabilities owed to DSHS by the BHO upon termination of any contract between the BHO and DSHS, or as a result of remedial action, from BHO funds in its possession;

(c) The Auditor of Skagit County serving as the auditing officer of the BHO's funds and accounts; and

(d) For the joint supervision and operation of services and facilities.

As of April 1, 2016 this Agreement shall serve as a joint operating agreement, as provided for in RCW 71.24.100 and 71.24.110, for a behavioral health organization with:

(a) Each County Authority bearing a share of the cost of behavioral health services;

(b) The Treasurer of Skagit County serving as the custodian of funds made available for the purposes of such mental health services and that the treasurer may make payments from such funds upon audit by the appropriate auditing officer of Skagit County and shall be responsible to DSHS for all debts, obligations, and liabilities owed to DSHS by the BHO upon termination of any contract between the BHO and DSHS, or as a result of remedial action, from BHO funds in its possession;

(c) The Auditor of Skagit County serving as the auditing officer of the BHO's funds and accounts; and

(d) For the joint supervision and operation of services and facilities.

The foregoing notwithstanding, the Executive Committee, as defined in Section 1.12 above and described below in Section 5.1, may by majority vote change the Treasurer and Auditor designation to another Treasurer and Auditor in the same county as any one of the County Authorities.

3.2. Business and Purpose. The business and the purpose of the BHO shall be:

3.2.1 To be recognized and operate as a regional support network to provide regional systems of care for mental health services as provided for in RCW 71.24.016 from the date of formation to March 31, 2016;

3.2.2 To be recognized and operate as a behavioral health organization to provide behavioral health services as provided for in RCW 71.24.016 from April 1, 2016;

3.2.3. To carry out any lawful, services, business or activity that may be conducted by a BHO or LLC as determined by the County Authorities; and

3.2.4 To exercise all other powers necessary to or reasonably connected with the BHO's business and services it provides that may be legally exercised by limited liability companies under the LLC Act.

ARTICLE 4 – NAMES, ADDRESSES AND STATUS OF COUNTY AUTHORITIES

The names and addresses of the County Authorities are set forth in the attached **Exhibit A**, as amended from time to time. Each of the five Counties identified in Section 1.9, once each executes this Agreement, shall be a County Authority of the BHO. A Tribal Authority may become a Tribal Member by executing an agreement in form approved by the Executive Committee. A Tribal Member may appoint one (1) non-voting, *ex officio* representative to the Executive Committee.

ARTICLE 5 -- MANAGEMENT

5.1 Management. The services, business and affairs of the BHO shall be managed by the County Authorities acting through the County Authorities Executive Committee ("Executive Committee"). The Executive Committee in turn shall work with and delegate to the NSBHO Administrator the administration, services, business and affairs of the BHO, as provided for in Section 5.3.5. Each representative serving on the Executive Committee shall devote to the BHO and apply to the accomplishment of the BHO's purposes so much of his or her time and attention as is reasonably necessary to manage the services and business of the BHO. Each Executive Committee representative shall serve at the pleasure of the County Authority that appointed him or her and may be removed or replaced at any time by such County Authority upon written notice to the other County Authorities and the NSBHO Administrator. The County Authorities recognize that from time to time Executive Committee representatives may not be able to attend Executive Committee meetings. Each County Authority, in addition to appointing Executive Committee representatives may also appoint delegates that may attend Executive Committee meetings on behalf of the County Authority and in lieu of the Executive Committee representative, provided the other County Authorities and the NSBHO Administrator are given written notice of the appointment of the delegate together with the delegate's name and contact information, in advance of the meeting. For those County Authorities that have County Administrators, the written notice must come from the County Executive or his or her designee, and for those County Authorities that are governed by a County Council, by the Secretary of the County Council.

Each County Authority shall provide to the other County Authorities and the NSBHO Administrator written notice of the following, together with contact information, including email addresses: 1) Executive Committee representatives and delegates; 2) Advisory Board representatives; and 3) a notice agent designated to receive notice on behalf of the County Authority as provided for in Section 12.1.

Except as otherwise expressly provided in this Agreement, the Executive Committee shall have full, complete and exclusive authority, power and discretion to manage and control the services provided by the BHO and the services, business, affairs and property of the BHO, to make all decisions regarding those matters and to perform any and all other acts or activities customary or incident to the management of the BHO's services and business. Only representatives of the County Authorities, or their approved delegates as provided for in the preceding paragraph, shall have any voting rights on the Executive Committee.

5.2 Decision-Making. The BHO shall make decisions, take actions and incur obligations as determined by the County Authorities acting through the Executive Committee. The Executive Committee shall take action, expend sums and enter into obligations approved by a quorum of the Executive Committee. A quorum of the Executive Committee shall consist of a majority of the County Authorities' Executive Committee representatives.

5.3 Power and Authority. Without limiting the scope and generality of the Executive Committee's actions, the Executive Committee shall have the power and authority, on behalf of the County Authorities, to undertake the following:

5.3.1 Pursuant to RCW 39.34.080, enter into contracts with the DSHS pursuant to the provisions of RCW Chapter 71.24;

5.3.2 Enter into contracts with individuals, public and private organizations, and individual counties, including with other County Authorities to this Agreement, to carry out the purposes of the contract with DSHS and other obligations of the BHO as defined in RCW Chapter 71.24, subject to available funds and to the purpose and goals of the BHO;

5.3.3 Accept and expend funds from the State of Washington, the Federal government, the other County Authorities, and from other public and private sources, including gifts, for activities and purposes related to RCW Chapter 71.24;

5.3.4 Prepare and submit to DSHS appropriate plans, both in length and duration, for mental health services and behavioral health services in accordance with the provisions of RCW Chapter 71.24 and the BHO Act;

5.3.5. Employ or contract for staff and consultants to carry out the responsibilities of this Agreement and the statutory requirements for a regional support network through March 31, 2016, followed by a behavioral health network as of April 1, 2016. In doing so, the Executive Committee shall hire, give authority to, evaluate, give direction to and terminate the BHO's administrator and employees (collectively "NSBHO

Administrator") who shall administer the BHO's operations, services and administration, including all hiring, development, approval and implementation of all policies and procedures, service delivery plans and operating plans. The NSBHO Administrator, and all of its employees and administrators, shall be employees of the BHO and not of individual County Authorities.

The NSBHO Administrator, under the direction of the Executive Committee, shall have the power and authority to:

(i) Prepare, review, modify and present to the Executive Committee for approval the BHO's annual budget;

(ii) Execute contracts for the provision of services and operation of the BHO, including leases for rental of real and personal property;

(iii) Take necessary and appropriate steps on behalf of the Executive Committee to ensure the BHO's compliance with all statutory and funding requirements; and

(iv) Take other actions as directed by the Executive Committee or the County Authorities by their respective resolution or consent.

5.3.6 Spend the capital and revenues of the BHO in the furtherance of the business of the BHO and the services it provides;

5.3.7 Acquire, improve, manage, lease, operate, sell, transfer, exchange, encumber, pledge and dispose of any real or personal property of the BHO;

5.3.8 Purchase such liability, casualty, property and other insurance as the Executive Committee, in its sole discretion, deems advisable to protect the BHO's assets against loss or claims of any nature; *provided*, however, the Executive Committee shall not be liable to the BHO, or to the County Authorities, for failure to purchase any insurance if such coverage should prove inadequate;

5.3.9 Enter into management agreements, service agreements, provider agreements, consultants and professional agreement, maintenance or other service agreements, short-term or long-term rental agreements, together with any other agreements;

5.3.10 As provided for in RCW 71.24.350, as amended, provide for and establish a separately funded mental health Ombuds' office that is:

(i) Independent of the BHO; and

(ii) That maximizes the use of consumer advocates.

5.3.11 Establish risk reserve funds as prudent and as required by its contracts. The NSBHO Administrator shall provide notice to the County Authorities of any need for Capital Contributions to the BHO and as required to fulfill the BHO's obligations and contractual requirements. Upon unanimous vote of the Executive Committee, each County Authority shall make Capital Contributions to the BHO as requested by the NSBHO Administrator and directed by the Executive Committee; *provided*, that such Capital Contributions shall be in proportion to the County Authority's share of Units. In addition, the NSBHO Administrator shall establish additional risk reserves.

5.3.12 Execute instruments and documents, including without limitation, negotiable instruments, documents providing for the acquisition or disposition of the BHO's property, assignments, bills of sale, leases, management agreements, agreements and any other instruments, agreements or documents necessary, in the opinion of the Executive Committee, to the business, and the services, of the BHO;

5.3.13 Employ accountants, legal counsel, independent contractors, managing agents, service providers, management companies or other experts to perform services for the BHO and to compensate them from BHO funds;

5.3.14 Enter into any and all other agreements for any purpose, in such form as the Executive Committee may approve;

5.3.15 Undertake any and all actions and activities authorized by Chapter 70.24 RCW, now or as hereafter amended or otherwise authorized by the laws of the State of Washington; and

5.3.16 To do and perform all other acts as may be necessary or appropriate to the conduct of the BHO's business and services provided.

Unless authorized to do so by this Agreement, or by the Executive Committee, no County Authority, individual representative, or delegate of the Executive Committee, the Advisory Board, any individual representative of the Advisory Board, employee, or other agent of the BHO shall have any power or authority to bind the BHO in any way, to pledge its credit, or to render it liable for any purpose.

