

12. FRAUD, WASTE AND ABUSE

- 12.1.** Contractor shall have administrative and managerial procedures in place that are designed to guard against fraud, waste and abuse. These procedures include:
- 12.1.1.** Provisions that ensure that Contractor does not 1) operate any physician incentive plan as described in 42 CFR 422.208; and 2) does not contract with any Subcontractor operating such a plan;
 - 12.1.2.** A mandatory compliance plan;
 - 12.1.3.** Written policies, procedures, and standards of conduct, which articulate the Contractor's commitment to comply with all applicable federal and state standards;
 - 12.1.4.** Designation of a compliance officer that is accountable to senior management;
 - 12.1.5.** Name of the Contractor's compliance officer and her/his contact information (email address, phone number and mailing address);
 - 12.1.6.** Effective ongoing training and education for the compliance officer and staff as well as appropriate subcontractor staff;
 - 12.1.7.** Effective lines of communication between the compliance officer and the Optum PRSN's Fraud and Abuse Compliance Officer;
 - 12.1.8.** Enforcement of standards through well-publicized disciplinary guidelines;
 - 12.1.9.** Provision of internal monitoring and auditing; and
 - 12.1.10.** Provision for prompt response to detected offenses, development of corrective action initiatives, and notification of Optum PRSN.
- 12.2.** Contractor shall submit a current mandatory compliance plan and annual work plan to Optum PRSN within ninety (90) calendar days of the signing of this Contract. The plan must be updated to address the provisions of the False Claims Act (31 USC 3729 et seq.).
- 12.3.** Contractor must report fraud, waste and/or abuse information to the Optum PRSN Fraud and Abuse Compliance Officer *as soon as it is discovered* including the source of the complaint, the party complained against, nature of fraud, waste, and/or abuse complaint, approximate dollar amount(s) involved, and the legal and administrative disposition of the case. Notice of fraud and abuse must be reported to the Optum PRSN Fraud and Abuse Compliance Officer.
- 12.4.** Contractor shall cooperate in any investigation conducted by Optum PRSN. Contractor shall cooperate in any investigation or prosecution conducted by the Washington State Attorney General Medicaid Fraud Control Unit (MFCU).
- 12.5.** Contractor shall comply with Optum Pierce RSN's Policies and Procedures regarding Fraud and Abuse and related topics.

13. INSURANCE

13.1. Liability Insurance – Medical Malpractice or Professional Liability, and Comprehensive General.

- 13.1.1. Inpatient Providers.** Contractor shall procure and maintain, at Contractor's sole expense, (a) medical malpractice or professional liability insurance in the amount of \$5,000,000 per occurrence and \$5,000,000 in aggregate with a maximum deductible of \$5,000; or
- 13.1.2. All Other Facility or Agency-Based Providers.** Contractor shall procure and maintain, at Contractor's sole expense, (a) medical malpractice or professional liability insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 in aggregate with a maximum deductible of \$5,000, and
- 13.1.3. All Providers.** (b) Comprehensive general and/or umbrella liability insurance in the amount of \$1,000,000 per occurrence and \$1,000,000 in aggregate; and
- 13.1.4. All Providers.** (c) Contractor shall require that all health care professionals employed by or under contract with Contractor to render services to Consumers procure and maintain malpractice insurance unless they are covered under Contractor's insurance policies. Contractor's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by Optum PRSN. Prior to the Effective Date of this Contract and at each policy renewal thereafter, Contractor shall submit to the Optum PRSN Provider Relations Manager in writing evidence of all of the above required insurance coverage, and upon policy renewal.
- 13.1.5. Liability Insurance - Use of Motor Vehicles.** If Contractor's employees and/or volunteers use motor vehicles in conducting activities, such as Consumer services, under this Contract, liability insurance covering bodily injury and property damage shall be provided by Contractor through a commercial automobile insurance policy. The policy shall cover all owned and non-owned vehicles. Such insurance shall have minimum limits of \$500,000 per occurrence, combined single limit for bodily injury liability and property damage liability with a \$1,000,000 annual aggregate limit. If Contractor does not use motor vehicles in conducting activities under this Contract, then written confirmation to that effect on Contractor letterhead shall be submitted by the Contractor to Optum PRSN within thirty (30) calendar days of execution of this Contract, and upon policy renewal.
- 13.1.6. Insurance or Bond for Officers, Directors and/or Employees.** Contractor shall ensure that every officer, director, or employee who is authorized to act on behalf of the Contractor for the purpose of receiving or depositing funds into program accounts or issuing financial documents, checks, or other instruments of payment for program costs shall be bonded or be covered by fidelity insurance to provide protection against loss in an amount not less than \$50,000.

The insurance or bond must be secured for the term of the Contract and must name "Optum Behavioral Health Solutions" as beneficiary. The bond or certificate shall show the bonding or insurance coverage, the designated beneficiaries, covered parties, and the amounts. If the Contractor chooses to purchase fidelity insurance, the coverage must include employee theft per loss, employee theft per employee, and theft (disappearance and destruction). Documentation of insurance or bond must be provided to the Optum PRSN within thirty (30) calendar days of execution of this Contract, and upon policy renewal.

13.1.7. Workers' Compensation Insurance. Contractor shall comply with the provisions of Title 51 Revised Code of Washington (RCW), Industrial Insurance. Upon request, Contractor shall provide documentation to Optum PRSN of its having current workers' compensation insurance coverage, or being lawfully self-insured for workers' compensation under the law, by providing the appropriate documentation from the Washington State Department of Labor and Industries (L&I) within thirty (30) calendar days of execution of this Contract.

14. LAWS

14.1. Applicable Laws, Rules, and Regulations. Contractor shall provide services described in this Contract in accordance with all applicable state and federal laws and regulations, including but not limited to the Washington Administrative Code (WAC), especially WAC 388-865, or successor, and the Revised Code of Washington (RCW), especially Chapter 70.02 RCW, Chapter 70.96C RCW, Chapter 71.05 RCW, Chapter 71.24 RCW, and Chapter 71.34 RCW, or successors. Contractor and all of its Subcontractors under this Contract must comply with 42 CFR 438, or any successors as enacted or amended; Federal 1915(b) Mental Health Waiver, Medicaid State Plan or any successors; Omnibus Crime Control and Safe Streets Act of 1968; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; Title II of the Americans with Disabilities Act of 1990; Title IX of the Education Amendments of 1972; The Age Discrimination Act of 1975; 28 CFR Part 42; and 28 CFR Parts 35 and 39. Contractor shall fulfill its obligations relating to the implementation of the Health Insurance Portability and Accountability Act (HIPAA) and regulations promulgated thereunder, 45 CFR 160, 162 and 164, and the American Recovery & Reinvestment Act of 2009 (ARRA), including ARRA's Health Information Technology for Economic and Clinical Health Act ("HITECH Act") provisions. Where more stringent, Contractor shall follow 42 CFR Part 2 and applicable Washington State law. Contractor shall comply with all state and federal professional and facility licensing, certification and registration (e.g., Washington State Department of Health (DOH) and DSHS) standards that apply to services under the terms of this Contract; and Washington State Office of Insurance Commissioner's (OIC) laws, rules and regulations.

Contractor is responsible for complying with successor federal and state statutes, rules and regulations, including the USC, CFRs, RCWs and WACs cited in these Terms and Conditions, Statement(s) of Work, and other documents in this Contract.

- 14.2. Effects of New Statutes, Rules, and Regulations and Changes of Conditions.** The Parties agree to re-negotiate this Contract if either Party would be materially adversely affected by continued performance as a result of a change in laws, rules, or regulations; a requirement that one of the Parties comply with an existing law, rule, or regulation contrary to the other Party's prior reasonable understanding; or a change in Optum PRSN's arrangements with DSHS. The Party affected must promptly notify the other Party of the change or required compliance and its desire to re-negotiate this Contract. If a new Contract is not executed within thirty (30) calendar days of receipt of the re-negotiation notice, the Party adversely affected shall have the right to terminate this Contract upon forty-five (45) calendar days prior written notice to the other Party. Any such notice of termination must be given within ten (10) days following the expiration of the thirty (30) calendar day re-negotiation period.
- 14.3. Governing Law and Venue.** This Contract is and shall be construed as being executed and delivered within the State of Washington, governed and construed in accordance with applicable state and federal, statutes rules and regulations, and it is mutually understood and agreed by each Party hereto that all modifications shall be governed by the laws of the State of Washington, both as to interpretation and performance.
- 14.4. Laws, Regulations and Licenses.** Contractor shall maintain in good standing with all federal, state, and local licenses, certifications, accreditations, and permits – without sanction, revocations, suspension, censure, prohibition, or material restriction – which are required to provide health care and mental health services according to the laws of the jurisdiction in which services are provided, and shall comply with all applicable state and federal laws, rules, and regulations. Contractor shall require that all health care and mental health professionals employed by or under contract with the Contractor to render services to Consumers comply with this provision.
- 14.4.1.** Within ten (10) calendar days of Contractor's knowledge, the Contractor shall notify Optum PRSN in the event of a loss or material restriction of any program or facility or health profession license, certification, or registration of Contractor of any employee, volunteer or student at Contractor's program(s), Contractor's facility/facilities, or of a Subcontractor.
- 14.4.2.** Failure to comply with the Licensing and Certification Section shall result in a corrective action, and may lead to termination of this Contract. Optum PRSN will operate consistent with WAC 388-865-0284(4) and "*Terminate its contract with the provider if the mental health division notifies the regional support network of a provider's failure to attain or maintain licensure or certification, if applicable*".

15. LIABILITIES OF THE PARTIES

- 15.1. Damages.** Any and all damages, claims, liabilities, judgments, attorney fees, and fines which may arise as a result of Contractor's or its employee's or Subcontractor's negligence or intentional wrong-doing shall be the sole responsibility of Contractor.

15.2. Indemnify and Hold Harmless. Contractor shall indemnify and hold Optum PRSN, DSHS, and Consumers harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct of Contractor, its employees, students, volunteers, and agents, arising in connection with this Contract. This clause shall survive the termination of the Contract for any reason, including breach due to insolvency by either Party. Optum PRSN shall indemnify and hold Contractor harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct of Optum PRSN, its employees, students, volunteers, and agents, arising in connection with this Contract. This clause shall survive the termination of the Contract for any reason, including breach due to insolvency by either Party.

16. NOTICES

16.1. Notices – In General. Contractor shall notify Optum PRSN within ten (10) working days of knowledge of any of the following:

- 16.1.1.** Change in Contractor's name, address (mailing address or physical location), name(s) of representatives or designees that should receive certain Contract related notices or communications, ownership, or Federal Tax ID number;
- 16.1.2.** Changes in liability insurance carriers, termination of, renewal of or any other material changes in Contractor's liability insurance or other applicable insurances, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
- 16.1.3.** Action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification, or other material restriction on Contractor's licenses, certifications or permits by any government or applicable licensing, certifying, disciplinary, regulatory or accrediting agency, under which Contractor is accredited, certified, or regulated by or authorized to provide health care or mental health services, or the performance of its employees, Subcontractors, or any suspension, revocation, condition, limitation, qualification, or other material restriction of the health professional licensing credential (e.g., license, certification, registration) of Contractor's employees;
- 16.1.4.** Contractor's employee, student, or volunteer with unsupervised access to Consumers that is indicted, arrested, or convicted of a felony or for any criminal charge related to the practice of health care or mental health services;
- 16.1.5.** Contractor's claims or legal actions for professional negligence or bankruptcy;
- 16.1.6.** Contractor's termination, for cause, from DSHS or any other state or county agency, to provide Consumer services in Pierce County, Washington;
- 16.1.7.** DSHS or any other state, county, or federal agency termination, for cause, of any contract to provide client services in Pierce County, Washington;
- 16.1.8.** DSHS or any other state or county agency lack of renewal of any contract to provide client services in Pierce County, Washington;
- 16.1.9.** Any occurrence or condition that might materially impair the ability of Contractor to perform its duties under this Contract; or

- 16.1.10.** Any condition or circumstance that may pose a direct threat to the safety of Consumers, Contractor, Contractor's staff, DSHS employees, or other applicable state employees.
- 16.1.11.** Failure to comply with this provision may result in corrective action, and may result in immediate termination of this Contract.

16.2. Notices - Method and Delivery. Unless otherwise specified in this Contract, each and every notice and communication to the other Party shall be in writing. All written notices or communications shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth on the signature page of this Contract, or to another address of which the sending party has been notified, including without limitation, to the Optum Pierce Executive Director and Optum Pierce Senior Director of Operations at the address for notice as identified in the Optum PRSN Policies & Procedures Manual.

17. QUALITY IMPROVEMENT, PROGRAM MONITORING AND UTILIZATION REVIEW

17.1. Quality Assurance. Contractor shall maintain internal policies and procedures that emphasize Quality Assurance with measurable outcomes. Contractor shall also participate, as requested by Optum PRSN, in system development, implementation and on-going process of quality improvement, program monitoring and utilization reviews. Treatment providers shall participate in Optum PRSN Performance Improvement Project (PIP) Teams as requested, and in Optum PRSN Quality Assurance and Performance Improvement Committee (QA/PI) that meets monthly and quarterly subcommittee meetings as appropriate.

17.2. Quality Assurance / Management Plan. Contractor shall maintain and update annually its Quality Assurance/Management Plan in compliance with WAC 388-865-0280 and 0284 and submit it to Optum PRSN within thirty (30) calendar days of the signing of this Contract. This plan must meet the requirements of Optum PRSN and DSHS.