5.4 Advisory Board. In addition to the Executive Committee the BHO shall have in place an advisory board of the BHO ("Advisory Board") with representatives from each county. The Advisory Board representatives shall be appointed according to each County Authority's usual and customary method of appointment with terms to be determined by each County Authority, conforming with its respective County Code. Each County Authority shall endeavor to include as part of its appointment representatives from the County Authority's mental health and/or behavioral health advisory board. The Advisory Board shall review and provide comments on plans and policies developed pursuant to RCW Chapter 71.24, provide local oversight regarding the activities of the BHO, and work with the BHO to address and resolve significant concerns regarding service delivery and outcomes. Two of the representatives of the Advisory Board will sit as ex-officio, non-voting representatives on the Executive Committee.

The Advisory Board shall consist of the following twenty-six representatives representing and apportioned to each County Authority as follows:

County Authorities	Representatives
Island	Four
San Juan	Three
Skagit	Four
Snohomish	Nine
Whatcom	Six

In addition to the representatives noted above, each of the Tribal Authorities shall have a representative on the Advisory Board. The Executive Committee shall assure the composition of the Advisory Board is broadly representative of the demographic character of the region and shall include, but not be limited to, representatives of consumers and families, law enforcement and Tribal Authorities.

5.5 Compensation. The BHO will not pay the County Authorities or the representatives of the Executive Committee or representatives of the Advisory Board any fees or other compensation for its services provided except as set forth in this Agreement.

5.6 Limitation on Liability; Indemnification. Neither the Executive Committee nor the Advisory Board, or their respective representatives, officials, County Authorities, managers, employees or agents, shall be liable, responsible or accountable in damages or otherwise to the BHO or the County Authorities for any act or omission performed in good faith pursuant to the authority granted by this Agreement or in accordance with its provisions, and in a manner reasonably believed to be within the scope of the authority granted and in the best interest of the BHO; provided that such act or omission did not constitute fraud, intentional misconduct, or gross negligence. The BHO shall indemnify and hold harmless the Executive Committee and the Advisory Board and any of their respective representatives, officials, County Authorities, managers, employees or agents thereof, against any liability, loss, damage, cost or expense incurred by them on behalf of the BHO or in furtherance of the BHO's interests without relieving any such person of liability for fraud, misconduct, bad faith or negligence. No County Authority or representative of the Executive Committee or the Advisory Board shall have any personal liability with respect to the satisfaction of any required indemnification of the above mentioned persons.

Any indemnification required to be made by the BHO shall be made promptly following the fixing of the liability, loss, damage, cost or expense incurred or suffered by a final judgment of any court, settlement, contract or otherwise. In addition, the BHO shall reimburse a person claiming indemnification under this Section 5.6 for legal expenses and other costs incurred as a result of a legal action brought against such person if: (i) the legal action relates to the performance of duties or services by the person on behalf of the BHO; (ii) the legal action is initiated by a party other than a County Authority; and (iii) such person undertakes to repay the advanced funds to the BHO if it is determined that such person is not entitled to indemnification pursuant to the terms of this Agreement.

5.7 Right to Rely on the Executive Committee. Any person dealing with the BHO may rely (without duty of further inquiry) upon a certificate signed by the Executive Committee as to the identity and authority of any the Executive Committee or other person to act on behalf of the BHO or any County Authority.

ARTICLE 6 -- RIGHTS AND OBLIGATIONS OF COUNTY AUTHORITIES

6.1 Obligations of County Authorities. Each County Authority shall carry out its obligations under this Agreement including appointments of representatives to the Executive Committee and to the Advisory Board. In addition each County Authority shall: (i) designate staff and resources to plan for local behavioral health needs; (ii) monitor local contracts and, upon request, participate in monitoring BHO contracts; (iii) develop local crisis response systems; and (iv) provide local resource coordination.

6.2 Limitation of County Authorities' Liability. No County Authority or County Authority's representative, official County Authority, manager, employee or agent shall be personally liable, merely as a County Authority, for any debts, losses or liabilities of the BHO beyond the County Authority's respective contributions and any obligation of the County Authority hereunder to make contributions, except as otherwise specifically provided by law. No County Authority shall have liability to the BHO or its County Authorities for monetary damages for conduct merely as a County Authority, except for acts or omissions that involve intentional misconduct, fraud, gross negligence, or for any transaction for which the County Authority has personally received a benefit in money, property or services to which the County Authority was not legally entitled. If the Act is hereafter amended to authorize BHO action further eliminating or limiting the personal liability of County Authorities, then the liability of a County Authority shall be eliminated or limited to the full extent permitted by the Act, as so amended. Any repeal or modification of this Section of the Act shall not adversely affect any right or protection of a County Authority of the BHO existing at the time of such repeal or modification for or with respect to an act or omission or such County Authority occurring prior to such repeal or modification. The foregoing notwithstanding, nothing herein shall limit the debts, obligations, and liabilities of County Authorities to DSHS, including, but not limited to, the requirements of County Authorities under chapter 71.24 RCW and any requirements of this Agreement or of any agreement between the BHO and DSHS regarding use of funds, reserves and fund balances.

The BHO shall indemnify and hold harmless the County Authorities and any of their respective representatives, officials, County Authorities, managers, employees or agents thereof, against any liability, loss, damage, cost or expense incurred by them on behalf of the BHO or in furtherance of the BHO's interests without relieving any such person of liability for fraud, misconduct, bad faith or negligence. No County Authority shall have any personal liability with respect to the satisfaction of any required indemnification of the above mentioned persons.

Any indemnification required to be made by the BHO shall be made promptly following the fixing of the liability, loss, damage, cost or expense incurred or suffered by a final judgment of any court, settlement, contract or otherwise. In addition, the BHO shall reimburse a person claiming indemnification under this Section 6.2 for legal expenses and other costs incurred as a result of a legal action brought against such person if: (i) the legal action relates to the performance of duties or services by the person on behalf of the BHO; (ii) the legal action is initiated by a party other than a County Authority; and (iii) such person undertakes to repay the advanced funds to the BHO if it is determined that such person is not entitled to indemnification pursuant to the terms of this Agreement.

6.3 Inspection of Records. Each County Authority shall have the right to inspect and copy at such County Authority's expense, the records required to be maintained by the BHO pursuant to Section 9.7.

6.4 No Priority and Return of Capital. Except as expressly provided in Article 8 or 9, no County Authority shall have priority over any other County Authority, either as to the return of Capital Contributions or as to distributions.

6.5 Withdrawal of County Authority. A County Authority may voluntarily resign or otherwise withdraw as a County Authority; *provided*:

(i) the withdrawing County Authority provides the other County Authorities and the NSBHO Administrator with written notice of withdrawal at least three hundred sixty-five (365) days prior to the expiration of the BHO's current fiscal year; and

(ii) the withdrawing County Authority shall not be entitled to payment or return of Capital Contributions or other monies made to the BHO or held by the BHO whether prior to the date of the notice or between the date of notice and the date of withdrawal.

ARTICLE 7 -- MEETINGS OF EXECUTIVE COMMITTEE

7.1 Meetings. All meetings of the Executive Committee will be held in full compliance with the Washington Open Public Meetings Act, RCW Chapter 42.30. The Executive Committee shall establish a regular business meeting time in compliance with RCW 42.30.070. Special meetings of the Executive Committee, as authorized by RCW 42.30.080, may be called by (i) the presiding officer of the Executive Committee; or by (ii) a majority of the representatives of the Executive Committee.

7.2 Place of Meetings. The party or body calling the meeting as provided for in Section 7.1 may designate any place within a County Authority County as the meeting site. If no designation is made, the place of meeting shall be the principal office of the BHO specified in Section 2.3.

7.3 Notice of Meetings/Agendas. Written notice stating the place, day and hour of the meeting, and in case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered not less than five (5) nor more than thirty (30) days before the date of the meeting, either personally, by mail or by email, either by or before the date of the meeting by or at the direction of the Executive Committee or the Executive Committee representatives calling the meeting, to each representative of the Executive Committee entitled to vote at such meeting. If mailed, such notice shall be deemed to be delivered three (3) calendar days after being deposited in the United States Mail, addressed to the party as specified herein with postage thereon prepaid. An agenda of every meeting of the Executive Committee shall be posted on the BHO's web site at least twenty-four (24) hours in advance of the meeting.

7.4 Record Date. For the purpose of determining the Executive Committee representatives entitled to notice of or to vote at any meeting of the Executive Committee or any adjournment thereof, the date on which notice of the meeting is mailed or the date on which the resolution declaring such distribution is adopted, as the case may be, shall be the record date for such determination. When a determination of representatives entitled to vote at any meeting of the Executive Committee has been made as provided in this Section, such determination shall apply to any adjournment thereof.

7.5 Quorum. A Majority Interest represented in person shall constitute a quorum at any meeting of the Executive Committee. In the absence of a quorum at any such meeting, the meeting may be adjourned as allowed by and pursuant to RCW 42.30.090. The Executive Committee representatives present at a duly organized meeting may continue to transact business until adjournment, notwithstanding the withdrawal during such meeting of that number of Units whose absence would cause less than a quorum. Any meeting may be continued as allowed by and pursuant to RCW 42.30.100.

7.6 Manner of Acting. If a quorum is present, the affirmative vote of representatives from the Executive Committee holding more than fifty percent (50%) of the Units represented at the meeting in person or by proxy shall be the act of the Executive Committee and of the County Authorities, unless the vote of a greater or lesser percentage is required by this Agreement or the Act.

7.7 Proxies. At all meetings of the Executive Committee a representative may only vote in person in a session of the meeting open to the public; no proxies or secret voting shall be permitted. Notwithstanding the foregoing, as provided for in Section 5.1, Executive Committee representatives may delegate other representatives from their County Authority County to attend Executive Committee meetings.

7.8 No Action by County Authorities Without a Meeting. No action required or permitted to be taken at a meeting of the Executive Committee may be taken without a meeting.

7.9 Waiver of Notice. When any notice is required to be given to a County Authority, a waiver thereof in writing signed by the County Authority entitled to such notice, whether before, at, or after the time stated therein, shall be equivalent to the giving of such notice.

7.10 Failure to Observe Formalities. Pursuant to RCW 25.15.060, notwithstanding anything herein to the contrary, this Agreement does not expressly require the County Authorities to hold any meetings and the failure to observe any formalities requiring the calling or conduct of any meeting shall not be considered a factor tending to establish personal liability of the County Authorities; provided that this provision shall not be construed to permit actions in violation of RCW Chapter 42.30.

ARTICLE 8
CONTRIBUTIONS TO THE BHO AND CAPITAL ACCOUNTS

8.1 County Authorities' Initial Capital Contributions. Each County Authority's initial Capital Contribution shall consist of its respective pro rata share of the assets of North Sound Regional Support Network. All Capital Contributions, if any, shall be made prorata, based on each County Authority's respective Percentage Interest.

8.2 Additional Capital Contributions. Each County Authority shall be required to make such additional Capital Contributions as shall be determined by a unanimous vote of the Executive Committee as necessary to meet the expenses of the BHO. All such Capital Contributions, if any, shall be made prorata, based on each County Authority's respective Percentage Interest.

The Executive Committee shall give written notice to each County Authority of the amount of any required additional Capital Contribution, and each County Authority shall pay to the BHO such additional Capital Contribution no later than thirty (30) days following the date such notice is given. Nothing contained in this Section 8.2 is or shall be deemed to be for the benefit of any Person other than the County Authorities and the BHO, and no such Person shall under any circumstances have any right to compel any actions or payments by the County Authorities.

8.3 Capital Accounts.

8.3.1 Establishment and Maintenance. A separate Capital Account will be maintained for each County Authority throughout the term of the BHO. Each County Authority's Capital Account will be increased by (1) the amount of money contributed by such County Authority to the BHO; and (2) the fair market value of property contributed by such County Authority to the BHO (net of liabilities secured by such contributed property that the BHO is considered to assume.

8.3.2 Compliance with Regulations. The manner in which Capital Accounts are to be maintained pursuant to this Section 8.3 is intended to comply with the requirements of Code Section 704 (b) and the Regulations promulgated thereunder. If in the opinion of the BHO's legal counsel or auditors the manner in which Capital Accounts are to be maintained pursuant to the preceding provisions of this Section 8.3 should be modified in order to comply with Code Section 704 (b) and the Regulations thereunder, then notwithstanding anything to the contrary contained in the preceding provisions of this Section 8.3, the method in which Capital Accounts are maintained shall be so modified; provided, however, that any change in the manner of maintaining Capital Accounts shall not materially alter the economic agreement between or among the County Authorities.

ARTICLE 9 -- ACCOUNTING, BOOKS, AND RECORDS

9.1 Accounting Methods. The BHO's books and records shall be kept, and its financial statements prepared, under such permissible methods of accounting, consistently applied, as the Executive Committee determines is in the best interest of the BHO and its County Authorities and in full compliance with record-keeping and accounting methods required by Washington law and/or the Washington State Auditor and in compliance with the requirements of any state or federal program providing funding or other support for the BHO's programs and services.

9.2 Budget. The NSBHO Administrator shall prepare, and the Executive Committee shall consider and adopt, an annual budget reflecting proposed revenues and expenditures for the next fiscal year no later than December 1, of each preceding fiscal year.

9.3 Disbursements. Funds received by contract from the DSHS shall be disbursed according to the budget as approved. Vouchering and reimbursement procedures shall be developed in accordance with relevant regulations and approved equitable allocation formulas.

9.4 Funds and Audit. Funds provided to the BHO from all sources shall be maintained as a separate fund in the Skagit County Treasury or other County Treasury as designated by the BHO's Executive Committee. Such funds shall be designated as the Operating Fund of the BHO per RCW 39.34.030(4)(b) in the Skagit County Treasury or other County Treasury as determined by the Executive Committee. These monies shall be subject to the same audit and fiscal controls as other funds held by the designated County Treasury. Interest on investment of the BHO's funds shall accrue to the benefit of the BHO.

9.5 Interest on and Return of Capital Contributions. No County Authority shall be entitled to interest on its Capital Contribution or to return of its Capital Contribution, except as otherwise specifically provided for herein.

9.6 Accounting Period. The BHO's fiscal year shall be January 1 through December 31.

9.7 Records, Audits and Reports. At the expense of the BHO, the NSBHO Administrator shall maintain records and accounts of all operations and expenditures of the BHO. All records shall be maintained and be available to the public pursuant to RCW Chapter 42.56, RCW Chapter 70.02, the Health Insurance Portability and Accountability Act ("HIPAA"), PL 104-191, as amended and retained pursuant to retention requirements as set forth in RCW Title 40, WAC 434 and schedules established by the Washington Secretary of State, all as may be amended from time to time. At the minimum the BHO shall keep at its principal place of business the following records:

(a) A current list and past list, setting forth the full name and contact information for each County Authority and each County Authority representative serving on the Executive Committee;

(b) A current list and past list, setting forth the full name and contact information for each representative sitting on the Advisory Board;

(c) A copy of the Certificate of Formation and all amendments thereto;

(d) Copies of this Agreement and all amendments hereto;

(e) Minutes of the County Authority meeting and any written consents obtained from County Authorities for actions taken by County Authorities without a meeting; and

(f) Copies of the BHO's financial statements for the seven (7) most recent years.

ARTICLE 10 -- TRANSFERABILITY

10.1 General. Except as otherwise expressly provided in this Agreement, a County Authority shall not have the right to:

(a) Sell, assign, transfer, exchange or otherwise transfer for consideration, (collectively, "sell" or "sale"); or

(b) Pledge, encumber or otherwise use all or part of its County Authorities Interest in the BHO as security for a loan or other obligation.

ARTICLE 11 -- DISSOLUTION AND TERMINATION

11.1 Dissolution. The BHO shall be dissolved upon the unanimous vote of the County Authorities of the BHO held at the time of the vote.

11.2 Winding Up, Liquidation and Distribution of Assets. Upon dissolution, the Executive Committee shall immediately proceed to wind up the affairs of the BHO. The Executive Committee shall sell or otherwise liquidate all of the BHO's assets as promptly as practicable (except to the extent the Executive Committee may determine to distribute any assets to the County Authorities in kind) and shall apply the proceeds of such sale and the remaining BHO assets in the following order of priority:

11.2.1 Payment of creditors, to the extent otherwise permitted by law, in satisfaction of liabilities of the BHO;

11.2.2 To establish any reserves that the Executive Committee deems reasonably necessary for contingent or unforeseen obligations of the BHO and, at the expiration of such period as the Executive Committee shall deem advisable, the balance then remaining in the manner provided in Section 11.3.3 below;

11.2.3 By the end of the fiscal year in which the liquidation occurs (or, if later, within ninety (90) days after the date of such liquidation), to the County Authorities in proportion to the positive balances of their respective Capital Accounts, as determined after taking into account all Capital Account adjustments for the taxable year during which the liquidation occurs (other than those made pursuant to this Section 11.3.3).

11.3 Termination. The Executive Committee shall comply with any applicable requirements of applicable law pertaining to the winding up of affairs of the BHO and the final distribution of its assets. Upon completion of the winding up, liquidation and distribution of the assets, the BHO shall be deemed terminated.

11.4 Certificate of Cancellation. When all debts, liabilities and obligations have been paid and discharged or adequate provisions have been made therefor and all of the remaining property and assets have been distributed to the County Authorities, the Executive Committee shall file a certificate of cancellation as required by RCW 25.15.080. Upon filing the certificate of cancellation, the existence of the BHO shall cease, except as otherwise provided in the LLC Act.

11.5 Return of Contribution Nonrecourse to Other County Authorities. Except as provided by law or as expressly provided in this Agreement, upon dissolution each County Authority shall look solely to the assets of the BHO for the return of its Capital Contributions, if any. If the property remaining after the payment or discharge of liabilities of the BHO is insufficient to return the contributions to the County Authorities, no County Authority shall have recourse against any other County Authority, the BHO or NSBHO Administrator.

ARTICLE 12 -- MISCELLANEOUS PROVISIONS

12.1 Notices. Any notice, demand, or communication required or permitted under this Agreement shall be deemed to have been duly given if delivered personally to the party to whom directed or, if mailed by registered or certified mail, postage and charges prepaid, addressed: (a) if to a County Authority, to the County Authority's address specified in the attached **Exhibit A**; (b) if to the BHO, to the address specified in Section 2.3; and (c) if to the NSBHO Administrator to the address specified in Section 2.3. Except as otherwise provided herein, any such notice shall be deemed to be given when personally delivered or, if mailed, three (3) business days after the date of mailing. A County Authority, the BHO or the NSBHO Administrator may change its address for the purposes of notices hereunder by giving notice to the others specifying such changed address in the manner specified in this Section 12.1. Notwithstanding the foregoing with respect to ordinary communications between the County Authorities, the Executive Committee representatives and the NSBHO Administrators communication via email is permitted.

12.2 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Washington.

12.3 Amendments. This Agreement may not be amended except by the written agreement of all the County Authorities holding a County Authorities Interest in the BHO.

12.4 Construction. Whenever the singular number is used in this Agreement and when required by the context, the same shall include the plural and vice versa, and the masculine gender shall include the feminine and neuter genders and vice versa.