17.3. Quality Review Activities. Contractor shall cooperate with Quality Review Activities and provide access to their facilities, personnel and records. Contractor must provide unencumbered access to the Quality Review Team (QRT) and other quality review activities as needed, in compliance with WAC 388-865-0282. Contractor shall cooperate with announced or unannounced quality/administrative review activities by DSHS, Office of the State Auditor, the U.S. Department of Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) and/or the Comptroller General.

17.4. Other Audits and Reviews. Contractor shall immediately notify Optum PRSN when an entity other than Optum PRSN requests to perform any review or audit described in this contract.

17.5. Utilization Management and Quality Improvement – Access to Information and Records. In order to perform its utilization management and quality improvement activities, Optum PRSN shall have access to such information and records, including billing and reimbursement claims, within seven (7) calendar days from the date the request is made, except that in the case of an audit by Optum PRSN, such access shall be given at the time of the audit. If requested by Optum PRSN, Contractor shall provide copies of such records free of charge. During the term of this Contract, Optum PRSN shall have access to and the right to audit information and records. Said rights shall continue following the termination hereof for the longer of three (3) years or for such period as may be permitted by applicable state or federal law, regulatory authority or protocols. Contractor shall cooperate, as needed, in Quarterly Comprehensive Reviews by Optum PRSN regarding Consumers enrolled with the DSHS Developmental Disabilities Administration (DDA), formerly hospitalized at Western State Hospital or Eastern State Hospital, and currently living in the Pierce County community.

18. RECORDS

18.1. Records Maintenance. Contractor shall maintain an adequate record keeping system for recording services, charges, dates, and other commonly accepted information elements for services rendered to Consumers. Contractor's medical, mental health, treatment, fiscal, and administrative records shall be maintained consistent with the standards of the community and in accordance with Optum PRSN Policies and Procedures Manual, and all applicable state and federal laws, rules, and regulations.

18.2. Records Retention. Contractor shall retain records for any period as required by Optum PRSN's contracts with DSHS and the law. Contractor shall ensure that it has internal policies and procedures that include the requirement to retain all books, records, documents and other material relevant to this Contract for a period of not less than seven (7) years after the termination hereof in compliance with Medicaid records retention standards. Contractor may choose to retain records for a longer period as outlined in RCW 4.16.350. If any audit, claim, inspection, litigation, other legal action, or a review involving the records set forth is started before expiration of the seven (7) year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the seven (7) years, whichever is later.

19. SERVICE REQUIREMENTS

19.1. Consumer Voice. Contractor shall ensure all person-centered service plans (PCSPs), sometimes referred to as Person-Centered Treatment Plans (PCTP), Advance Directives, and crisis plans are developed in partnership with Consumers. This shall include but is not limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings). Each PCSP needs to be written in language that the Consumer understands, and documentation must be included in the clinical record describing how the Consumer sees her/his progress. The Consumer's participation may be demonstrated by the individual's signature and/or quotes documented in the plan. Contractor must notify Optum Pierce RSN of all

situations where the Consumer disagrees with the PCSP so that Optum Pierce RSN can send a Notice of Action letter.

19.2. Coverage and Provision of Services. Contractor shall follow the DSHS and Optum PRSN provisions for the coverage and provision of services to Consumers under this Contract. Contractor shall provide services described in each respective Statement of Work that is part of this Contract. This includes Contractor performing services in accordance with requirements set forth in the DSHS-Optum PRSN contracts, including any amendments and successors, and the Optum PRSN Policies and Procedures. Service requirements include, but are not limited to, the following:

19.2.1. Co-Occurring Disorder Screening and Assessment. The Contractor shall use the DSHS provided Integrated Co-Occurring Disorder Screening and Assessment Tool (Global Assessment of Individual Needs – Short Screener: GAIN-SS) for Consumers who are thirteen (13) years of age and older 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 Contract.

Contractor must attempt to screen all individuals aged thirteen (13) and above through the use of the DSHS Global Appraisal of Individual Needs – Short Screener (GAIN-SS) during:

19.2.1.1. All new intakes.

19.2.1.2. The provision of each crisis episode of care including Involuntary Treatment Act (ITA) investigations services, except when:

- The service results in a referral for an intake assessment.
- The service results in an involuntary detention under Chapter 71.05 RCW, Chapter 71.34 RCW, or Chapter 70.96B RCW.
- The contact is by telephone only.
- The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous twelve (12) months.

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

The results of the GAIN-SS screening, including refusals and any time the Consumer was unable to complete, must be reported to Optum PRSN through the MIS system.

The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by DSHS

and/or Optum PRSN and outlined in SAMHSA Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a 2 or higher on either of the first two scales (ID Screen & ED Screen) and a 2 or higher on the third (SD Screen).

The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities. The assessment is not required during crisis interventions or ITA investigations.

The quadrant placements are defined as:

- Less severe mental health disorder/less severe substance disorder.
- More severe mental health disorder/less severe substance disorder.
- Less severe mental health disorder/more severe substance disorder.
- More severe mental health disorder/more severe substance disorder.
- The quadrant placement must be reported to DSHS through the MIS system.

19.2.2. Customer Service. The Contractor shall provide customer service to Consumers that is customer-friendly, flexible, proactive, and responsive to Consumers, families, and stakeholders.

19.2.3. Early Periodic Screening Diagnosis and Treatment (EPSDT) EPSDT services must be structured in ways that are culturally and age appropriate, involve the family and be available to all Consumers under the age of twenty-one (21). Intake evaluations provided under EPSDT must include an assessment of the family's needs. EPSDT requires the Contractor to facilitate communication between physicians and mental health clinicians. This must include at least:

19.2.3.1. A written notice replying to the Physician, ARNP, Physician Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake and diagnosis and level of care assignment.

19.2.3.2. When mental health services are requested without an EPSDT referral the Contractor must send a formal written notice to the Consumer's medical care provider. The notice shall request that either documentation is provided that a Health Child screening has been provided or that one will be provided if one has not occurred. A copy of this notice shall be provided to the Consumer or Consumer's family.

- 19.2.3.3.** If the Consumer does not identify a medical care provider, Contractor must provide a copy of the EPSDT rights contained in the DSHS Mental Health Benefits booklet to the Consumer. The following number must be provided to assist them to locate a provider: Toll free number: 1-800-562-3022.
- 19.2.3.4.** Contractor shall contact the enrollee within ten (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. The 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 ten (10) working days to confirm whether these services are being requested.
- 19.2.3.5.** Children authorized who are involved with one or more service systems, and who meet the criteria below, must be provided an Individual Service Team (IST).

Criteria:

- Diagnosed with substance abuse or addiction;
- Receiving special education services; or
- A chronic disabling medical condition.

The IST may include, but is not limited to, representatives from education, child welfare, mental health, drug and alcohol, developmental disabilities, and juvenile justice systems as appropriate. The parent or guardian of the child may be included as appropriate. The child must be included if age 13 or older. Younger children may be included if the IST agrees. The IST must develop a cross-system individual service plan. The cross-system individual service plan must address the overall needs of the child and family, not just Medicaid reimbursable services, in all life areas including when appropriate residential, family, social, and medical needs. The individual service plan must clearly identify which system is responsible for each identified need.

- 19.2.4. After Hours On-Call Person.** Designate someone within the Contractor's agency as the Contractor's after hours on-call person, and provide the designated on-call person's name and phone number(s) to the Mobile Outreach Crisis Team (MOCT).
- 19.2.5. Medicaid Health Plan Enrollees.** Provide an assessment for Medicaid health plan enrollees who self-refer, or have been referred by the Medicaid health plan enrollee's managed care plan. Medicaid health plans will have screened Consumers for the probability of meeting the DSHS Access to Care Standards and will coordinate care with the Contractor.

19.2.6. Professional Scope of Practice. Contractor shall prohibit an individual employee, student, or volunteer from providing mental health or related services that are not within that individual's professional scope of practice as defined under Title 18 RCW or Title 246 WAC, or other applicable laws, rules or regulations. Further, Contractor shall only permit a student, employee, or volunteer to provide mental health or related services that are within the individual's clinical expertise.

19.2.7. Referrals. Contractor shall accept all Consumers referred to Contractor by Optum PRSN or according to the Optum PRSN Policies & Procedures Manual, or other documents established by Optum PRSN.

19.2.8. Timely Access to Appointments. Contractor must provide for timely access for Consumers' appointments in accordance with Optum PRSN Policies and Procedures, including the appointment availability requirements. These requirements include without limitation, the following availability schedule:

- A routine intake evaluation appointment must be available and offered to every Consumer within ten (10) working days of the request, and authorization requests occur within three (3) calendar days of the intake, unless both of the following conditions are met:
 - When a consumer requests readmission to a Contracted Mental Health Agency, the Contractor schedules an intake session to update changes from the previous intake evaluation completed within the last twelve (12) month period of time and documents in the progress note any changes to the intake information, lists current symptomatology, completes a diagnostic formulation that establishes medical necessity and identifies a five Axis DSM diagnosis; the Contractor agrees to use the previous intake document completed within the previous twelve (12) months, write an update in a progress note; the Contractor agrees to schedule and code the update session as an intake evaluation; Optum PRSN agrees to recognize the intake document from the previous twelve (12) months and the update progress note as the documentation for the intake evaluation, and use the previous intake evaluation, and use the previous intake evaluation and update progress note as the basis for authorization decisions.
- Emergent care must occur within two (2) hours of request by any source/referral.
- Urgent care must occur within twenty-four (24) hours from the time of request for services from any source.
- Ensure and document that Consumers receive an outpatient service within five (5) calendar days of discharge from a psychiatric inpatient

hospital, an evaluation and treatment program, or from Juvenile Justice & Rehabilitation Administration (JJRA).

- Ensure that the elapsed time from request for services to first routine service does not exceed twenty-eight (28) calendar days.
- Appointment waiting lists may not be implemented without prior written approval from Optum PRSN.

19.2.9. Contractor shall notify Optum PRSN if it cannot meet Optum PRSN's timely access to appointments standards.

19.2.10. Where a Consumer's health care needs are identified, Medicaid Consumers of all ages are referred to physical health care, diagnostic services, treatment, and other measures within the initial thirty (30) calendar day intake. These referrals and evidence of on-going coordination will be documented in the Consumers' files.

19.2.11. Standard of Care. Optum PRSN Policies and Procedures Manual, including without limitation, Optum PRSN's utilization management and quality assurance and improvement standards and procedures, shall dictate services provided by Contractor or otherwise diminish Contractor's obligation to freely communicate with and/or provide services to Consumers in accordance with the applicable standard of care.

20. STATEMENTS OF WORK

20.1. All services provided under this Contract are confirmed and described in a Statement of Work that is signed by both Parties. Contractor may have one or more Statements of Work under this Contract. Each Statement of Work has a Contract Term specified, showing contract start and end dates. Changes to a Statement of Work must be made by a written Amendment signed and dated by both Parties.

21. SUBCONTRACTS

21.1. Contractor shall be responsible for the acts and omissions of any of its Subcontractors under this Contract. Contractor may Subcontract services to be provided under this Contract subject to the following requirements:

21.1.1. All of Contractor's Subcontracts must be in writing and specify all duties, responsibilities and reports contracted for under this Contract and require adherence with all state and federal laws, rules, and regulations; the Optum Pierce RSN Policies and Procedures Manual, the Optum Pierce RSN MIS Policies and Procedures Manual, and other documents that are applicable to the Subcontract. Contractors are responsible for ensuring that Subcontractors hold

all necessary licenses, certifications, and/or permits as required by law for the performance of the services performed under this Contractor. Contractors are responsible for monitoring compliance with the Subcontracts they hold with Subcontractors. Additionally, Contractors are responsible for ensuring their Subcontracts are consistent with the contract requirements between Optum PRSN and Contractor under this Contract, the contract requirements between DSHS and Optum PRSN, and applicable state and federal laws, rules, and regulations. Contractor shall be responsible for ensuring Subcontractor performs all subcontracted services under this Contract consistent with all applicable requirements in Contractor's Contract with Optum PRSN, Optum PRSN's contracts with DSHS, and all applicable laws, rules, and regulations.

- 21.1.2. Optum PRSN must approve of Contractor's Subcontracts *prior* to their execution.
- 21.1.3. Optum PRSN must be provided with copies of all of Contractor's most current, fully executed Subcontracts no later than ninety (90) calendar days after the effective date of this Contract, and any and all fully executed amendments thereafter within fifteen (15) calendar days.
- 21.1.4. Within thirty (30) days of signing this Contract, Contractor shall submit to Optum PRSN an Annual Subcontractor Monitoring Plan. The Monitoring Plan, which may be in the Contractor's own format, must include:
 - 21.1.4.1. The name of each Subcontractor;
 - 21.1.4.2. List of specific contracted services;
 - 21.1.4.3. Detailed compensation arrangement between Contractor and Subcontractor;
 - 21.1.4.4. Monitoring Plan for period of Subcontract;
 - 21.1.4.5. Last contract year's or calendar year's evaluation by Contractor of the Subcontractor's ability to perform duties as delineated in the Subcontract;
 - 21.1.4.6. Any corrective action taken by Contractor against Subcontractor within past 18 months; and
 - 21.1.4.7. Corrective action plan by Subcontractor to address issues / any outstanding issues.

22. TERM

- 22.1. The term of this Contract expires when all of its applicable Statements of Work have ended.

23. TERMINATION

23.1. This Contract may be terminated by:

- 23.1.1. **Mutual Contract.** Optum PRSN and Contractor may mutually agree in writing to terminate this Contract.
- 23.1.2. **Termination for Convenience.** Optum PRSN may terminate this Contract in whole or in part for convenience by giving the Contractor at least ninety (90) calendar days written notice. The Contractor may terminate this Contractor for convenience by giving Optum PRSN at least ninety (90) calendar days written notice addressed to the Optum Pierce Executive Director and Optum Pierce Senior Director of Operations.
- 23.1.3. **Material Breach.** Either Party, in the event of a material breach of this Contract by the other Party, upon thirty (30) calendar days prior written notice to the other Party. The written notice shall specify the precise nature of the breach. In the event the breaching Party cures the breach to the reasonable satisfaction of the non-breaching Party, within thirty (30) calendar days after the non-breaching Party's written notice, this Contract shall not terminate.
- 23.1.4. **Concern for Health & Safety.** Optum PRSN may immediately terminate this Contract if Optum PRSN determines, in its sole discretion, that the health, safety, and/or welfare of Consumers may be jeopardized by the continuation of this Contract.
- 23.1.5. **Other.** In addition to its termination rights under this Contract, Optum PRSN shall have the right to revoke any functions or activities delegated to the Contractor or impose other sanctions if in its sole judgment Optum PRSN determines that Contractor's performance is inadequate.

23.2. Consumers and Termination.

- 23.2.1. **Continuation of Services.** At the option of Optum PRSN, Contractor shall continue to provide services authorized by Optum PRSN to Consumers who are receiving services from Contractor as of the effective date of the termination of this Contract, until Consumer can be satisfactorily transferred to another Contractor / Participating Provider in the Optum PRSN Provider Network. Optum PRSN shall continue to reimburse Contractor for such services at Contractor's rate(s) under this Contract.
- 23.2.2. **Contractor Communications with Consumer.** Contractor agrees to clearly inform Consumers of Contractor's impending non-participation status upon the earlier of Consumer's next appointment or prior to the effective termination date. Contractor agrees to cooperate in providing other information that may be required about this transition by DSHS. Contractor must ensure that Consumers receiving services from the Subcontractor receive thirty (30)

calendar days written notification of termination by either Contractor or Subcontractor.

23.2.3. Optum PRSN Communications with Consumers. Contractor acknowledges and agrees that Optum PRSN has the right to inform Consumers of Contractor's termination and/or the notice of termination to Contractor, and agrees to cooperate in good faith with Optum PRSN in matters concerning the termination/transition, and agrees to hold Optum PRSN harmless for exercising its rights hereinunder.

23.2.4. Transfer of Consumers. During periods of notice of termination, Optum PRSN reserves the right to transfer Consumers to another Contractor, and Contractor agrees to cooperate and assist with such transfers.

SAMPLE

OPTUM PIERCE RSN

STATEMENT OF WORK

ADULT AND OLDER ADULT OUTPATIENT MENTAL HEALTH SERVICES

No.	SOW	PAYMENT TYPE	REVENUE SOURCE	BARS CODE	MAXIMUM CONSIDERATION	CONTRACT TERM
	Adult and Older Adult Outpatient Services	MFS	PIHP	564.44		
		MFS	State	564.44		
			Third Party Reimbursement			

I. OVERVIEW

Outpatient services are the primary form of assistance for persons enrolled in Optum Pierce Regional Support Network (RSN). These services are brief to moderate in intensity and delivered in a location based on the individual's choice, preferably in a natural environment. As with all levels of care, these services must be person-centered and individualized to meet the unique needs of each person. Services shall be recovery-oriented and build on the strengths of the individual.

II. GOALS AND OBJECTIVES

- A. Provide services that are strength-based promoting growth and wellness/recovery with a focus on community reintegration.
- B. Assist individuals (ages 18 – 59) and older adults (age 60 and older) to return to optimal functioning.
- C. Provide age and culturally sensitive services.
- D. Improve access to health care during the course of treatment by initiating the following: 1) Enter reported health issues on AXIS 3; and 2) Refer all individuals to a primary care provider (PCP) or the Mobile Integrated Health Clinic if they have not been seen by a PCP within the last twelve (12) months. Referrals or documentation that the individual has a PCP should be retained in their clinical record.

III. SERVICE REQUIREMENTS

A. Authorization Type

The Authorization Types under this Statement of Work are:

- **BSA** – Brief Services Adult
- **MOA** – Medication Only Adults
- **OUTA** – Outpatient Adult.

These routine authorizations will be for six (6) months.

Contractor shall use the appropriate authorization type which should correspond to the exact service that the individual is receiving, such as MOA (Medication Only Adults) when that is all they are receiving.

Refer to Optum Pierce RSN MIS Policies and Procedures for modalities included in each Authorization Type. The varying amounts of services will depend on level of need as presented by the individual.

Optum Pierce RSN Care Managers will monitor authorization types for appropriate levels and types of services.

B. The Contractor will:

1. Provide person-centered, culturally and linguistically appropriate intake evaluations addressing all major life domains at a location that is convenient for the individual. For older adults, ensure the intake evaluation is conducted by a Geriatric Mental Health Specialist or a Mental Health Professional supervised by a Geriatric Mental Health Specialist.
 - a) This includes the ability to provide an intake evaluation at an individual's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to individuals discharged from a state hospital or evaluation & treatment facilities to such placements when the individual requires an on-site service due to medical needs or lack of transportation.
2. Maintain the ability to provide services to individuals in their residence, including adult family homes, assisted living facilities and skilled nursing facilities when required due to medical needs or lack of transportation.
3. Ensure that trauma-informed and strength-based services are designed creatively and flexibly to meet the unique needs of the individual and support recovery, rehabilitation and community reintegration and ensure

formal/informal, natural supports, and community strengths are incorporated into the PCTP.

4. Screen for depression by administering and scoring the Patient Health Questionnaire (PHQ-9) to adults age eighteen (18) and older.
5. Offer Certified Peer Counseling support services to individuals at intake to provide encouragement, recovery support and health goal planning.
6. When individuals choose to receive their primary care services from the Mobile Integrated Health Clinic, the provider must ensure that Case Managers and Certified Peer Counselors play a key role in assuring that the PCTPs incorporate selected general healthcare and wellness goals.
 - a) Case Managers will share treatment plans and current medication lists prior to the first visit at the Mobile Integrated Health Clinic.
 - b) Case Managers will alert individuals' PCP of any changes in medication or treatment plan updates when a change occurs.
 - c) Case Managers or Certified Peer Support Counselors will accompany individuals to all appointments at the Mobile Integrated Health Clinic Van.
7. Provide wellness planning that focuses on self-management and health education. Support the individual reaching his/her identified wellness goals, assist in identifying barriers that may interfere with the individual achieving these goals, and problem solve solutions to overcome barriers and assist the individual in implementing wellness activities.
8. Provide a skilled care coordination process that promotes rapid and successful reintegration of individuals back into the community from long term placements or any hospitalization. Coordinate with the Optum Pierce RSN Discharge Coordinators / Peer Bridgers in any discharge planning. Ensure an outpatient service occurs within five (5) days of inpatient discharge.
9. Implement outreach and engagement including: linking individuals to appropriate level of support services; and contacting individuals who fail to keep an appointment through phone calls or home visits.
10. Ensure that the development of the PCTP is a collaborative effort between the individual, clinician, and others as requested.
11. Coordinate care and services with involved and necessary others (e.g., primary care physician, Home and Community Services (HCS), drug/alcohol system, Department of Corrections (DOC), Developmental Disabilities Administration (DDA), Division of Vocational Rehabilitation (DVR), U.S. Department of Veterans Affairs, housing and employment/vocational

services and other community resources) as needed. For individuals involved in multi-system care create linkages with both formal and natural supports.

12. Serve within twenty-eight (28) calendar days any individual who has been identified through a PASRR (Pre-Admission Screening and Resident Review) as needing mental health services.
13. Make available psychiatric consultation in a timely manner when determined to be medically necessary. Provide medically necessary medication evaluation, management and monitoring services. Assist individuals in obtaining medication management services from their PCP when appropriate.
14. Work with Optum Pierce RSN Care Managers to coordinate care with participating Medicaid health plans.

IV. REPORTING REQUIREMENTS/ DELIVERABLES

- A. The Contractor shall comply with Optum Pierce RSN Management Information System (MIS) Policies and Procedures Manual for reporting data.
- B. Provide Optum Pierce RSN and Optum Pierce RSN's Crisis Service Contractor with an after hour on-call contact name, phone number, email, and access to all crisis plans and existing cross-system crisis plans.
- C. The Contractor shall provide contract deliverables for this Statement of Work according to the **DELIVERABLES TABLE** in a complete, accurate and timely manner.

V. PAYMENT

- A. State Only funds shall be utilized for the following: Request for Service, GAIN-SS Screening Matrix and Rehabilitation Case Management Services.

Payment for this Statement of Work shall be on a Modified Fee for Service (MFS) basis with a maximum budget authority not to exceed \$_____. It will consist of Medicaid, State Only and Third Party Reimbursement dollars budgeted not to exceed the schedule below. Payments may be from the different amounts stated below based on performance as outlined in the terms and conditions section of the contract.

Attachment B

Prospective Providers		Adult Outpatient	Criminal Justice (Assessment Only)	Detox	Involuntary Commitment	OST	Pregnant Parenting Women (PPW) - Outpatient	TANF	Youth Outpatient
1	Asian Counseling Treatment Services (ACTS) Tacoma	X	X						
2	Consejo Counseling Referral Services - Tacoma	X							X
3	Foundation for Multicultural Resources								X
4	Gig Harbor Counseling - Gig Harbor (Olalla Recovery Services)	X	X						X
5	MultiCare Health System Behavioral Health - Puyallup	X	X						X
6	MultiCare Health System Behavioral Health - Tacoma	X	X		X				
7	Northwest Center for Integrated Health	X							
8	Pierce County Alliance - Tacoma	X	X						
9	Pioneer Counseling Services - Tacoma	X	X						
10	Pioneer Co-Occuring Residential Treatment		X						
11	Prosperity Wellness Center	X		X					
12	Sea Mar Community Centers Behavioral Health - Tacoma Ave So.	X	X				X	X	X
13	Sea Mar Community Centers Behavioral Health - Puyallup	X	X				X	X	X
14	Tacoma - Pierce County Methodone Maintenance Program Unit 1	X				X			
15	Tacoma - Pierce County Methodone Maintenance Program Unit 2	X				X			
16	MDC - Tacoma Detox Center			X					
17	MDC - The Center - Tacoma	X	X						X
18	MDC - The Center - East Sumner	X	X						X
19	MDC - The Center - Lakewood	X	X						X
	Note: "X" identifies SUD services a provider is licensed / certified by DSHS DBHR to provide; Pierce County Community Connections does not necessarily purchase the service								

Attachment IVe

Currently Contracted Optum Pierce RSN Mental Health Providers

Providers		Payment Method (FFS or CAP) FFS = Fee for Service, CAP = Capacity	PIHP Funds Paid to Contractor	SMHC Paid to Contractor	Brief Intervention Treatment	Crisis Services	Family Treatment	Freestanding E&T Services	Group Treatment Services	High Intensity Treatment	Individual Treatment Services	Intake Evaluation	Medication Management	Medication Monitoring	MH Serv. in Residential Setting	Peer Support	Psychological Assessment	Rehab Case Management	Respite Services	Special Population Evaluation	Stabilization Services	Supported Employment	Therapeutic Psychoeducation	Court ITA Hearings (72 Hour, 14 Day, 90 Day)	Court ITA Hearings (State Cases - 180 Day)	Jail Transition Services	Mental Health Ombuds	Service Support of Recovery & Resiliency
1	Catholic Community Services of Western WA	CAP	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
2	Comprehensive Life Resources	FFS & CAP	X	X	X		X		X		X	X	X	X	X	X	X	X		X		X						
3	Greater Lakes Mental Healthcare	FFS & CAP	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X		X	X	X				X		
4	MDC	CAP	X	X				X					X	X														
5	Multicare Health Systems Behavioral Health	FFS & CAP	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X		X	X	X						
6	Pierce County	FFS & CAP		X																			X	X				
7	Pierce County Sheriff Dept.	CAP		X																					X			
8	ProCall Services	FFS	X	X		X																						
9	Recovery Innovations	CAP	X	X		X		X				X	X	X							X							
10	Sea Mar Com. Health Centers	CAP	X		X		X		X		X	X	X	X							X		X					
11	TACID	CAP	X	X																						X		
12	Telecare	CAP	X	X									X	X													X	
13	A Common Voice	CAP												X														X

OPTUM PIERCE REGIONAL SUPPORT NETWORK

ADMINISTRATIVE POLICY

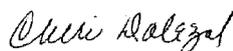
Provider Credentialing and Re-Credentialing

Policy #: AD-03

Section: Administrative

Approved by Cheri Dolezal, CEO, Optum Specialty Networks, Washington

Effective Date: July 2009



Last Review Date: September 2014

Approved by:

Revision Date: January 2014



APPLICABILITY:

This policy meets the applicable requirements of the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP) as well as regulatory requirements as outlined in: WAC 388-865-0229(2)(c), 388-865-0235(5), 388-865-0265(2), 388-865-0265(3), 388.865.0284, 388.877, 388-76, 388-79, 388-78A, 246-325, 388-865-0150, 388-865-0260, 388-865-0405; RCW 48.43, 18.57, 18.71, 18.83, 18.79, 43.43.830, 70.02, 71.05, 71.24, 71.34; 42 CFR 438, 42 CFR § 438.214, 42 U.S.C. 1320a-7 (§§1128 or 1128A Social Security Act), Title XIX Contract and Federal Waiver, Federal 1915 (b) Mental Health Waiver, Medicaid State plan, other provisions of Title XIX of the Social Security Act or any successors.