12.5 Headings. The headings in this Agreement are inserted for convenience only and shall not affect the interpretations of this Agreement.

12.6 Waivers. The failure to seek redress for violation of or to insist upon the strict performance of any covenant or condition of this Agreement shall not prevent a subsequent act, which would have originally constituted a violation, from having the effect of an original violation.

12.7 Rights and Remedies Cumulative. The rights and remedies provided by this Agreement are cumulative and the use of any one right or remedy shall not preclude or waive the right to use any or all other remedies. Said rights and remedies are given in addition to any other rights the parties may have by law, statute, ordinance or otherwise.

12.8 Severability. If any provision of this Agreement or the application thereof to any Person or circumstance shall be invalid, illegal or unenforceable to any extent, the remainder of this Agreement and the application thereof shall not be affected and shall be enforceable to the fullest extent permitted by law.

12.9 Successors and Assigns. Each of the covenants, terms, provisions and agreements herein contained shall be binding upon and inure to the benefit of the parties hereto and, to the extent permitted by this Agreement, their respective legal representatives, successors and assigns.

12.10 Creditors/Third Parties. None of the provisions of this Agreement shall be for the benefit of or enforceable by any of the creditors of the BHO or any third parties.

12.11 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original and all of which shall constitute one and the same instrument.

12.12 Investment Representations. The Units have not been registered under the Securities Act of 1933, the Securities Act of Washington or any other state securities laws (collectively, the "Securities Acts"). Each County Authority hereby confirms the Units have been acquired for such County Authority's own account, for investment and not with a view to the resale or distribution thereof and may not be offered or sold to anyone unless there is an effective registration or other qualification relating thereto under all applicable Securities Acts.

Executed by the undersigned County Authorities effective as of the date first above written.

COUNTY AUTHORITIES:

ISLAND COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

SAN JUAN COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

SKAGIT COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

SNOHOMISH COUNTY

By: _____
Its: _____

Approved at to form:

By: _____
_____, Prosecuting Attorney

WHATCOM COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

EXHIBIT A

COUNTY AUTHORITY INFORMATION

AS OF _____, 2016

Names and Addresses of County Authorities	Units	Percentage Interest
Island County 1 NE 7th St #214 Coupeville, WA 98239	1	11.111111%
San Juan County 55 2nd St N #1 Friday Harbor, WA 98250	1	11.111111%
Skagit County 1800 Continental Pl #100 Mount Vernon, WA 98273	1	11.111111%
Snohomish County 3000 Rockefeller Ave., M/S 609 Everett, WA 98201	4	44.4444444%
Whatcom County 311 Grand Avenue, Suite 105 Bellingham, WA 98225	2	22.222222%

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
	Implementation Plan			**Progress Report**
1. Ensure that American Indians are receiving the services they need within counties through participation in NSMHA Board of Directors meetings.	**1.1** • Tribal membership on NSMHA Board of Directors. (and standing committees): • Board of Directors (BOD) • Planning Committee • Strategic Planning Committee • Quality Management Oversight Committee • Tribal Committee • Annual letter will go out to Tribes to invite them to NSMHA Board of Directors and/or Advisory Board.	Tribal members on NSMHA Board of Directors at meetings and other committee meetings. Tribal Representatives appointed to the NSMHA Advisory Board	NSMHA Executive Director Target Date: Ongoing NSMHA Executive Director	There is currently one seat on the NSMHA Board of Directors representing the following Tribes: • Tulalip Tribes • The Nooksack Tribe • The Samish Tribe The issue of having separate seats on the NSMHA Board for each of the 8 North Sound Tribes has never been resolved. **August, 2015 Update** Begin discussion with 7.01 Committee regarding Tribal representation on the 2016 Behavioral Health Organization [BHO] Board
	1.2 Follow Centennial Accord Communication and Consultation Protocol.	Collaborate with Tribes on the interpretation and implementation of the Centennial Accord Communication Protocol. Implement Centennial Accord Communication and Consultation Protocol.	NSMHA Executive Director / Tribes Target Date: ongoing	Information about 7.01 Trainings provided by the DSHS Office of Indian Affairs are forwarded to NSMHA staff and providers on an ongoing basis.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
2. Optimum access to and inclusion in NSMHA contracted programs and/or culturally appropriate services for which Tribal members are eligible.	2.1 Collect, record, and provide access data: Identify census of Tribal communities and individuals receiving mental health services by NSMHA PHP contractors. • Collect data to support Tribal statements of need. • Seek a grant to pay for a plan to identify issues and gaps in services. Submit to Tribes. • Provide information to Tribes during Tribal/NSMHA monthly meeting. • Create opportunity for Tribes to identify service gaps. • Plan to collect Tribal specific data related to Crisis ServicesUse data to identify services needs related to the planning for the BHO implementation of BHO	• Number of PHP Provider Encounters • Primary/secondary diagnoses • Referring Tribes – Non-Indians • Data Dictionary to Tribes • Provide suitable reports of access data to Tribes for program planning and evaluation • NSMHA UR reviews will report on culturally appropriate services NSMHA can limit this to American Indian numbers. This should be an aggregate number. • Elements of plan incorporated into NSMHA planning, to include Strategic Planning. • Comprehensive Final Plan to address outstanding issues and gaps that is funded, supported by data, endorsed by Tribal Councils and NSMHA Board of Directors, published and distributed?	NSMHA Data Analyst Target Dates: Ongoing NSMHA Executive Director & Tribes, Target Date Revised: 12-31-2016	1. Data reports include: • Provider agency. • Age Groups ○ 0-17 ○ 18-59 ○ 60+ • Number people served. • Number of Service Hours. • Number of Services Provided. • List of Services provided. Updated data from NSMHA reviewed at the February 6, 2013 meeting. Discussion took place regarding whether this data could be combined with data on the number of persons being served in Tribal Behavioral Health programs. Tim will research to see what data might be available from DSHS. **August, 2015 Update** NSMHA will urge DBHR to include a field in the new state BHO Integrated Data Base for identification of Tribal members. NSMHA will also continue to work on including a field in its own data base to identify Tribal members once we receive the data layout for the new state BHO data base that can be used to identify Tribal members receiving Crisis Services.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
	2.2 Initiate process to enhance traditional healing through Federal Block Grant Funds Tulalip Tribes use FBG funds for youth engagement and tribal traditions	Tribal proposals which go to NSMHA Board of Directors for use of Federal Block Grant Funds NSHMA will continue to set aside FMHBG funds for Tribal treatment services. New SAMSHA requirements call for targeting BG services to the seriously mentally ill.	Tribes and NSMHA Ongoing	NSMHA currently has a traditional healing contract with the Tulalip Tribe utilizing Federal Block Grant Funds.An RFP for FBG funding is released every two years. Current providers must reapply every two years. **August 2015 Update**: The contract with Tulalip for healing programs will be for providing "wrap-around" services to high risk Tribal youth

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
	2.3 Tribal Mental Health Depts. have the capacity to initiate certification for voluntary admissions to inpatient services. • The initiation of certification for and admission to inpatient services will be provided to those Tribal community members receiving services at a Tribal mental health facility through the Tribe. • Establish agreed-on definitions of terms. • Update agreed-upon protocols. • Redevelop the protocol for change from APN to VOA • NSMHA to partner with Tribes on State options available. • Identify provider contacts for Tribes. Implement new state contract requirements for RSNs to develop coordination agreements with each tribe regarding Crisis Services and Psychiatric Hospitalization **New:** 2014 Involve Tribal input into the development of a North Sound Behavioral Health Organization	Tribes will provide aggregate reports of inpatient initiation. This will include: • Admission criteria consistent with Tribal evaluation criteria • The number of initiated referrals. • Response times to initiation. • Outcome of certification. • Current status Inpatient outcome sheet on voluntary admissions will be developed. • Consensus on this new protocol • Review at Tribal Mental Health Provider meetings Written coordination agreements developed with each tribe regarding Crisis Services and Psychiatric Hospitalization	NSMHA Executive Director in collaboration and partnership with the Tribes. Target Date for written coordination agreements revised: 3-1-2015 for Crisis Agreements. November 2015 for BHO Coordination Plans	Tribal Mental Health Departments have the capacity to initiate certifications for voluntary hospitalizations. This process has been working with no major problems Crisis Services agreements will be developed with each Tribe. **August 2014** Consulted with Tribes on the process to use to develop the coordination agreements. A draft template was shared and discussed. This will also be placed for discussion on the next RTCC meeting agenda. **August 2015 Update** NSHMA Continues its meetings with individual Tribes on the Crisis Services Agreements. To date, two meetings have been held with Upper Skagit and Lummi and initial meetings with Stillaguamish and Sauk-Suiattle. Potential meeting dates have been offered to other tribes. Guidelines for use by Tribal Behavioral Health professional have been drafted to assist in requesting for NSMHA Mental Health Crisis Services.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
	NEW **2.4 Develop a coordination agreement with Tribes related to Tribal ITA Court Orders for Substance Use Disorder Treatment Services**	• Initial discussions with Tribes that use Tribal ITA Court Orders	NSMHA Director and Tribes 12/31/2016	Coordinating with Tribes related to Tribal ITA Court Orders for Substance Use Disorder Treatment Services will be a new requirement for BHOs.
3. Provide culturally appropriate treatment for all Tribal consumers, and collaborative relationships between Tribes and PHP's in the treatment of Tribal individuals. (2003)	**3.1** Support and encourage NSMHA providers to incorporate Tribal resources when treating Tribal individuals. Review appropriate NSMHA polices. Support and encourage NSMHA providers	• Revise Tribal MH brochure, list contacts by Tribal position and contact number and review brochure yearly. • Revise Tribal Brochure to include references for Substance Use Disorder Treatment services	NSMHA Executive Director Ongoing October 2016	Related NSMHA Policies: 1521 – Cultural & Linguistic Competency 1530 – Cross System Coordination 1545—Vol. Hosp. Cert-Tribal members 1558 – Mental Health Specialist 6001 – 7.01 Plan Related NSMHA Training Modules: NSMHA 7.01 Administrative Policy/American Indian Training Module NSMHA Cultural Competence Training Module **August 2015** NSMHA is currently updating its Cultural Competency Plan. The following policies and Training Modules will need to be updated to incorporate BHO requirements and goals from the Cultural Competency Plan: 1521 – Cultural & Linguistic Competency 1545—Vol. Hosp. Cert-Tribal members 1558 – Mental Health Specialist 6001 – 7.01 Plan NSMHA 7.01 Administrative Policy/American Indian Training Module NSMHA Cultural Competence Training Module

Appendix, Section XI-02

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
	3.2 Encourage providers to offer Tribal consumer's traditional cultural treatment options as part of the intake process. Encourage Tribal consumers to seek cultural options as part of the intake process.	• All NSMHA providers routinely offer Tribal clients referrals to Tribal traditional cultural treatment, using contacts listed in the Tribal Mental Health Brochure.	NSMHA Executive Director Audit of Tribal files yearly Completed: ongoing	Providers are audited for compliance during NSMHA Administrative audits. **August 2015:** NSMHA will consult with Tribes on how to continue to meet this goal when transitioning to a BHO.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
	3.3 Develop and implement a plan with contracted NSMHA providers for incorporating traditional/cultural Tribal mental health services when treating Tribal consumers. This will include developing educational programs for provider staff on working with Tribal healing resource programs and people that identifies outstanding issues and/or gaps in services identified by Tribes. See 4.1 [moved to 4.1]	• Provider staff will notify Tribal mental health when a self-identified Tribal consumer presents for treatment and will routinely collaborate with Tribal Mental Health providers when treating a member of that Tribe. • .	NSMHA Executive Director in partnership with Tribes Ongoing	Training on incorporating traditional/cultural Tribal mental health services is included in the annual NSMHA/Tribal Mental Health Conferences. **August** The Annual Tribal Mental Health Conference was held on May 12 and 13 – See 4.1.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
	3.4 Foster collaborations between Tribes and NSMHA providers, County Mental Health, DMHPs, staff & case managers of Tribal consumers, and other components of mental health that result in culturally appropriate treatment. Encourage linkages among Tribes, DSHS agencies and County Health Programs that promote seamless services and inclusive treatment access for Tribal individuals.	• A working procedure is in place to notify Tribes when a self-identified service population member presents for services. • Tribal Mental Health Specialist is called in for consultation/ therapy within 30 days of access appointment. • Revise protocol at Tribal Mental Health Provider Meetings.	NSMHA Executive Director Target Date: Ongoing	Related NSMHA Policies: 1521 – Cultural & Linguistic Competency 1530 – Cross System Coordination 1558 – Mental Health Specialist 1545—Vol. Hosp. Cert-Tribal members 6001 – 7.01 Plan Related NSMHA Training Modules: NSMHA 7.01 Administrative Policy/American Indian Training Module NSMHA Cultural Competence Training Module **August 2015** The above NSMHA Policies will be reviewed and revised for the transition to a Behavioral Health Organization
4. All Stakeholder Training (2003)	**4.1** Provide training opportunities that address cultural sensitivity to Tribal Mental Health Workers and the public.	• Workshops, trainings seminars, and conferences held each year.	NSMHA Executive Director Ongoing	Another successful Tribal Mental Health Conference was held on May 13 and 14: "Listening with Open Hearts". There were over 200 participants.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	Lead Staff and Target Date	Status Updated for the Fiscal Year Starting July 1, 2015
				August 2015 The Annual Tribal Mental Health Conference was held on May 12 and 13. Over 180 persons attended representing a broad spectrum of Tribal and non-Tribal behavioral health providers, other public and private sector agencies, and students. Conference evaluations were very positive and there was strong support for continuing the focus on tribal health practices and critical issues such as suicide and drug addiction.
	4.2 Workshop, training, seminar and conference need and subject matter are directed by Tribes who attend the NSMHA/Tribal meetings.	• Joint NSMHA/Tribal workshops, trainings, seminars and conferences to address specific Tribal mental health issues. • Tribes direct Tribal-specific design and presentation of workshops, trainings, seminars and/or conferences. • Provide two workshops/trainings annually.	NSMHA Executive Director & Tribes Ongoing	The Themes for each year's conference are selected by the NSMHA/Tribal Mental Health workgroup by reviewing the evaluations from each year's conference and consulting with the tribal representatives to the mental health 7.01 group. See updates under 4.1

	4.3 Continue to hold bi-monthly joint Tribal/NSMHA meetings to identify common issues and goals and to collaborate on addressing them.	• Continued collaboration on mental health issues of concern between Tribes and NSMHA. Expand the existing Tribal-NSMHA Mental Health Committee into a Tribal "Behavioral Health Committee" to include representative from Tribal Substance Use Disorder Treatment programs.	NSMHA Executive Director & Tribes Ongoing December, 2016	*NSMHA has conducted monthly Tribal/NSMHA Meetings and our intention is to continue these meetings.* **August 2015 Update** Regular meetings of the Tribal Mental Health Committee have continued. In 2015, these meetings have focused on: planning the May Tribal Mental Health Conference, Tribal-NSMHA Crisis Services agreements, and NSMHA planning for the Behavioral Health Organization.

5. Increase in census of enrolled Tribal members employed by NSMHA-contracted PHP providers by county.	**5.1** NSMHA providers include Tribal employment on mailing lists/publicity for job announcements. NSMHA will examine provider hiring process to make sure the American Indian communities as well as non-Native Tribal mental health specialists are involved.	• Tribal employment offices routinely receive job announcements from providers. • Tribes are included in PHP provider recruitment; i.e., employment opportunity announcements. • NSMHA will evaluate the use of tribal interns • Tribes are included in recruitment for training opportunities and internships • Tribes provide mailing lists of individuals from their Tribes be notified when training and internships are available. • Increase in the amount of American Indians employed by provider agencies.	NSMHA Executive Director & Tribes DSHS Office of Indian Policy – Region 2 Manager Ongoing Activity	*Tribes are notified of all NSMHA Advertised Staff Openings via email/ direction to posting on NSMHA website.* **August 2015 Update:** NSMHA will be recruiting to fill its vacant Tribal Liaison position and will be restructuring this position a Tribal Crisis Services Liaison position.

6. Broad knowledge and understanding of the concepts in the Centennial Accord and of 7.01 planning throughout Region II North, especially among all NSMHA stakeholders, including NSMHA staff, contractors, Governing Board, and Advisory Board members.	**6.1** Incorporate awareness and oversight of special needs of AI/AN consumers into the NSMHA process of governance, to include Board of Directors, the Quality Management Oversight Committee and Children's Policy Executive Team (CPET)	• Outstanding issues and/or gaps in services identified by Tribes appear on Board and Committee agendas and are addressed routinely. • Tribes are appropriately represented on NSMHA Boards and Committees.	NSMHA Executive Director & Tribes Target Date: Ongoing activities	Three Tribal representatives on NSMHA Board of Directors, a member of the Tulalip Tribe has been actively attending meetings. One Tribal Representative on the Quality Management Oversight Committee (QMOC), vacant-6/2009 In addition, the Children's Policy Executive Team (CPET) charter shows one spot for a Tribal Liaison. 3 new slots have been created on the NSMHA Advisory Board. Appointments from the Tribes are pending. **August 2015** Sherry Guzman has been actively participating in Board of Director meetings. When she retires, we will need to ask the Tribes to appoint a new representative.
	6.2 Incorporate North Sound Region 7.01 Plan in all NSMHA contracts. Incorporate provisions of 7.01 Plan in NSMHA and Provider Policy & Procedure Manuals, and all other planning and procedure documents.	• Execute contract revisions that include 7.01 Plan. • Review NSMHA and contractor Policy & Procedure Manuals along with all planning and procedure documents.	Contracts/Fiscal Manager Target Date: Ongoing NSMHA Executive Director & Tribes Target Date: Ongoing activities	7.01 Plan is incorporated in State and Medicaid funded contracts. **August 2015** New State contract requirement for RSN coordination with Tribes, especially for Crisis Services, have been updated in the July 2015 State-RSN Contracts.

7. Mental Health Community awareness and understanding of outstanding issues and/or gaps in services identified by Tribes.	**7.1** NSMHA will work with Tribes to identify the most effective way to obtain Tribal customer satisfaction input on NSMHA funded services.	• Elements of plan incorporated into NSMHA BHO planning •	NSMHA Executive Director & Tribes Target Date: 12-31-16	MHD Adult Consumer Survey & Child Consumer Survey in 7.01 Plan folder. **August 2015:** A new process for customer satisfaction surveys will be developed as part of the BHO plan.