PURPOSE:

To outline the credentialing and re-credentialing requirements for the Optum Pierce Regional Support Network (RSN) network of providers. This policy will also outline requirements of network providers in terms of credentialing their mental health care provider staff.

POLICY:

Optum Pierce RSN monitors provider credentials initially upon joining the network and annually during the clinical and administrative on-site reviews. Providers also submit an updated Practitioner Report that lists the credentials, license and practice specialties of its clinical staff.

PROCEDURAL GUIDELINES FOR POLICY IMPLEMENTATION:

1. In accordance with WAC 388-865-0284, only Community Mental Health Agencies (CMHAs) that are licensed and/or certified by the State of Washington may join the Optum Pierce RSN network.
 - 1.1. All mental health care providing agencies who deliver evaluation and treatment services are to be certified by the Department of Social and Health Services (DSHS) and licensed by the Department of Health.
 - 1.2. The Certification and license provided by DSHS is monitored on an annual basis through Optum Pierce RSN's Clinical and Administrative On-site Review process.
 - 1.3. Optum Pierce RSN retains copies of certification and licenses of contractor and subcontractor providers, per WAC 388-865-0284(1) in credentialing and re-credentialing files.

- 1.4. Per WAC 388-865-0284(2), Optum Pierce RSN follows all applicable requirements of the Prepaid Inpatient Health Plan (PIHP) and State Mental Health (SMH) agreements with DSHS.
2. Clubhouse providers may exist outside of a CMHA and be directly contracted with Optum Pierce RSN but must meet all of the credentialing requirements listed by the State of Washington.
3. In accordance with WAC 388-865-0235(5), supervised residential services are provided only in licensed facilities such as:
 - 3.1. An adult family home that is licensed under *chapter 388-76 WAC*.
 - 3.2. A boarding home facility that is licensed under *chapter 388-78A WAC*.
 - 3.3. An adult residential rehabilitative center facility that is licensed under *chapter 246-325 WAC*.
4. Criminal history background checks are required for any employee or volunteer at Optum Pierce RSN who will have unsupervised access to children, people with developmental disabilities or vulnerable adults. These background checks are to be performed through the Washington State Patrol.
5. For provider agencies seeking Optum Pierce RSN network membership, the following agency credentialing information must be submitted to Optum Pierce RSN along with the *Provider Network Application* (see Appendix A). Optum Pierce RSN reviews, at a minimum:
 - 5.1. A certificate or license from the DSHS and/or the Department of Health;
 - 5.2. A standard application to become a network provider (see Appendix A);
 - 5.3. Letters of Certificates of Approval from national accreditation organizations (see list in the network provider application Appendix A);
 - 5.4. A brief history of the organization describing the number of years in business, type of work provided, and types of consumers served;
 - 5.5. Proof of worker's compensation insurance;
 - 5.6. Proof of general and professional liability insurance:
 - 5.6.1. For Inpatient Providers:
 - 5.6.2. \$5 million per occurrence / \$5 million aggregate general;
 - 5.6.3. All other facility or agency-based providers:
 - 5.6.4. \$1 million per occurrence / \$1 million aggregate general.
 - 5.6.5. \$1 million per occurrence / \$3 million aggregate professional.
 - 5.7. The history of professional liability claims which resulted in settlements or judgments paid by or on behalf of the agency or its practitioners;
 - 5.8. A statement of malpractice history and/or information regarding actions taken by organizations that limited, suspended, or abolished privileges for the last five (5) years and completed *Malpractice Questionnaire* (see Appendix A);
 - 5.9. A copy of current business license;
 - 5.10. A copy of current fire inspection;
 - 5.11. Medicaid and/or Medicare provider numbers as appropriate;
 - 5.12. A listing of the clinical staff that will be providing mental health services:
 - 5.12.1. Name and degree;

- 5.12.2. Training and/or experience;
- 5.12.3. Title of certification(s) and/or license(s) and number(s); and
- 5.12.4. Specialist designation and spoken language capabilities (e.g. special population clinician: child, older adult, developmental disability, and/or ethnic specialist; languages spoken other than English);
- 5.13. For all psychiatric, medical and clinical staff that have direct service responsibilities within an agency, Optum Pierce RSN is to review at a minimum:
 - 5.13.1. Confirm licensing, degree, training and experience via primary source verification;
 - 5.13.2. History of loss of license;
 - 5.13.3. History of felony convictions;
 - 5.13.4. History of loss or limitation of privileges or disciplinary activity;
 - 5.13.5. Level of clinical supervision and frequency;
 - 5.13.6. Training and experience to provide the services which supports the staff person's position;
 - 5.13.7. History of previous sanction activity by Medicare and Medicaid; and
 - 5.13.8. History of convictions for a drug or alcohol related offense.
- 5.14. Organizational Chart;
- 5.15. After hours crisis contact procedures;
- 5.16. Quality Management Plan;
- 5.17. Agency complaint and grievance procedure;
- 5.18. Critical Incident/Extraordinary Occurrence Notification form;
- 5.19. Management Information System quality control and disaster plan;
- 5.20. Compliance with confidentiality requirements, including HIPAA regulations;
- 5.21. Americans with Disabilities Act (ADA) facilities plan and compliance review;
- 5.22. Sliding fee scale and related policies; and
- 5.23. W9 Form (if multiple tax ID numbers used, one (1) W9 Form is to be submitted for each ID number.
- 6. The Optum Pierce RSN provider network re-credentialing process occurs annually during one (1) of the biennial clinical and administrative on-site reviews and at a minimum includes the following:
 - 6.1. The network provider agencies is to submit any and all changes to the initial application and supportive documentation listed under section E above;
 - 6.2. Optum Pierce RSN reviews provider information from appropriate accreditation, certifying and/or licensing organizations;
 - 6.3. Optum Pierce RSN review the results of federal, state or other relevant site review reports;
 - 6.4. Optum Pierce RSN reviews annual contract deliverables as defined in the Optum Pierce RSN network provider agreements;
 - 6.5. Optum Pierce RSN reviews compliance with confidentiality requirements, including HIPAA regulations;

- 6.6. Optum Pierce RSN reviews at a minimum data from:
 - 6.6.1. Quality assurance and improvement activities including:
 - 6.6.1.1. Results from current and previous onsite clinical and administrative reviews;
 - 6.6.1.2. Optum Pierce RSN-administered annual consumer and/or allied service system surveys;
 - 6.6.1.3. Consumer complaints and grievances;
 - 6.6.1.4. Critical incident and adverse action reports;
 - 6.6.1.5. Performance improvement initiatives;
 - 6.6.1.6. Other quality assurance and improvement efforts, as delineated in Optum Pierce RSN network provider agreements and related policies and procedures.
 - 6.6.2. Medical chart review;
 - 6.6.3. Fiscal review;
 - 6.6.4. Supervision records to ensure that evaluations of the job performance of individual mental health professionals are conducted in accordance with WAC 388-865-0265(2).
- 6.7. The Optum Pierce RSN Provider Relations (PR) and Quality Assurance/ Performance Improvement (QA/PI) Units make recommendations for continued network provider membership to the Optum Pierce RSN Governing Board;
- 6.8. The Optum Pierce RSN Governing Board reviews and approves or rejects the PR and QA/PI Units recommendations for continuation of the provider agency's membership in the Optum Pierce RSN provider network;
- 6.9. Optum Pierce RSN reports evidence of practices which are illegal or unethical to authorities and/or appropriate accreditation, certifying, and/or licensing organizations;
- 6.10. Optum Pierce RSN does not discriminate against providers acting within the scope of their license or certification;
- 6.11. Optum Pierce RSN does not employ or contract with any providers excluded from federal health care programs;
- 6.12. In the event that the Optum Pierce RSN Governing Board recommends denial or termination of a provider network membership, the provider may submit an appeal in writing to the Optum Pierce RSN Governing Board;
- 6.13. Optum Pierce RSN staff retains the right to make periodic site visits during the contract period. At least two monitoring visits are completed annually;
- 6.14. In accordance with WAC 388-865-0284(3), if Optum Pierce RSN staff discover during a site visit that a provider is out of compliance with statutes, rules and regulations, this is addressed immediately with the provider and a report is made to any applicable authorities including, but not limited to, the MHD.
7. Concerns about a network provider's performance are addressed in accordance with the Optum Pierce RSN policy QA-08, titled *Site Visits: Clinical and Administrative Review Including Annual Review of CMHAs*.
8. Providers are to follow the Optum Pierce RSN policy AD-16, titled *Provider Complaint and Grievance Process* for resolution of disputes after the Optum Pierce RSN final written report has been issued.

9. If Optum Pierce RSN is notified by the DSHS that a mental health care providing agency has failed to attain or maintain licensure or certification, that provider agency's contract will be terminated, per *WAC 388-865-0284(4)*.
10. Contracted mental health care providers perform credentialing/re-credentialing, appointment and privileging activities in accordance with their policies and procedures that substantially comply with the procedures of this policy:
 - 10.1. An applicant's current registration, licensure, and/or certification are verified from the primary source where claimed and relevant to the functions of the job to be performed;
 - 10.2. Successful completion of a course of study is verified from the primary source, where claimed and relevant to the functions of the job to be performed;
 - 10.3. Experience is verified from the primary source, where claimed and relevant to the functions of the job to be performed;
 - 10.4. Information about involvement in professional liability actions is verified as in good standing is confirmed where relevant to the functions of the job to be performed;
 - 10.5. When information from a primary source is not available, a reliable secondary source is used. The attempt to contact the primary source is documented;
 - 10.6. Contracted mental health care providers are to report to the Optum Pierce RSN QA/PI Manager or designee any individual reports of change in licensure or certification status, and/or any adverse actions;
 - 10.7. Exceptions are to be granted to the requirement of substantial compliance upon a showing that the contracted mental health care provider's policies and procedure meets generally accepted industry standards.
11. Exceptions to mental health professional requirements:
 - 11.1. In accordance with *WAC 388-865-0265(1)*, Optum Pierce RSN may request an exception to the requirements of a mental health professional for a person with less than a master's degree level of training, if necessary to meet the needs on the Pierce service area. DSHS may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an exception under the following conditions:
 - 11.2. Optum Pierce RSN has made a written request for an exception including:
 - 11.2.1. Demonstration of the need for an exception;
 - 11.2.2. The name of the person for whom an exception is being requested; and
 - 11.2.3. The functions which the person will be performing;
 - 11.2.4. A statement from the regional support network that the person is qualified to perform the required functions based on verification of required education and training, including:
 - 11.2.4.1. Bachelor of Arts or Sciences degree from an accredited college or university;
 - 11.2.4.2. Course work or training in making diagnoses, assessments, and developing treatment plans; and
 - 11.2.4.3. Documentation of at least five (5) years of direct treatment of persons with mental illness under the supervision of a mental health professional.

- 11.3. When an exception is granted, per *WAC 388-865-0265(3)*, a plan of action is to be put in place to assure the individual will become qualified no later than two (2) years from the date of exception.
- 11.4. Optum Pierce RSN may apply for renewal of the exception. However, the exception may not be transferred to a different RSN or applied to any individual other than the person named in the exception request.

RELATED POLICIES:

- Pierce Regional Support Network policy: AD-10 - *Designated Mental Health Professional (DMHP)*
- Pierce Regional Support Network policy: QA-08 - *Site Visits: Clinical and Administrative Review*
- Pierce Regional Support Network policy: AD-16 - *Provider Complaint and Grievance Process*

APPROVAL HISTORY:

- Policy and Procedure Committee review and approval: 10/26/2009
- Policy and Procedure Committee review and approval: 08/23/2010
- Policy and Procedure Committee review and approval: 09/26/2011
- Policy and Procedure Committee review and approval: 08/27/2012
- Policy and Procedure Committee review and approval: 12/02/2013
- Policy and Procedure Committee review and approval: 09/22/2014

OPTUM PIERCE REGIONAL SUPPORT NETWORK

ADMINISTRATIVE POLICY

Network Adequacy

Policy #: AD-11

Section: Administrative

Approved by Cheri Dolezal, CEO, Optum Specialty Networks, Washington

Effective Date: July 2009



Last Review Date: September 2014

Approved by:

Revision Date: January 2014



APPLICABILITY:

This policy meets the applicable requirements of the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP) contract as well as regulatory requirements as outlined in: WAC 388-865; 865-0150, WAC 388.865.0220, WAC 388-865-0220(10), WAC 388-865-0260, WAC 388-865-0260(1), WAC 388-865-0260(3), 42 CFR 438.206(a-b)(1), 42 CFR 438.207, 42 CFR 438, or any successors, and Federal 1915 (b) Mental Health Waiver, Medicaid State plan or any successors, other provisions of Title XIX of the Social Security Act, or any successors, RCW 70.02, 71.05, 71.24, and 71.34, or any successors.

PURPOSE:

To describe Optum Pierce Regional Support Network (RSN) efforts to establish and maintain a network of providers to meet the needs of consumers and families.