Completed, Tabled, or continued in FY 2015 7.01 Plan

Goal/Activity/Outcome	Date	Outcome
Goal 1: Ensure that American Indians are receiving the Services they need within counties through participation in NSMHA Board Meetings		
1.1 Tribal membership on NSMHA Board of Directors	February, 2009 and November, 2011	• Membership letters were sent to every Tribe in the North Sound granting a full vote with the acceptance of financial risk. • No Tribe responded accepting financial risk. Samish Tribe responded for Board of Directors' membership. • There is currently one seat on the Board of Directors representing the Tulalip, Nooksack, and Samish Tribes
1.1 Tribal membership on NSMHA Advisory Board	**September, 2012**	• On September 13, 2012 NSMHA Board approved adding 3 Tribal Seats to the NSMHA Advisory Board with one shared seat. • An invitation to Tribes to submit names for representatives for the 3 new NSMHA Advisory Board Tribal seats was discussed at the December, 2012, and March, 2013 and March, 2014 RTCC meetings.
2.1 Collect, record, and provide access data: Identify census of Tribal communities and individuals receiving mental health services by NSMHA PHP contractors.	Ongoing	Data reports presented and reviewed at the May 1, 2012 and November 7, 2012 at 7.01 meetings **October 2013 Update** New NSMHA contracts for outpatient services went into effect on October 1. These expand services to rural areas and add two new providers for Children's Mental Health Services. August, 2014 Update Update on NSMHA's plan to try and collect data on Tribal member affiliation as part of the NSMHA/Tribal Crisis Services Coordination Agreements
2.2 Initiate process to enhance traditional healing through Federal Block Grant Funds Tulalip Tribes use FBG funds for youth engagement and tribal traditions	Ongoing	• Discussed at September 10, 2012 Tribal/NSMHA Meeting. Tribal representatives will check with Tribal Program Staff. • Reviewed again at October 22, 2012 Tribal NSMHA meeting; no additional issues identified. The need to improve coordination of discharge planning to tribal members being discharged from psychiatric hospitalization was discussed at the February 6, 2013 meeting. This issue will be referred to the Tribal MH provider group for discussion at future meetings. October 2013 2013-2014 Federal Mental Health Block Grant funds have been allocated. This includes continued funding

		for The Tulalip Tribes cultural activities program for youth. **May 2015** NSMHA has carved out of its June 2015-March 2016 FMHBG allocation the same proportion of funds for tribal healing programs
	2.3 Tribal Mental Health Depts. have the capacity to initiate certification for voluntary admissions to inpatient services.	**November 2014:** Preliminary briefing provided on the requirements for a Behavioral Health Organization (BHO) plan. **February 2015** NSMHA is meeting individually with each tribe to develop crisis services coordination agreements. Will continue to consult with tribes regarding coordination with future BHO programs. **May 2015** Initial meetings have been held with Upper Skagit, Lummi, Stillaguamish, and Sauk-Suiattle. We have also provided additional instructions to mental health crisis line and have drafted guidelines to assist Tribal behavioral health professionals
3.1 Support and encourage NSMHA providers to incorporate Tribal resources when treating Tribal individuals. Review appropriate NSMHA polices. Support and encourage NSMHA providers	Ongoing	September 2012 update Tribal representatives will review the draft brochure for needed updates; the updated brochure will be distributed and posted on the NSMHA website. Current brochure handed out at the November 7, 2012 7.01 Meeting. Send any corrections to the NSMHA Executive Director. Brochure reviewed again at February 6, 2013 meeting. No additional corrections were noted. NSMHA will re-distribute brochures to provider agencies with a reminder to hand it out to self-identified Native Americans who are served by RSN contracted providers. Lead Staff and Target Date: NSMHA Director: October 2013.
3.2 Encourage providers to offer Tribal consumer's traditional cultural treatment options as part of the intake process. Encourage Tribal consumers to seek cultural options as part of the intake process	Ongoing	**February 6, 2013 update**: NSMHA will strengthen the requirement in future contracts with provider agencies to make Native American consumers aware of services available through Tribal Behavioral Health providers. NSMHA will conduct a focused review in 2013 of a sample of Native American consumer charts to determine the extent to which this requirement is being met. **February 2014:** Data on the extent to which special

		population consultations involve Native American will be collected by NSMHA staff during their 2014 provider reviews. [not completed-new fields need to be added to collect this data]
3.3 Develop and implement a plan with contracted NSMHA providers for incorporating traditional/cultural Tribal mental health services when treating Tribal consumers.	Ongoing	Training on incorporating traditional/cultural Tribal mental health services is included in the annual NSMHA/Tribal Mental Health Conferences. Themes from the last 3 years were: 2011 Conference: "Wraparound in Indian Country." 2012 Conference: "Tribal Needs & Healthcare Reform" 2013 Conference: "Canoe Journey – Life's Journey **August 2014** The Annual Tribal Mental Health Conference, entitled "Listening with an Open Heart" was held on May 13 and 14. It focused specifically on understanding and using Tribal cultural and spiritual traditions. Over 200 participants attended.
3.4 Foster collaborations between Tribes and NSMHA providers, County Mental Health, DMHPs, staff & case managers of Tribal consumers, and other components of mental health that result in culturally appropriate treatment.	Ongoing	September 2012 update: Tribal representatives will check with Tribal program staff on how well this protocol is being followed. February 2013 update: NSMHA staff will continue to review whether its providers are consulting with Tribal Mental Health Specialists as part of their utilization reviews of provider agencies.
4.1 Provide training opportunities that address cultural sensitivity to Tribal Mental Health Workers and the public.	Tribal/NSMHA Annual Mental Health Conferences are provided every year.	2011 Conference: "Wraparound in Indian Country." 2012 Conference: "Tribal Needs & Healthcare Reform" 2013 Conference: "Canoe Journey – Life's Journey" **August 2014** The Annual Tribal Mental Health Conference, entitled "Listening with an Open Heart" was held on May 13 and 14. It focused specifically on understanding and using Tribal cultural and spiritual traditions. Over 200 participants attended.
4.3 Continue to hold bi-monthly joint Tribal/NSMHA meetings to identify common issues and goals and to collaborate on addressing them.	Ongoing	**2009 Meetings:** Feb.9th, Mar. 31st, May 18th, Jul 13th Sep 22nd, Oct 19th & Nov. 16th **2010 Meetings:** Jan. 25th, Feb. 22nd, Mar. 8th, Jun. 3rd, Sep.

		13th, Nov. 8th **2011 Meetings:** Jan 10, March 14, Oct 10, Nov 21 **2012 Meetings:** Jan 9, Feb 13, Mar 12, May 14, July 9, Sept 10, Nov: TBD November 2012 update: monthly meetings have resumed. Meetings were held in August, September and October. February 2013 update: Schedule for 2013 shared. Meetings will continue on the 2nd Monday of every other month, with monthly meetings up to the May conference. May 2013 Update: Meeting will continue to be scheduled every other month.
5.1 NSMHA providers include Tribal employment on mailing lists/publicity for job announcements	Ongoing	• No open positions at NSMHA in 2009. • 2010 Advertised and hired Operations Manager • 2011 2 positions (1.5 FTE) for Western State Hospital Liaison • 2011 Notified of 1 FTE Executive Director for NSMHA • 2012 Notified of one FTE Quality Specialist position.
6.1 Incorporate awareness and oversight of special needs of AI/AN consumers into the NSMHA process of governance, to include Board of Directors, the Quality Management Oversight Committee and Children's Policy Executive Team (CPET)	Ongoing	
6.2 Incorporate North Sound Region 7.01 Plan in all NSMHA contracts	•	**May, 2014 Update** The new draft state contact requirements for individual RSN/Tribal Coordination agreements related to Mental Health Crisis Services and psychiatric hospitalizations reviewed. The new contract requirements are scheduled to go into place on July 1, 2014 and NSHMA will have 120 days to develop agreements with the Tribes. To be discussed at the June RTCC meeting.
6.3 NSMHA should conduct case reviews to determine whether contracted agencies are consulting with Tribal Mental Health Specialists when serving Native American Consumers.	• Audits reveal that provider Policy & Procedure Manuals contain these procedures and clinical records show compliance. Review at Tribal Mental Provider meetings	Contracts/ Fiscal Manager Target Date: • Ongoing activities. The intent of activity 6.3 was clarified. This activity is identical to 3.2 and updates will be provided under that section.
7.1 NSMHA will jointly develop satisfaction surveys with all	Ongoing	Subcommittee to develop survey formed at July 09 meeting.

Tribes		Survey Tool Never Completed September 2012 update: NSMHA is currently developing a new consumer survey. A copy was shared at the September 10, 2012 Tribal/NSMHA meeting. Tribal representatives will review and send suggestions for changes to create a more tribal specific survey. November 2012 Update: NSMHA Director will send the NSMHA Consumer Survey to Region 2 OLP Manager for forwarding to 7.01 Members for their information. February 2013 update: results of the 2012 consumer survey will be shared and discussed at the next 7.01 meeting. **February 2015:** NSMHA is redesigning its consumer survey to focus more on individual outcomes. Questions will be added to the survey to allow respondents to self-identify as AI/AN and Tribal Members. [not yet completed]

Effective Date: 6/26/2004
Revised Date: 6/27/2008
Review Date: 7/7/2008

North Sound Mental Health Administration

Section 1500 – Clinical: Cultural and Linguistic Competence

Authorizing Source: 42 CFR 438.206(b); RCW 71.254.300; WAC 388-877-0600, 388-877-0620 State NSMHA Policies 1545.00, 1558.00 and 6001.00 – 7.01 Plan

Approved by: Executive Director Date:

Cancels:

See Also:

Responsible Staff: Quality Manager

Signature:

POLICY #1521.00

SUBJECT: CULTURAL AND LINGUISTIC COMPETENCE

PURPOSE

To promote, develop and maintain a culturally and linguistically competent public mental health service system of care for the North Sound Mental Health Administration (NSMHA) geographic service area.