POLICY:

Optum Pierce RSN has developed and maintains a network of contracted mental health care providers that is sufficient in number, mix, and geographical distribution with a wide range of specialties and levels of care to meet the needs of individuals and families enrolled in mental health care and the anticipated number of enrollees in its service area.

PROCEDURAL GUIDELINES FOR POLICY IMPLEMENTATION:

1. Optum Pierce RSN's Provider Relations Unit has primary responsibility for developing, managing, and monitoring the adequacy of the provider network, and works continuously to maintain a network of mental health care providers capable of providing care in compliance with all state and federal regulations and the Washington State Prepaid Inpatient Health Plan (PIHP) and state contracts.
2. Provider Relations staff of the Optum Pierce RSN monitor the status of the network, projecting future needs and identifying any network deficiencies or gaps.
3. Optum Pierce RSN maintains a network of mental health care providers supported by written agreements which provide adequate access to all services covered under the contract.
4. Optum Pierce RSN Provider Relations personnel monitor the status of the network, projecting future needs and identifying any network deficiencies or gaps and providing requested reports to the DSHS-Health Resources and Services Administration (HRSA) office in a timely fashion.

5. Optum Pierce RSN engages in a variety of monitoring activities to identify any concerning trends in network access, in accordance with *WAC 388-865-0220(10)*. Tools for identifying trends include:
 - 5.1. Analysis of current and projected enrollee and consumer needs;
 - 5.1.1. Medicaid and state-funded enrollment (current and projected) and penetration rate:
 - 5.1.1.1. Analysis by age group (0-17, 18-20, 21-59, 60+);
 - 5.1.1.2. Analysis by gender;
 - 5.1.1.3. Analysis by race/ethnicity;
 - 5.1.1.4. Analysis by primary language.
 - 5.1.2. Medicaid and state-funded utilization of services (current and projected):
 - 5.1.2.1. Analysis by age group (0-17, 18-20, 21-59, 60+);
 - 5.1.2.2. Analysis by gender;
 - 5.1.2.3. Analysis by race/ethnicity;
 - 5.1.2.4. Analysis by primary language.
 - 5.2. Review of mental health care provider input through monthly meetings as well as month end meetings individually with providers;
 - 5.3. Review of individual and family input through the Quality Review Team, Ombuds, and QA/PI Committees;
 - 5.4. Review of grievance trends and analysis;
 - 5.5. Review of annual consumer satisfaction survey trends and analysis;
 - 5.6. Review of critical incidents involving access to services concerns;
 - 5.7. Analysis of current and projected network capacity;
 - 5.7.1. Numbers and types of mental health care providers available to deliver contracted Medicaid services (including individual clinician licenses, specialists and cultural/linguistic capacity);
 - 5.8. Geographic location of providers and Medicaid consumers;
 - 5.8.1. GeoAccess reports verify the adequacy of the network and map the membership to the contracted providers.
 - 5.8.1.1. GeoAccess reports annually by age group (0-17, 18-20, 21-59, 60+) and race/ethnicity;
 - 5.8.1.2. Travel time analysis from Community Mental Health Agencies;
 - 5.8.1.3. Review of other data sources (medical record reviews, grievances) regarding pertinent issues (such as means of transportation, physical access for consumers with disabilities);
 - 5.8.2. Through analysis of these reports, Provider Relations staff target zip codes that might be identified as at risk for failure to meet standards.
 - 5.9. Access data analysis and review:
 - 5.9.1. Timeliness for routine service requests ;
 - 5.9.2. Timeliness for urgent service requests;
 - 5.9.3. Timeliness for emergent service requests;

- 5.9.4. Other access indicators, from medical record reviews, grievances and other data sources.
- 5.10. Optum Pierce RSN also conducts analyses of Medicaid enrollee access to specialty services by monitoring out-of-network utilization in addition to the regular GeoAccess reports. These analyses help Optum Pierce RSN understand any patterns of access to care that may need attention by Provider Relations staff.
- 6. In accordance with *WAC 388-835-0220(10)*, Optum Pierce RSN addresses service gaps through focused network recruitment and development efforts in geographic areas that do not have optimal access to mental health care providers.
- 7. In accordance with *WAC 388-865-0260(1)*, Optum Pierce RSN documents efforts to acquire the services of the required mental health professionals and specialists. These efforts are documented in the Optum Pierce RSN *Network Development and Management Plan*.
 - 7.1. The Network Development and Management Plan is designed to:
 - 7.1.1. Provide access to and support a "mental health home" for all Medicaid enrollees/consumers;
 - 7.1.2. Provide all Washington State Plan-covered services to Medicaid enrollees/consumers;
 - 7.1.3. Provide an intake evaluation by a Mental Health Professional within ten (10) working days of an enrollee's request;
 - 7.1.4. Ensure covered services are provided promptly and are reasonably accessible in terms of location and hours of operation;
 - 7.1.5. Provide crisis services on a twenty-four (24) hour a day, seven (7) day a week basis;
 - 7.1.6. Ensure that Medicaid enrollees/consumers have access equal to, or better than, community norms;
 - 7.1.7. Ensure that services are accessible to enrollees/consumers in terms of timeliness, amount, duration and scope;
 - 7.1.8. Provide Washington State Plan-covered services within designated time and distance limits according to DSHS standards;
 - 7.1.9. Meet the unique cultural and linguistic needs of all enrollees/consumers;
 - 7.1.10. Maintain the ability to adjust the number, mix and geographic distribution of mental health care providers to meet access and distance standards as the population of enrollees/consumers shifts within the service area;
 - 7.1.11. Maintain the ability to shift reimbursement amounts for different specialties to meet access and distance standards;
 - 7.1.12. Adhere to the principles of Recovery & Resiliency.
- 8. In accordance with *WAC 388-865-0260(3)*, if more than five hundred (500) persons in the total population in an RSN geographic area report in the U.S. census that they belong to racial/ethnic groups as defined in *WAC 388-865-0150*, the RSN is to contract or otherwise establish a working relationship with the required specialists to:
 - 8.1. Provide all or part of the care and services for these populations; or
 - 8.2. Supervise or provide consultation to staff members providing care and services to these populations.

9. Optum Pierce RSN systematically evaluates the overall adequacy of its provider network and the success of its interventions to fill current and future gaps and presents these findings annually in the updated *Network Development and Management Plan*.
 - 9.1. Measures of success include:
 - 9.1.1. GeoAccess Mapping reports;
 - 9.1.2. Quantitative analysis of current and anticipated service needs:
 - 9.1.2.1. Monthly reports of Medicaid enrollees/consumers, Medicaid enrollees/consumers served, Washington State-funded enrollees/consumers served, and service provided are made available to the QA/PI Committee and Provider Services staff.
 - 9.1.2.2. Breakdowns by age, gender, and race/ethnicity are incorporated into all of these reports.
 - 9.1.2.3. The reports are reviewed in month end review meetings with agency executive directors, clinical directors, and financial and information system managers.
 - 9.1.3. Medical Record Reviews:
 - 9.1.3.1. Data from network contracted mental health care provider medical records conducted during the administrative and clinical reviews for each provider specifically address cultural competency, including the appropriateness of services provided and their responsiveness to age, gender, and cultural needs.
 - 9.1.3.2. These reviews include a twenty-five percent (25%) representative sample of enrollees/consumers who are members of special populations as defined by the Department of Social and Health Services/Division of Behavioral Health and Recovery.
 - 9.2. Cultural Competency Subcommittee
 - 9.2.1. In addition to quantitative and medical record reviews, issues related to cultural competency are proactively addressed at the quarterly *Cultural Competency Subcommittee* meeting.
 - 9.2.2. These meetings proactively identify and address system stakeholders' perceptions of culturally competent services required of all providers, including availability of minority specialists and interpreters, network adequacy, and provider adherence to Optum Pierce RSN's *Clinical Practice Standards for Cultural Competency*.
 - 9.3. Age group specific service provider reviews:
 - 9.3.1. Monthly meetings are held with the leadership from major providers serving each primary age group of Medicaid and Washington State-Funded consumers.
 - 9.3.2. These meetings proactively identify and address mental health care provider perceptions of network adequacy for the age groups of consumers they serve.
 - 9.3.3. Agency-specific data on persons served, with breakdowns by age, gender and race/ethnicity; compliance with access standards; and overall network adequacy are addressed.
10. Further detail regarding current network development and maintenance activities can be found in the Optum Pierce RSN *Network Development and Management Plan*.

RELATED POLICIES:

- Pierce Regional Support Network policy: AD-03 - *Provider Credentialing and Re-Credentialing*
- Pierce Regional Support Network policy: AD-13 - *Provider Training*
- Pierce Regional Support Network policy: QA-01 - *QA/PI Program Description and Work Plan*
- Pierce Regional Support Network policy: QA-06 - *QA/PI Committee Structure*
- Pierce Regional Support Network policy: QA-08 - *Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies*

APPROVAL HISTORY:

- Policy and Procedure Committee review and approval: 10/26/2009
- Policy and Procedure Committee review and approval: 08/23/2010
- Policy and Procedure Committee review and approval: 09/26/2011
- Policy and Procedure Committee review and approval: 08/27/2012
- Policy and Procedure Committee review and approval: 12/02/2013
- Policy and Procedure Committee review and approval: 09/22/2014

OPTUM PIERCE REGIONAL SUPPORT NETWORK

ADMINISTRATIVE POLICY

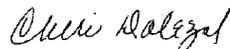
Compliance – Fraud and Abuse

Policy #: AD-01

Section: Administrative

Approved by Cheri Dolezal, CEO, Optum Specialty Networks, Washington

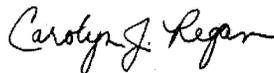
Effective Date: July 2009



Last Review Date: September 2014

Approved by:

Revision Date: January 2014



APPLICABILITY:

This policy meets the applicable requirements of the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP) contract as well as regulatory requirements as outlined in: WAC 388-856-0280 (2) (e) and 42 CFR 438 Subpart H: Certifications and Program Integrity, 42 CFR 438.608(a), 42 CFR 455, 42 CFR 1000 through 1008, and Social Security Act 1128 and any successors.

PURPOSE:

To describe Optum Pierce Regional Support Network's (RSN) compliance requirements for program integrity and fraud, waste, abuse, and neglect prevention, detection, and enforcement efforts.

POLICY:

Optum Pierce RSN has in place a compliance plan which details elements for both program integrity and fraud/waste/abuse/neglect prevention, detection, investigation, reporting and resolution.

PROCEDURAL GUIDELINES FOR POLICY IMPLEMENTATION:

1. Fraud, waste, abuse and neglect and program integrity requirements in the PIHP and other Washington State contracts are addressed by Optum Pierce RSN with the following:
 - 1.1. Mandatory trainings for all Pierce RSN staff including education on the False Claims Act, whistle blower protections, identification and reporting of fraud/waste/abuse, code of ethics, conflicts of interest, ethics and integrity.
 - 1.1.1. Optum's required six (6)-hour web-based training program that emphasizes: awareness, detection, and procedural issues (i.e., case identification and referral); early detection and prevention of payment for ineligible expenses; provider, claimant and eligibility fraud; impact of fraud and abuse; health fraud trends, schemes and those committing fraud and abuse; questionable cases to be sent to Compliance Officers for investigation; staff rights as whistle blowers; roles of compliance officers; and case studies.

- 1.1.2. Training exams are completed with scores of 80% or higher in order for staff to obtain credit for the training.
- 1.2. All contractors provide training to their staff on the False Claims Act, and on employee rights for whistle blower protections per Optum Pierce RSN's *Provider Training* policy (AD-13).
- 1.3. Optum Pierce RSN provides training support to all contractors through the Relias website. Optum encourages contractors to have staff complete at a minimum the one-hour training entitled "Deficit Reduction Act Compliance" or provide an equivalent course as required in Section 1.2.
2. Optum Pierce RSN's Compliance Plan includes The UnitedHealth Group's Integrity and Compliance Program which incorporates the seven basic elements required of a compliance program under the U.S. Sentencing Guidelines. The seven elements include:
 - 2.1. Oversight of the Integrity and Compliance Program
 - 2.2. Development and implementation of ethical standards and business conduct policies
 - 2.3. Creating awareness of the standards and policies by education of employees
 - 2.4. Assessing compliance by monitoring and auditing
 - 2.5. Responding to allegations or information regarding violations
 - 2.6. Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty
 - 2.7. Reporting mechanisms for employees, managers and others to alert management and/or the Integrity and Compliance Program staff to violations of law, regulations, policies and procedures or contractual obligations.
3. Optum Pierce RSN Executive Director or designee notifies the Washington State Medicaid Fraud Control Unit (MFCU) as soon as suspected fraud, waste, abuse or neglect is discovered. The Executive Director or designee additionally notifies the DSHS Incident Manager and the Optum Corporate Compliance staff within one working day of any compliance incident that was referred to the MFCU by the RSN or its Subcontractor.
4. The Compliance Officer for Optum Pierce RSN is the Quality Assurance/Performance Improvement Manager or other designee.
5. The Optum Pierce RSN Compliance Committee is accountable to the Executive Director and is convened on a quarterly basis or when needed to determine the appropriate course of action on program integrity and fraud, waste or abuse-related issues.
6. The Optum Pierce RSN QA/PI Manager, who serves as the designated Compliance Officer, is available at any time an employee or CMHA provider has a question about compliance or needs to submit a report of a possible compliance breach or potential fraud/abuse/waste.
 - 6.1. To encourage and facilitate reporting by employees, Optum maintains a 24-hour toll-free telephone hotline called the "Compliance HelpLine" through which incidents of suspected non-compliance or other misconduct can be reported. This hotline feeds into a voicemail box so that callers can call anonymously or can leave a call back number to discuss the reported issue further. The Compliance HelpLine number will be provided to each employee via Web portal displays and posters at all Optum locations.
 - 6.2. The Compliance Officer facilitates communication between Washington State, Optum Pierce RSN employees, and contracted providers.
7. Optum Pierce RSN compliance trainings for internal staff and network providers detail possible disciplinary actions taken when compliance/integrity standards are not met and/or when fraud, abuse or waste is detected. Such information is also included on the Optum

Pierce RSN Web site and in provider and consumer communications such as newsletters. Disciplinary action may include but is not limited to:

- 7.1. Corrective actions such as more intensive supervision or additional training
 - 7.2. Reporting to professional society disciplinary boards
 - 7.3. Criminal prosecution
 - 7.4. Termination of employment
 - 7.5. Termination of network participants
8. Optum Pierce RSN completes reviews of contractors to monitor for fraud, waste or abuse, compliance and integrity standards.
- 8.1. Encounter data audits are performed at least once per year to match paid service dates and times to provider records.
 - 8.2. The management information system is used to verify a number of points at which fraud or abuse could occur, including:
 - 8.2.1. Eligibility
 - 8.2.2. Whether the procedure has been authorized and is a covered service
 - 8.2.3. Coordination of benefits
 - 8.2.4. Whether a duplicate encounter exists in the system
 - 8.3. Optum Pierce RSN Care Managers review Level of Care Guidelines and Access to Care standards as well as applying Clinical Practice Guidelines and evidence-based practice guidelines when requests for authorization are submitted by a provider. Care Managers are trained to screen for potential cases of fraud and abuse during these reviews and to report such cases to the Compliance Officer or the United Health Group Compliance office for further investigation.
 - 8.4. To encourage and facilitate reporting by employees, Optum maintains a 24-hour toll-free telephone hotline called the "Compliance HelpLine," through which incidents of suspected non-compliance or other misconduct can be reported. This hotline feeds into a voicemail box so that callers can call anonymously or can leave a call back number to discuss the reported issue further. The Compliance Helpline number is provided to each employee via United Health Group's internal web portals and by posters at all Optum locations.
 - 8.5. Annual contractor reviews include an examination of the contractor's ongoing process (monthly checks, at a minimum) for ensuring that staff are not listed by a federal agency as debarred, excluded, or otherwise ineligible for federal program participation, as required by federal or state laws, or found to have a conviction or sanction related to health care as listed in the *Social Security Act, Title 11 Section 1128*.
9. If fraud or abuse, suspicious or unethical conduct is suspected in contractors who are reimbursed to serve individuals in the Pierce RSN, the Executive Director or designee will report the potential fraud and abuse information to the Medicaid Fraud Control Unit whenever it is suspected.
- 9.1. When notifying the Medicaid Fraud Control, Optum Pierce RSN includes:
 - 9.1.1. Source of the complaint or the data reviewed that raised the concern
 - 9.1.2. Name of the provider(s) who are suspected of involvement
 - 9.1.3. Approximate number of dollars in question
 - 9.1.4. Legal and administrative disposition of the case

- 9.2. Optum Pierce RSN notifies the DSHS Incident Manager and the Optum Corporate Compliance office within one working day of any incident that was referred to the Medicaid Fraud Control Unit by the RSN or its Subcontractor.
 - 9.3. If DSHS determines it is in the State's best interest for the Washington Attorney General to pursue the potential fraud and abuse, Optum Pierce RSN will cooperate fully with any with any investigation conducted by the State or federal authorities, including the Medicaid Fraud Control Unit (MFCU), the DEA, the FBI and other investigatory agencies.
 - 9.4. If, after discussion with DSHS and Optum Corporate Compliance staff, Optum Pierce RSN is directed to proceed, Optum will send Provider Relations, Clinical and/or IT staff to the provider site to review encounter data received against the provider's clinical record for a sample of consumers. The inquiry or investigation may include interviews of relevant personnel and review of relevant documentation regarding the matter as well as pertinent laws, regulations and policies and procedures.
 - 9.5. Once the preliminary investigation has been completed, results will be reported to DSHS or other DSHS designee and the Optum Corporate Compliance office. The report includes any evidence gathered.
 - 9.6. Corrective actions may be developed jointly with DSHS and the Optum Corporate Compliance office and may include additional training, increased oversight or punitive actions.
10. The Optum Pierce RSN's Compliance Plan is reviewed and updated on an annual basis, or more frequently, as required by state or federal law.
 11. The Compliance Officer oversees all compliance and program integrity related activities. The Compliance Officer:
 - 11.1. Provides local oversight for all compliance and program integrity related activities.
 - 11.2. Participates in compliance and program integrity related training provided by the Washington State DSHS or Medicaid Fraud Control Unit or by the Centers for Medicare and Medicaid Health Services (CMHS).
 - 11.3. Is responsible for ensuring training and serving as a resource to all RSN staff and contractors on compliance and program integrity issues including the False Claims Act and whistle blower protections.
 - 11.4. Convenes the Compliance Committee as necessary, and at least quarterly, to review reported incidents and program/procedural issues.
 - 11.5. Assists all staff in identifying opportunities to identify, investigate, rectify and reduce incidents of fraud, waste and abuse.
 - 11.6. Receives and investigates reports of possible fraud, abuse or integrity violations.
 - 11.7. Ensures there is no retaliation against staff, consumers, providers or other stakeholders for reporting fraud, abuse or integrity incidents.
 - 11.8. Develops corrective action plans to address fraud, waste and abuse and reduce future incidents.
 - 11.9. Reports corrective action plans and fraud, waste and abuse resolutions to the Pierce RSN Governing Board to keep them apprised of compliance related activities.
 - 11.10. Ensures Optum Pierce RSN staff are not listed by a federal agency as debarred, excluded, or otherwise ineligible for federal program participation, as required by federal or state laws, or found to have a conviction or sanction related to health care as listed in the *Social Security Act, Title 11 Section 1128*. Such exclusion will be checked at <http://www.oig.hhs.gov/fraud/exclusions.asp> or on Sanction Check

provided by contract through United Health Group at <https://app.sanctioncheck.com/scripts/logon.asp>. Sanction Check, through Compliance Concepts, Inc. is available for exclusion checks 24 hours a day, seven days a week, from any location throughout the world via the Internet and includes data from the Office of Inspector General's List of Excluded Individuals and Entities, General Service Administration's List of Excluded Parties, and the Office of Foreign Assets Controls Terrorists List.

- 11.11. Ensures that processes are in place to screen contractors and subcontractors' employees, individuals and entities with an ownership or control interest of 5% or more for exclusions prior to entering into a contractual or other relationship where the individual or entity would benefit directly from funds received under the relationship, and screened monthly for newly-added and existing employees, individuals and entities who would benefit directly from funds.
- 11.12. Ensures that processes are in place for Optum and contracted providers to screen new hires and monitor on-going staff for excluded providers. Optum and contracted providers screen and monitor their own staff, board members, and subcontractors to ensure they are not excluded entities.
12. The Compliance Committee is convened quarterly or when needed to determine the appropriate course of action on Program Integrity and fraud, waste and abuse-related issues. The Compliance Committee will review, update when necessary the AD-01 *Compliance-Fraud and Abuse Policy*, and recommend endorsement to the Pierce RSN QA/PI Committee. The Compliance Committee will include:
 - 12.1. QA/PI Manager, Chair
 - 12.2. Executive Director
 - 12.3. RSN Director
 - 12.4. Provider Relations Manager
 - 12.5. Finance Manager
 - 12.6. IT Manager
13. The following metrics are monitored to help detect fraud and abuse in the Pierce RSN system of care:
 - 13.1. Encounter Data Audits: Encounter data submitted to Pierce RSN electronically are compared to provider record reviews during onsite visits. These audits are conducted a minimum of once each year in compliance with QA-08, *Clinical and Administrative Review* Including Annual Review of Community Mental Health Agencies.
 - 13.2. Medical Record Audits: conducted in compliance with QA-08, *Clinical and Administrative Review* Including Annual Review of Community Mental Health Agencies review whether services were provided in a clinically appropriate matter and at the intensity appropriate to each consumer's needs. If services are consistently provided at too high an intensity for consumers, it may result in an investigation for abuse.
 - 13.3. Edits in the Management Information System are designed to detect irregular billing patterns and report them as errors for further investigation.
 - 13.4. Utilization management reporting such as inpatient census and average lengths of stay for all levels of care shall be reviewed by the Clinical Manager or designee to detect any trends indicating possible over-utilization of services. If over-utilization is detected, utilization management reporting by providers will be used to determine if particular providers have patterns such as longer lengths of stay which may indicate the need to investigate further.

- 13.5. The Quality Review Team (QRT) conducts provider site visits and gathers feedback about providers through "Speak Outs" and other community interactions. If the QRT encounters anything which may indicate fraud or abuse, they report directly to the Compliance Officer for investigation. They may do so anonymously if preferred.
 - 13.6. Grievance and critical incident data, including data from providers and the Ombuds, and complaints from contractors and community members is reviewed for specific incidents or trends which may indicate fraud or abuse.
 - 13.7. Licensing reports from the Washington DSHS are reviewed during contracting and annually thereafter to determine if DSHS has investigated a contracted provider agency for fraud or abuse.
 - 13.8. Disciplinary reports from the Washington Department of Health are reviewed as they are circulated by the Compliance Officer and Compliance Representatives from each contracting organization to identify any staff or organizations barred from work with Medicaid beneficiaries.
14. Optum Pierce RSN has contracting practices which avoid fraud and abuse, such as:
 - 14.1. Optum Pierce RSN does not contract with providers who directly or indirectly offer rewards for the referral of consumers to the provider.
 - 14.2. Optum Pierce RSN does not provide additional compensation or incentives to providers for reducing the volume of Medicaid services provided or of services funded by other federal or state health care programs.
 - 14.3. Optum Pierce RSN does not provide or contract with entities that provide physician incentive plans as described in *42 CFR 422.208*.
 - 14.4. Optum Pierce RSN does not approve or cause claims to be submitted to the Medicaid program or other federal or state health care program for
 - 14.4.1. Services provided as a result of payments made in violation of #1 above.
 - 14.4.2. Services that are not reasonable or necessary.
 - 14.4.3. Services that cannot be supported by the documentation in the medical record.
 - 14.5. Optum Pierce RSN does not falsify or misrepresent facts concerning the delivery of services or payments of claims in connection with the Medicaid program or other federal or state health care benefit programs.
 - 14.6. Optum Pierce RSN employees, or any other person associated with the RSN, cooperate with the Compliance Officer in communicating information or records related to possible violations of the compliance and integrity programs.
 - 14.7. Optum Pierce RSN does not allow participation by or payment to agencies, agency employees, subcontractors or individuals listed by a federal agency as debarred, excluded, or otherwise ineligible for federal program participation, as required by federal or state laws, or who are found to have a conviction or sanction related to health care.
 - 14.8. Optum Pierce RSN screens contracted providers' employees and individuals and entities with ownership or control interest for exclusion prior to contracting and on a monthly basis thereafter.
 15. Contractors in the Optum Pierce RSN are responsible for:
 - 15.1. Their staff's completion of training on the False Claims Act and Whistle Blower Protections.