DEFINITIONS

Culture

The integrated patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious and/or social groups.

Competence

Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.

Cultural Identity

The extent to which one relates self to race, ethnicity, language, age, gender, sexual orientation, physical ability, region or country of origin, degree of acculturation, socioeconomic status, religious beliefs and the makeup of one's family.

Cultural and Linguistic Competence

Cultural Competence means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

POLICY

NSMHA and its providers will develop policies and procedures designed to promote the development and maintenance of cultural and linguistic competence toward its consumers, employees and the community at large.

PROCEDURES

1. AGENCY CULTURAL AND LINGUISTIC COMPETENCE

1.1 NSMHA will develop and establish policies and procedures that support cultural and linguistic competence in its Human Resources practices, system of care and service delivery to consumers and public relations with the community at large.

1.2 NSMHA will review its providers' policies and procedures periodically to ensure the promotion of cultural and linguistic competence throughout the mental health system of care at all levels. This will include a review of Individual Service Plans to assess whether they address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative [WAC 388-877-0620 (b)].

1.3 NSMHA will periodically assess, as part of its Quality Management Plan, the bilingual and bicultural capabilities of its service delivery system. A thorough analysis of all consumer and consumer-related data will be performed to ascertain the level of need for bilingual/bicultural staff. These analyses will include, but not be limited to:

a. Consumer demographic data;
b. Minority consumer penetration rates;
c. Provider periodic on-site contract review reports;
d. Consumer grievances, appeals and fair hearings.

1.4 Publications routinely circulated among minority communities will be regularly included in advertising for NSMHA and provider staff vacancies. Additionally, culturally sensitive groups, organizations and academic institutions may be contacted to maximize recruitment potential.

1.5 NSMHA conducts periodic on-site contract reviews of providers, which include review of documentation for orientation and training on cultural competence. This includes reviews conducted by the NSMHA Quality Review Team. In addition, NSMHA conducts a cultural and linguistic competence review of provider staff that includes:

a. Education level;
b. Knowledge of culturally competent policies and/or plan;
c. Participation in cultural competence training; and
d. Experience working with specific minority groups.

1.6 Providers shall develop and maintain a listing of their employees or others in the community who are certified interpreters in other languages, including American Sign Language, to ensure interpreter services are available. These lists shall be updated and submitted annually to NSMHA so that a master regional list can be established and maintained.

1.7 NSMHA will utilize the aggregate related data (e.g., review of provider policies and procedures, onsite contract reviews) to periodically assess its performance and effectiveness in developing, implementing, and maintaining cultural and linguistic competence.

2. SPECIAL POPULATIONS [State RSN Contract Requirement 9.6.2.2.12]

Special Populations – The Contractor shall ensure that individuals who self-identify as having specialized cultural, ethnic, linguistic, disability, or age related needs have those needs addressed. Referrals for specialty service consultation should be tracked through the treatment plan and progress notes. If a provider identifies a need, but it is deferred by the Consumer, the provider must document why they are not addressing it at this time.

3. TRIBAL COORDINATION

NSMHA will maintain a 7.01 Plan to describe the Goals and Activities identified by the North Sound Tribal Nations to ensure equal access to behavioral health services for American Indians/Alaska Natives. The 7.01 Plan will include:

a. Arrangements for representation on the NSMHA Board of Directors and Advisory Board
b. Information about 7.01 Trainings provided by DSHS Office of Indian Affairs being forwarded to NSMHA Staff and Provider Agencies
c. Strategies to ensure optimum access to and inclusion in NSMHA contracted programs and/or culturally appropriate services for which Tribal Members are eligible.
d. Strategies to provide culturally appropriate treatment for all Tribal consumers, and collaborative relationships between Tribes and PHP's in the treatment of Tribal individuals.
e. A plan for providing training opportunities that address cultural sensitivity to Tribal Mental Health Workers and the public.
f. Agreements to ensure that Tribes are notified of employment openings within NSMHA and Provider Agencies
g. A plan for the development of written Crisis Services agreements between NSMHA and each Tribal Authority to increase coordination in mental health crisis services, including psychiatric inpatient discharge planning, between Tribes and NSMHA Provider Agencies.

4. CULTURAL COMPETENCE TRAINING

4.1 NSMHA and its Provider Agencies will be required to conduct bi-annual Cultural Competence Self-Assessments to identify areas for staff training, strategies to strengthen culturally sensitive trauma informed systems of care, and plans for specialty service consultations.

4.2 The NSMHA Training Committee will review the NSMHA and Provider Agency Self-Assessments, on-site provider reviews, service data, and recommendations from Tribes to identify training opportunities to include in NSMHA's annual training plan, including trainings that can be hosted on the Relias On-Line learning system

**NOTE: *This is a template and a guide for developing a working agreement between a tribe and the North Sound Mental Health Administration [NSMHA]. The terms of the final agreement between a tribe and NSMHA will depend on the needs and resources of both parties.*

MEMORANDUM OF UNDERSTANDING BETWEEN [TRIBE] AND NORTH SOUND MENTAL HEALTH ADMINISTRATION REGARDING THE MENTAL HEALTH COORDINATION PLAN

I. INTRODUCTION

This memorandum of agreement is entered into between the (the Tribe or Nation) and the North Sound Mental Health Administration, each acting in its representative capacity. This Agreement is based on the fundamental principles of the government-to-government relationship acknowledged in the 1989 Centennial Accord, the "Tribal Centric Behavioral System" Report to the Legislature, and the collaborative relationship developed by the Tribe and NSMHA through contract, practice, and policy, including the DSHS 7.01 Administrative Policy.

This Agreement recognizes the sovereignty of the Tribe and of the State of Washington and each respective sovereign's interests.

II. PURPOSE

Washington State law established Regional Support Network Services to address the needs of people with mental disorders with a targeted, coordinated, and comprehensive set of evidence-based practices that are effective in serving individuals in their community and will reduce the need for placements in state mental hospitals. These services include 24 hour crisis response services and the evaluation and detention of persons who present a likelihood of serious harm and/or are gravely disabled as a result of a mental illness.

State Law now also requires the Department of Social and Health Services to enter into agreements with the tribes and urban Indian health programs and to modify regional support network contracts as necessary to develop a tribal-centric behavioral health system that better serves the needs of the tribes.

III. AUTHORITY

The following statutes, regulations, policies, and agreements govern the provision of Crisis Services by Regional Support Networks and for coordination with Tribal Authorities:

RCW 71.24.030	Regional Support Networks – Inclusion of Tribal Authorities
RCW 71.05	Detention of Persons with Mental Disorders
RCW 71.24	Community Mental Health Services Act
WAC 388-365	Community Mental Health and Involuntary Treatment Programs
WAC 388-877A-022	Crisis Mental Health Services
State of Washington State Mental Health RSN Contract	Section 14 – Tribal Relationships
November 30, 2013 Report to the Legislature	Tribal Centric Behavioral Health System
North Sound Mental Health-Tribal 7.01 Plan	
NSMHA Policy #1500	Voluntary Hospital Certification – Tribal Community Liaison
NSMHA Policy Section #1700	Crisis Services

IV. DEFINITIONS

Crisis Services
Crisis outreach services are face-to-face intervention services provided to assist individuals in a community setting [WAC 388-877A-0240].

Designated Mental Health Professional
"Designated mental health professional" means a mental health professional designated by the county or other authority authorized in rule to perform the duties specified in this chapter [RCW 71.24.025].

Evaluation and Treatment Facility [E&T]
"Evaluation and treatment facility" means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is certified as such by the department. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility [RCW 71.05.020].

Involuntary Treatment Act Evaluation Services" [ITA]
Emergency involuntary detention services are services provided by a designated mental health professional (DMHP) to evaluate an individual in crisis and determine if involuntary services are required [WAC 388-877A-0300].

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North Sound Mental Health Administration [NSMHA]:
The State Contracted Regional Support Network established through an Inter-Local Agreement between Snohomish, Skagit, Whatcom, Island, and San Juan Counties.

Regional Support Network [RSN]
"Regional support network" means a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region [RCW 71.24.025].

Tribal Authority
"Tribal authority," for the purposes of this section and RCW 71.24.300 only, means: The federally recognized Indian tribes and the major Indian organizations recognized by the secretary insofar as these organizations do not have a financial relationship with any regional support network that would present a conflict of interest [RCW 71.24.025].

Voluntary Inpatient Services
Inpatient Psychiatric Services provided to persons for whom inpatient care is deemed medically necessary as defined in WAC 388-865-0450 and whose treatment has been authorized by the designated NSHMA hospital certification team [NSMHA Policy #1545.00].

V. TRIBAL COORDINATION FOR CRISIS, VOLUNTARY INPATIENT AND INVOLUNTARY COMMITMENT SERVICES

The following agreements are made regarding the authorities and protocols that will apply to providing crisis, ITA evaluation, voluntary inpatient authorization and discharge planning services on tribal lands within the North Sound Regional Support Network service area.

1. Coordination with Tribal Authorities

a. The following notifications are needed to provide services on Tribal lands:
   1) During business hours: [insert authority, persons to notify].
   2) During evenings, weekends, and holidays [insert authority, person to notify].

b. The following elements need to be included in the notification: [insert].

c. Notifications are to be provided within the following timelines:
   1) During business hours: [insert timeline].
   2) During evenings, weekends, and holidays [insert timeline].

d. Procedures for coordination with designated Tribal Mental Health providers
   1) Coordination before a crisis service is provided: [insert]
   2) Process for consulting with Tribal Mental Health provider in determining whether a DMHP is being requested to conduct an ITA determination [insert].
   3) Procedure for debriefing with Tribal Mental Health provider after crisis service has occurred [insert].