- 15.2. Complying with requests during an investigation of fraud, waste or abuse. Providers are also responsible for developing their own internal compliance and program integrity plan.
 - 15.2.1. Screening employees and subcontractors on a monthly basis to determine if they have been:
 - 15.2.1.1. Convicted of a criminal offense related to health care
 - 15.2.1.2. Listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation. Such exclusion will be checked via <http://exclusions.oig.hhs.gov> and/or other widely approved methods.
 - 15.2.1.3. Such individuals shall not be directly involved in Optum Pierce RSN-funded services.
 - 15.2.2. Reporting incidents of fraud, waste or abuse or related activities to the Optum Pierce RSN Compliance Officer.
 - 15.2.3. Certifying that the data submitted to Optum Pierce RSN are in substantial compliance with contract terms.
16. Multiple mechanisms are in place in the Optum Pierce RSN to report fraud, waste, abuse, or other compliance/program integrity related incidents. Reports can be made:
 - 16.1. To the Compliance Officer
 - 16.1.1. In person at the Optum Pierce RSN office, 3315 S. 23rd Street, Suite 310, Tacoma, WA 98405
 - 16.1.2. During community meetings
 - 16.1.3. Telephonically at 253-292-4187
 - 16.1.4. Via email at Raetta.Daws@Optum.com
 - 16.2. Via fax to 253-292-4219
 - 16.3. Optum maintains a 24-hour toll-free telephone hotline called the "Compliance HelpLine," through which incidents of suspected non-compliance or other misconduct can be reported. This hotline feeds into a voicemail box so that callers can call anonymously or can leave a call back number to discuss the reported issue further. The number for the Compliance Helpline is 1-800-455-4521.
 - 16.4. Report in writing to:

Compliance Officer
Optum Pierce RSN
3315 South 23rd Street, Suite 310
Tacoma, WA 98405
17. Any Optum Pierce RSN staff member, contracted provider, individual in services, or other stakeholder may contact the Compliance Officer with any compliance, fraud, or abuse related question or concern.
18. If fraud or abuse, suspicious or unethical conduct is suspected in providers who have been reimbursed to serve individuals in mental health services in the Pierce RSN, the Executive Director reports the potential fraud and abuse information to DSHS whenever it is suspected.
 - 18.1. When notifying DSHS, Optum Pierce RSN includes:
 - 18.1.1. Source of the complaint or the data reviewed that raised the concern
 - 18.1.2. Name of the contracted agency and names of mental health care provider(s) who are suspected of involvement

- 18.1.3. Names of the contracted agencies and names of employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in *SSA Section 1128* within ten (10) business days of awareness of the conviction.
- 18.1.4. Approximate number of dollars in question including any payments made by the contractor or subcontractor that directly or indirectly benefited excluded employees, individuals and/or entities.
- 18.1.5. Legal and administrative disposition of the case, including any actions taken by Optum Pierce RSN to terminate relationships with the contractor or subcontractors' employees, individuals or entities with an ownership or control interest.
- 18.2. Optum Pierce RSN notifies the DSHS Incident Manager and the Optum Corporate Compliance staff within one working day of any incident that was referred to the Medicaid Fraud Control Unit by the RSN or its Subcontractor.
- 18.3. If DSHS determines it is in the state's best interest for the Washington Attorney General to pursue the potential fraud and abuse, Optum Pierce RSN cooperates fully with any investigation conducted by state or federal authorities, including the Medicaid Fraud Control Unit (MFCU), the DEA, the FBI and other investigatory agencies.
- 18.4. If, after discussion with DSHS, Optum Pierce RSN is directed to proceed, Optum shall conduct the Investigative Steps detailed under B: Internal Investigative Steps, below.
- 18.5. Once the preliminary investigation has been completed, results will be reported to DSHS and the Optum Corporate Compliance staff. The report will include any evidence gathered.
- 19. After a determination has been made that a referral or tip should be investigated, and that a full investigation is warranted, the Compliance Officer performs the following investigative steps.
 - 19.1. The Compliance Officer must analyze the information to determine priority by considering:
 - 19.2. The impact of the case upon the consumer. For example, if a consumer is receiving multiple treatments that are potentially harmful, the case should be given a high priority. Treatments negatively affecting a consumer's health and/or insurability are factors in making this judgment.
 - 19.3. The financial impact of the case. If the case consists of a large dollar amount, the case has a larger impact and should be given a high priority.
 - 19.4. Developing an action plan that plots the course and describes the scope of the investigation and the approaches to be employed. The investigative work plan includes a checklist of sequential tasks to be performed during the investigation, but is flexible and allows for modification as the situation demands.
 - 19.5. The investigative work plan includes a timeline for the accomplishment of specific tasks.
 - 19.6. Generally, any investigation will feature the following elements:
 - 19.6.1. Identifying potential sources of information on the matter in question;
 - 19.6.2. Gathering relevant information from those sources through medical records, interviews or data collection;
 - 19.6.3. Recording the results of the investigation in writing; and

- 19.6.4. Evaluating investigative findings and potential resolution strategies in cooperation with the team, the Counsel or a Medical Director;
- 19.6.5. Initiating a resolution strategy.
- 19.6.6. In conducting investigations, the Compliance Officer collects information and evidence from a wide variety of sources. Internal sources consist, in part, of past abuse & fraud cases or intelligence files; claim/encounter data history extracts via data analysis tools; canceled checks; original claim forms; 1099 reporting; internal experts: medical director, care management, provider relations, finance and IT staff. External sources of information/evidence collection include, but are not limited to present or former employees of a suspect provider; present or former consumers; other providers in the community, or business associates of the subject; a subject's present or former spouse; the subject himself or herself; prior complaints and allegations made by state or federal agencies or departments of professional regulation, and any media reports on same; public court records; Department of Motor Vehicle records; online sources, i.e., the internet; consumer advocate groups, i.e., public citizens and the Better Business Bureau; Medicare sanction list; Office and hospital medical records; law enforcement; if a foreign claim: passport and airline tickets/ itinerary; IRS tax identification verification line; information shared by other insurers; vendors that provide such services as surveillance (photos, audio & video), interviews or public record searches; asset checks; and the referring party.
- 19.7. In the final stage of the case, the Compliance Officer, in consultation with the investigative team, determines recommended actions based on the investigator's evaluation of the investigative findings to be presented to the Compliance Committee.
- 19.8. The Compliance Officer convenes the Compliance Committee and presents findings. The Compliance Committee is asked to recommend a resolution to the case. Resolution recommendations are reported to the Pierce RSN Governing Board to keep them apprised of compliance-related activities.
- 19.9. Optum shall contact the DSHS designee and Optum Corporate Compliance staff to discuss possible resolutions.
- 20. Following are the resolution strategies commonly pursued in resolving cases:
 - 20.1. Closing the case may be the best option when the evidence does not support findings of inappropriate benefit payments or the legal or medical merits of the case are ill defined.
 - 20.2. If investigation results indicate that the claim contained unintentional billing errors, the provider will be contacted, advised of the errors and provided with tips on appropriate billing techniques.
 - 20.3. When the results of an investigation do not indicate that all of the elements of fraud have been established, the Compliance Officer may flag a provider or consumer in the system to monitor future activity to determine if a pattern of fraud or abuse is evident.
 - 20.4. Optum may include discipline and/or network dismissal.
 - 20.5. Pursuing mediation or arbitration.
 - 20.6. Optum will file a civil suit against a provider or consumer to recover defrauded funds. Optum attorneys will consider the merits of each case and proceed in a manner which they determine is legally sound.

RELATED POLICIES:

- Pierce Regional Support Network policy: *AD-04 Governing Board*
- Pierce Regional Support Network policy: *AD-08 Mental Health Advisory Board*
- Pierce Regional Support Network policy: *AD-17 Biennial Plan*

APPROVAL HISTORY:

- Policy and Procedure Committee review and approval: 10/26/2009
- Policy and Procedure Committee review and approval: 08/23/2010
- Policy and Procedure Committee review and approval: 08/27/2012
- Policy and Procedure Committee review and approval: 12/02/2013
- Policy and Procedure Committee review and approval: 09/22/2014

OPTUM PIERCE REGIONAL SUPPORT NETWORK

ADMINISTRATIVE POLICY

Provider Training

Policy #: AD-13

Section: Administrative

Approved by Cheri Dolezal, CEO, Optum Specialty Networks, Washington

Effective Date: July 2009



Last Review Date: September 2014

Approved by:

Revision Date: January 2014



APPLICABILITY:

This policy meets the applicable requirements of the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP) contract as well as regulatory requirements as outlined in: WAC 388-865, 388-865-0260; RCW 70.02, 71.05, 71.24, 71.34; CFR 42 CFR 438, Federal 1915 (b) Mental Health Waiver, Medicaid State plan, other provisions of Title XIX of the Social Security Act or any successors.

PURPOSE:

To describe the training delivered to Optum Pierce Regional Support Network's (RSN) provider network.

POLICY:

Optum Pierce RSN provides comprehensive orientation and ongoing training to providers on clinical and administrative functions and requirements.

PROCEDURAL GUIDELINES FOR POLICY IMPLEMENTATION:

1. In compliance with WAC 388-865 and 388-865-0260(2), Optum Pierce RSN has developed a provider training program using in-service training and/or outside resources to assist service providers to acquire necessary skills and experience to serve the needs of the consumer.
2. Optum Pierce RSN provides initial and ongoing orientation and training to contracted providers, including training on:
 - 2.1. Optum Pierce RSN Policies and Procedures;
 - 2.2. Clinical Practice Guidelines;
 - 2.3. Evidence-Based Practices;
 - 2.4. Emerging Best Practices;
 - 2.5. Level of Care Guidelines;
 - 2.6. When and how to request a prior-authorization;
 - 2.7. Requirements related to documentation;

- 2.8. Adherence to principles of Recovery and Resiliency;
 - 2.9. Administrative requirements;
 - 2.10. The Grievance System;
 - 2.11. Advance Directives;
 - 2.12. Cultural Competency;
 - 2.13. Fraud and abuse, including whistle blower protections and the False Claims Act;
 - 2.14. Third party liability;
 - 2.15. Encounter reporting;
 - 2.16. The Quality Review Team;
 - 2.17. Performance Improvement Projects (PIPs);
 - 2.18. Performance measures; and
 - 2.19. Quality Assurance/Performance Improvement (QA/PI).
3. Information and training is provided to contracted Mental Health Care Provider Representatives at meetings such as the QA/PI Committee and Subcommittee Meetings and the Provider Operations Meeting. Representatives are expected to take the information back to their agency and share it with the staff. All contractors are encouraged to request on-site training, coaching or technical support, particularly if their staff members are having difficulty in complying with specific policies.
 4. Subcontracts for the provision of mental health services must require subcontractors to participate in training offered by DSHS on the implementation of Evidence-Based Practices and Promising Practices. Requests for DSHS to allow an exception to participation in required training is to be in writing and include a plan for how the required information will be provided to targeted subcontractor staff.
 5. Annually, all community mental health employees who work directly with consumers are to be provided with training on safety and violence prevention topics described in *RCW 49.19.030*. The curriculum for the training is to be developed collaboratively among the DSHS, contracted mental health providers, and employee organizations that represent community mental health workers.
 6. Annually, all contracted providers and the employees are expected to provide a minimum of one (1) hour of training on cultural competency. Optum Pierce RSN offers in-depth training annually, plus provides the web-based Relias Training Program to all staff and consumers throughout the Pierce RSN.
 7. Subcontracts for the provision of mental health services require the use of the DSHS-provided *Global Appraisal of Individual Needs - Short Screener* and require staff who will be using the tool to attend trainings on the use of the screening and assessment process that includes use of the tool and quadrant placement. Optum Pierce RSN will perform annual monitoring as an oversight.
 8. Optum Pierce RSN provides training, mental health staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations.
 9. Optum Pierce RSN requires in subcontracts that WA-PACT providers attend and participate in DSHS-required training and technical assistance activities.
 10. Optum Pierce RSN requires that crisis responders complete all training required by the DSHS and meet all qualifications of *RCW 70.96B*.

11. Optum Pierce RSN works with DSHS and Washington State University (WSU) to expand efforts and focus in encouraging consumers to complete Washington State's *Certified Peer Specialist* training and become Peer Support Providers.

11.1. Optum Pierce RSN provides training to Peer Counselors under the following provisions:

- 11.1.1. Training is structured in compliance with the *Peer Counseling Program Guidelines* posted on the DSHS intranet. The guidelines specify the amount of classroom time required for completion and define participant responsibilities.
- 11.1.2. Training is provided consistent with the *Peer Counseling Training Manual* posted on the DSHS intranet.
- 11.1.3. Each participant is provided with a training manual and a copy of *Wellness Recovery Action Plan* by Mary Ellen Copeland.
- 11.1.4. A copy of all training materials that are to be provided to participants is submitted to the DSHS for approval 30 days prior to dissemination. This excludes materials contained in the *Peer Counseling Training Manual* issued by DSHS.
- 11.1.5. The names and qualifications of each presenter are submitted to the DSHS for approval no later than 30 days prior to initiation of training.
- 11.1.6. A completed *Peer Counselor Application*, provided on the DSHS website, is submitted by each participant and is approved by the DSHS no later than 45 days prior to the start of training. Participants are invited to attend based on priorities as published by DSHS.
- 11.1.7. Each participant is over age 18 and will meet the *WAC 388-865-0150* definition of "consumer", unless the DSHS approval for exception has been obtained in writing prior to attendance at the training.

11.2. Within 14 days of the completed training a list is submitted to DSHS of all participant names and verification of their completion of the required 40 hours of training

RELATED POLICIES:

- Pierce Regional Support Network policy: AD-03 - *Provider Credentialing and Re-Credentialing*
- Pierce Regional Support Network policy: AD-11 - *Network Adequacy*
- Pierce Regional Support Network policy: AD12 - *Orientation and Training of Optum Pierce RSN Staff*

APPROVAL HISTORY:

- Policy and Procedure Committee review and approval: 10/26/2009
- Policy and Procedure Committee review and approval: 08/23/2010
- Policy and Procedure Committee review and approval: 09/26/2011
- Policy and Procedure Committee review and approval: 08/27/2012
- Policy and Procedure Committee review and approval: 12/02/2013
- Policy and Procedure Committee review and approval: 09/22/2014

OPTUM PIERCE REGIONAL SUPPORT NETWORK

QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT POLICIES AND PROCEDURES

Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies

Policy # QA-08

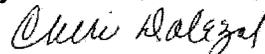
**Section: Quality Assurance/Performance
Improvement**

Effective Date: July 2009

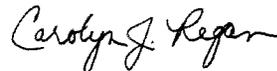
Revision Date: December 2013

Last Review Date: December 2014

**Approved by: Cheri Dolezal, CEO, Optum
Specialty Networks, Washington**



Approved by:



APPLICABILITY:

This policy meets the applicable requirements of the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP) contract as well as regulatory requirements as outlined in: WAC 388-865-0229(2)(d), 388-865-0280, 388-865-0284, 388-865-0310, 388-877-0400, 388-877-0410, 388-877-0420, 388-877-0430, 388-877-0500, 388-877-0510, 388-877-0520, 388-877-0530, 388-877-0600, 388-877-0610, 388-877-0620, 388-877-0630, 388-877-0640, 388-877-0650; RCW 70.02, 71.05, 71.24, 71.34; 42 CFR 438.230, Federal 1915 (b) Mental Health Waiver, Medicaid State plan, other provisions of Title XIX of the Social Security Act or any successors.