2. **ITA Evaluation Services**
   1) Authority for DMHPs to conduct ITA evaluations on Tribal lands:
   2) If ITA evaluations cannot be conducted on Tribal lands, procedures for transporting Tribal members to non-Tribal lands for ITA evaluations and detentions:
   3) Procedures for coordination with Tribal authorities when conducting ITA evaluations:
   4) Plan for where detained Tribal members will be held if no E&T beds are available.

3. **Voluntary Hospital Authorization**
   1) Procedures for how Tribal Mental Health providers will request voluntary psychiatric hospitalization authorizations for Medicaid-eligible consumers.
   2) NSMHA policy and procedures for requesting voluntary authorization, appeals and expedited appeals [see Appendix B- NSMHA Policy #1545-"Voluntary Hospital Certification-Tribal Community Members"].

4. **Inpatient Discharge Planning**
   1) Procedure for identifying the Tribal Mental Health provider as the liaison for inpatient coordination of care when the Consumer is an identified Tribal member and has not expressed a preference regarding involvement by the Tribe in their care [see Appendix B].

VI. INFORMATION SHARING AND CONFIDENTIALITY

1. It is the policy of both the Tribe and NSMHA to share with each other full information about a Tribal member Consumer that will assist in the coordination of all medically necessary mental health services. NSMHA is required to follow state and federal laws governing confidentiality of mental health consumer records. The Tribe agrees that it will follow state and federal law, or tribal law, if the Tribal Code meets or exceeds state and federal law requirements to protect the records of consumers receiving services from NSMHA contracted providers.

VII. CONFLICT RESOLUTION

The Tribe and NSMHA agree that if a dispute arises under this agreement, the process set forth in the 7.01 Policy or in the General Terms and Conditions of the Intergovernmental Agreement will apply. A copy of the applicable process is set forth in Attachment C.

VIII. EFFECT AND MODIFICATION

This is a working document to guide the Tribe and NSMHA in coordination of mental health service to Tribal members. Its description of services may be changed as programs are added or eligibility requirements are changed. Contact persons, services and other subjects set forth in the Attachments may be updated at any time at the request of either party.

This agreement will be reviewed every two years and will continue in effect until modified or terminated. However, this agreement may be modified at any time by mutual agreement of the Tribe and NSMHA. Any modification may be reflected in an addendum and attached to the agreement.

This agreement is subject to state and federal law and Tribal code, as they exist and as amended during the course of this agreement.

ATTACHMENTS

ATTACHMENT A – Tribal and NSMHA contact list

ATTACHMENT B – NSMH Policy # 1545-"Voluntary Hospital Certification-Tribal Community Members"

ATTACHMENT C - Dispute resolution process

ATTACHMENT E – NSMHA Policy #17.04 – "Crisis Services-General Policies"

ATTACHMENT F – Dispute resolution

In light of the sovereign government status of Tribes, when consultation alone has not been successful in resolving issues at the regional level, Tribes have the authority to raise the issues to the Assistant Secretary, Secretary, or the Governor.

[From 2007 7.01 Policy]

Attachment A
Tribal and NSMHA Contact List

XII. Appendix:
Evidence-Based, Research-Based and Promising Practices Analysis and Development

DELETED BY THE DIVISION OF BEHAVIORAL HEALTH AND RECOVERY (DBHR)

XIII. Appendix:
Behavioral Health Data Consolidation Project Plan

CONTAINS NO APPENDICES

Behavioral Health Organization (BHO) Acronym List

A

ACS	Access to Care Standards
ADAI	Alcohol and Drug Abuse Institute
ADIS	Alcohol and Drug Information System
ADL	Activity of Daily Living
AI/AN	American Indians/Alaskan Natives
ALF	Assisted Living Facility
APA	American Psychiatric Association
ASAM	American Society of Addiction Medicine
ASAM PPC	American Society of Addiction Medicine Patient Placement Criteria
ATR	Access to Recovery
ATTC	Addiction Technology Transfer Center

B

BH	Behavioral Health
BHA	Behavioral Health Agency
BHDC	Behavioral Health Data Consolidation
BHO	Behavioral Health Organization
BHP	Behavioral Health Professionals
BOD	Board of Directors

C

CADC	County Alcohol Drug Coordinators
CALOCUS	Child/Adolescent Level of Care Utilization System
CASC	Community Action of Skagit County
CBHC	County Behavioral Health Coordinators
CBT	Cognitive Behavioral Therapy
CCAR	Connecticut Community for Addiction Recovery
CAP	Corrective Action Plan
CCC	Children's Care Coordinator
CCDC	County Chemical Dependency Coordinators
CCSNW	Catholic Community Services Northwest
CD	Chemical Dependency
CDP	Chemical Dependency Professional
CDS	Chemical Dependency Specialist
CETA	Common Elements Treatment Approach
CEU	Continuing Education Units
CFR	Code of Federal Regulations
CIS	Consumer Information System
CJTA	Criminal Justice Treatment Account
CLIP	Children's Long-term Inpatient Program

CLIP-IT	Children's Long-term Inpatient Program Improvement Team
CMHS	Community Mental Health Specialist
CMS	Center for Medicare and Medicaid Services
COD	Co-Occurring Disorders
CPIT	Crisis Prevention Intervention Team
CPWI	Community Prevention and Wellness Initiative
CR	Conditional Release
CSO	Community Services Office

D

DBHR	Division of Behavioral Health and Recovery
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DDMHT	Developmental Disability Mental Health Team
DFC	Drug Free Communities
DMHP	Designated Mental Health Professional
DOC	Department of Corrections
DSHS	Department of Social and Health Services
DSM	Diagnostic and Statistical Manual
DUI	Driving Under the Influence

E

E&T	Evaluation and Treatment
EBP	Evidenced-Based Practices
ED	Emergency Department
EDIE	Emergency Department Information Exchange
EDV	Encounter Data Validation
EMS	Emergency Medical Services
EQRO	External Quality Review Organization

F

FBG	Federal Block Grant
FMHBG	Federal Mental Health Block Grant
FQHC	Federally Qualified Health Centers
FYSPRT	Family Youth System Partner Round Tables

G

GAIN-SS	Global Appraisal of Individual Needs – Short Screener

H

HARPS	Housing and Recovery Through Peer Support
HCA	Health Care Alliance
HIT	High Intensity Treatment

I

ICRS	Integrated Crisis Response System
IDDT	Integrated Dual Disorder Treatment
IIP	Intensive Inpatient
IMD	Institution for Mental Diseases
IMR	Illness Management and Recovery
IOP	Intensive Outpatient Program
IQMC	Internal Quality Management Committee
ISP	Individual Service Plan
ITA	Involuntary Treatment Act

J

JOA	Joint Operating Agreements
JTS	Jail Transition Services

L

LCSW	Licensed Clinical Social Worker
LLC	Limited Liability Corporation
LOC	Level of Care
LOCUS	Level of Care Utilization System
LR	Less Restrictive
LRO	Less Restrictive Order
LTR	Long-term Residential
LWC	Lake Whatcom Center
LWRTC	Lake Whatcom Residential Treatment Center

M

MAT	Medication Assisted Treatment
MAR	Medication Assisted Recovery
MCO	Managed Care Organizations
MH	Mental Health
MHBG	Mental Health Block Grant
MHD	Mental Health Division (now known as DBHR)
MHP	Mental Health Professional
MHT	Mental Health Therapist
MI	Motivational Interviewing
MIT	Motivational Interviewing Training
MOU	Memorandum of Understanding
MPC	Medicaid Personal Care

N

NAMI	National Alliance for the Mentally Ill
NOA	Notice of Action
NSACH	North Sound Accountable Community of Health
NSBHO	North Sound Behavioral Health Organization
NSMHA	North Sound Mental Health Administration

O

OP	Outpatient
OST	Opiate Substitution Treatment

P

PACT	Program for Assertive Community Treatment
PCC	Primary Care Clinic
PCN	Pioneer Center North
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Projects
PM	Performance Measures
PP	Promising Practices
PPR	Patient Placement Referral
PPW	Pregnant, Post-Partum and Parenting Women
PRISM	Predictive Risk Intelligence System

Q

QAPI	Quality Assessment and Performance Improvement
QIC	Quality Improvement Coordinator
QUI	Quality Improvement Coordinator
QMOC	Quality Management Oversight Committee
QMP	Quality Management Plan
QRT	Quality Review Team

R

RCW	Revised Code of Washington
RFP	Request for Proposals
RFQ	Request for Qualifications
RH	Recovery House
ROI	Release of Information
RN	Registered Nurse
RP	Researched-Based Practices
RSN	Regional Support Networks
RTC	Regional Training Committee
RTCC	Regional Tribal Coordinating Council
RTF	Residential Treatment Facilities

S

SAP	Substance Abuse Prevention
SAPT	Substance Abuse Prevention Treatment
SBIRT	Screening, Brief Interventions and Referral to Treatment
SCCC	Skagit County Crisis Center
SERI	Service Encounter Reporting Instructions
SMI	Serious Mental Illness
SOCI	Systems of Care Institute
SUD	Substance Use Disorder

T

TAY	Transition Age Youth
TEC	The Everett Clinic
TTY/TDD	Teletypewriter/Telecommunication Devices for the Deaf

U

UR	Utilization Review
UW	University of Washington
UWADAI	University of WA Alcohol and Drug Abuse Institute

V

VOA	Volunteers of America

W

WAC	Washington Administrative Code
WISe	Wraparound with Intensive Services
WSH	Western State Hospital