PURPOSE:

To describe clinical and administrative assessment of network providers through site visits and clinical record review.

POLICY:

Optum Pierce Regional Support Network (RSN) performs on-site visits of network providers to review clinical and administrative policies and procedures, clinical records against standards, and administrative practices for the purpose of monitoring compliance with the Optum Pierce RSN contract, including state and federal requirements.

PROCEDURAL GUIDELINES FOR POLICY IMPLEMENTATION:

1. In accordance with WAC 388-865-0284(3), Optum Pierce RSN monitors contracts with providers and notifies the DSHS of observations and information indicating that providers may not be in compliance with licensing and certification requirements.
2. Optum Pierce RSN conducts, at minimum, an annual site visit to providers in its network. Network providers are notified in writing at least one (1) week prior to a site visit about the purpose of the review and to arrange a convenient time and date. The site visit protocol is comprehensive and includes a review of the following elements stipulated in the PIHP contract:
 - 2.1. Traceability of Services —Optum Pierce RSN staff assess whether medical necessity is established and documented, and that access to care standards are

- met. Staff examines the clinical records to ensure that authorized services are appropriate for the diagnosis that the treatment plan reflects the identified needs, and that progress notes support the use of each authorized state-plan service. The staff checks records to make sure that an appropriate 180 day review was conducted to update the service plan, diagnostic information and provide justification for level of continued treatment.
- 2.2. Timeliness of Services – Optum staff goes over the chart documentation to ensure that individuals in behavioral health services access care in a timely manner.
 - 2.2.1. Emergent Mental Health Services = 2 hours from request.
 - 2.2.2. Urgent Health Services = 24 hours from request.
 - 2.2.3. Initial Inpatient Certification = 12 hours from request.
 - 2.2.4. Crisis and Phone Service = 24/7/365 availability. Phones answered by live person.
 - 2.2.5. Post stabilization Services = Individuals need to receive an outpatient service within 7-days of discharge from a psychiatric inpatient stay.
 - 2.2.6. Routine Intake Evaluation = 14 days from request
 - 2.2.7. First Routine Outpatient Service = 28 days from request
 - 2.2.8. If mental health services are not rendered within these guidelines, the clinical record is required to list the reason and appropriateness of the delay.
 - 2.3. Range of Services / Network Adequacy -- Optum staff gathers information from contracted community mental health agency to ensure that it has the capacity to provide all state-plan services (including second opinions, interpretive services, requests for written information in alternative formats, and referrals to out-of-network providers) to meet the clinical needs of its population. In order to ensure adequate capacity, the contracted provider agency must evaluate its anticipated Medicaid enrollment, expected utilization of services, characteristics and health care needs of the population, the number and types of direct mental health care providers (training, experience and specialization) able to furnish services, and the geographic location of providers and enrollees (including distance, travel time, means of transportation ordinarily used by enrollees, and whether the location is ADA accessible).
 - 2.4. Special Populations –Contracted community mental health agencies demonstrate during the review 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 are tracked through the treatment plan and progress notes. If a mental health care provider identifies a need, but it is deferred by the individual in services, the mental health care provider documents the reason it is not being addressed at this time.
 - 2.5. Coordination of Primary Care –Optum staff review clinical records to ensure that individuals with complex medical needs, who have no assigned primary care provider (PCP) are assisted in obtaining a PCP. For individuals in behavioral health services who already have a PCP, staff evaluates whether the mental health care provider coordinated care as needed. Staff also evaluates whether coordination for individuals with complex medical needs was tracked through the treatment plan and progress notes.
 - 2.6. Practice Guidelines -- Optum staff examines documentation to determine whether the mental health care providers are using identified practice guidelines.
 - 2.7. Complaints/Grievance –Optum staff analyzes each network provider's process for reporting, tracking, and resolving expressions of dissatisfaction (grievances) from

individuals in services and concerns from families, allied professionals and the community (complaints).

- 2.8. Critical Incidents – Optum staff reviews the network provider’s process for reporting and managing critical incidents.
 - 2.9. Information Security – Optum staff monitors network providers to ensure they are actively following federal regulations for managing personal health information (HIPPA / Hi-Tech), and appropriately report any violations.
 - 2.10. Disaster Recovery Plans –Optum staff checks each network provider’s Disaster Recovery and Business Continuity Plan to ensure that a plan is in place and that the plan is periodically tested and updated.
 - 2.11. Excluded Providers -- Optum staff examines mental health care providers personnel records to ensure that network providers have documentation that shows the completion of an initial screen and on-going monitoring for excluded providers. Exclusion checks are reviewed for all staff, board members, and subcontractors to ensure that they are not excluded entities.
 - 2.12. Fiscal Management –Optum staff monitors documentation of the network provider’s cost allocations, revenues, expenditures and reserves in order to ensure that Medicaid dollars under this Contract are being spent appropriately under WAC 388-865-0270.
 - 2.13. Licensing and Certification Issues – Optum staff additionally follows up on any issues noted during licensing and/or certification reviews conducted by DSHS.
3. Administrative Review Component
- 3.1. All network providers are reviewed using a standardized protocol.
 - 3.2. In order to work in close coordination with DSHS, Optum Pierce RSN uses the *DSHS Quality Assurance/Quality Improvement Provider Agency Self Evaluation and State Licensing/Certification Survey Tool* with some additional items to measure compliance with the Optum Pierce RSN Policies and Procedures.
 - 3.3. Areas of focus include:
 - 3.3.1. Inspection of the physical site to ensure that requirements for the following are met:
 - 3.3.1.1. Rights for individuals involved in mental health services;
 - 3.3.1.2. Medication storage and handling;
 - 3.3.1.3. Physical accessibility; and
 - 3.3.1.4. Confidentiality of medical record storage and computer access.
 - 3.3.2. Review of policies, procedures and administrative practices related to *Washington Administrative Code (WAC)*, federal *Balanced Budget Act (BBA)*, and Optum Pierce RSN contract requirements; and
 - 3.3.3. Review of supervisory protocols, supervisory records and the staff training programs.
4. Personnel Record Review Component
- 4.1. All contracted mental health care providers are reviewed using this protocol.
 - 4.2. The Personnel Record Review protocol is used to document qualifications, licensure, and competencies of contracted mental health care provider clinical staff.
 - 4.3. Optum Pierce RSN staff uses the Staff Competency Requirements section of the *DSHS Administrative Licensing Tool* to review compliance with WAC statutes.

- 4.4. Optum Pierce RSN staff also employs the DBHR *Personnel Record Review Tool* to document personnel requirements. RSN staff review one hundred percent (100%) of personnel files to document the following:
 - 4.4.1. Mental health care provider staff credentials (licensing and registration, educational degrees, mental health experience, specialty certifications);
 - 4.4.2. Training (that each mental health care provider has an annual training plan, that training is documented in their personnel file, and supervisors have completed required supervisory training);
 - 4.4.3. Supervision (that mental health care providers receive regular supervision) and annual evaluations (that evaluations are done annually), per WAC 388-865-0265(2);
 - 4.4.4. Follow-up related to substantiated grievances filed about an individual.
5. Clinical/Medical Record Review Component
 - 5.1. The Medical Record Review protocol is applied at site visits to document requirements related to WAC, BBA, general standards of clinical practice, quality and appropriateness of care, as well as quality indicators from the Optum Pierce RSN *QA/PI Plan* that specify chart reviews as the data source.
 - 5.2. A representative sample of 500 medical records is reviewed across the Pierce RSN. Optum Pierce RSN staff employs a modified version of the DBHR *Clinical Record Review Tool* with some additions.
 - 5.3. Areas reviewed include, but are not limited to:
 - 5.3.1. Initiation of services/consents;
 - 5.3.2. Legal status;
 - 5.3.3. Intake assessment;
 - 5.3.4. Care and service planning;
 - 5.3.5. Services are provided by staff with the appropriate credentials;
 - 5.3.6. Age, culturally and linguistically appropriate services;
 - 5.3.7. Active participation of consumers and families in treatment planning and goal setting;
 - 5.3.8. Diagnostic education;
 - 5.3.9. Recovery oriented, strengths based documentation;
 - 5.3.10. Special health care needs and special population consults;
 - 5.3.11. Referrals;
 - 5.3.12. Crisis Planning;
 - 5.3.13. Timely progress notes; and
 - 5.3.14. Psychiatric treatment, including complete medications lists with a need for labs and frequencies;
 - 5.3.15. Coordination with medical providers;
 - 5.3.16. Discharge summaries.
 - 5.4. Optum Pierce RSN staff also conducts focused medical record reviews for targeted quality monitoring for mental health care providers with specialized programs (including fidelity reviews of evidence-based and promising practices) and performance evaluation related to contract performance incentives.

6. Data Integrity Review Component
 - 6.1. Optum Pierce RSN Information Technology (IT) staff conducts the *Data Integrity Review* to match data in the Optum Pierce RSN and state information systems with information in provider medical records, to ensure data completeness and accuracy at the state, Optum Pierce RSN and provider levels.
 - 6.2. Random samples are drawn by Optum Pierce RSN staff for the medical record reviews.
 - 6.3. For the selected sample, MIS staff employs a tool to evaluate data compliance with timeliness of key data transmissions, data completeness for required fields and data match between the medical record and our data warehouse.
7. Billing/Encounter Data Review Component
 - 7.1. Optum Pierce RSN uses the *Billing/Encounter Data Review* protocol to verify that encounter data in the information system matches reported services documented in the medical record.
 - 7.2. A minimum of one percent (1%) of all encounters reported for each twelve (12) month period are reviewed.
 - 7.3. This review is completed using a random sample of consumer medical records for each agency. The sample is drawn from records that include services received during the audit period.
 - 7.4. For the selected sample, Optum Pierce RSN staff match reported encounters for the review period with documentation in the medical record, as well as unreported encounters. Specifically, for each reported service, Optum staff look at whether there is a progress note in the record, whether the date is correct, and whether the mental health care provider identified and duration of service noted in the record matches what is in the Optum Pierce RSN and state information systems.
 - 7.5. These reviews may also include a clinical component conducted by Optum Pierce RSN clinical staff that assesses whether the service provided was included on the active treatment plan of care and whether the content of the progress note matches the service reported.
8. In the spirit of cooperation and to decrease the duplication of services, Optum Pierce RSN respects the findings of DSHS Licensing Reviews at the Community Mental Health Agencies. During the year of the DSHS review, Optum Pierce RSN staff may follow up on DSHS-discovered areas of deficiencies and have the option of not repeating the review in areas found to be compliant. During the year of a DSHS review, Optum Pierce RSN staff may focus the review on a specific focal point, federal requirements for mental health services, Washington State regulations, and/or policy standards not covered in the DSHS review.
9. If Optum Pierce RSN staff discover during a site visit that a network provider is not in compliance with licensing or certification requirements, Optum Pierce RSN staff notify DSHS.
10. If Optum Pierce RSN staff have concerns about potential fraud and/or abuse identified through the clinical, administrative, or personnel review process, the staff report the potential fraud or abuse to the Optum Pierce RSN Compliance Officer for further investigation.
11. In accordance with *WAC 388-865-0229(2)(d)*, the Optum Pierce RSN conducts at minimum annual reviews of the evaluation and treatment service facilities consistent with regional support network procedures and notifies the appropriate authorities if it believes that a facility is not in compliance with applicable statutes, rules and regulations.
12. If Optum Pierce RSN staff discovers during site visits that any network provider is out of compliance with statutes, rules and regulations, this is addressed immediately with the

provider and reports are made to any applicable authorities including, but not limited to, the DSHS.

13. If an Optum Pierce RSN staff reviewer has immediate concerns about the current care and services and/or appropriateness of the level of care of a consumer whose record is under review, the reviewer flags the case for immediate feedback to the contracted mental health care provider, with a request for immediate review or corrective action. The reviewer also may request a consultation and/or on site review by the Optum Pierce RSN Clinical Manager or Medical Director.
14. A brief exit summary of major findings and impressions is presented at the close of each review. A written report of the site review findings and recommendations is to be forwarded to the network provider within thirty (30) calendar days. If more than thirty days is required to complete a report, Optum staff provides a updates to the network provider about the reason for the delay and the expected timeframe for completion. If necessary, a request for corrective action is included with the written report that identifies areas in which requirements were not met and any actions required to correct the deficiencies is to be included.
 - 14.1. Providers are to respond to the report of findings and recommendations within fourteen (14) calendar days with additional documentation and/or plans for corrective actions as applicable. If more than fourteen days is needed to complete a response, the network provider's director submits a written request to Optum with the reason for the delay and expected timeframe for completion.
 - 14.2. Providers are to follow the Optum Pierce RSN policy AD-16 entitled, "*Provider Complaints and Grievances*" to appeal a decision or for resolution of disputes after Optum Pierce RSN's final written report has been issued.
15. Optum Pierce RSN participates with the DSHS in review activities. Participation includes at a minimum:
 - 15.1. The submission of requested materials necessary for the DSHS-initiated review within thirty (30) days of the request;
 - 15.2. The completion of site visit protocols provided by DSHS; and
 - 15.3. Assistance in scheduling interviews and agency visits required for completion of the review.

RELATED POLICIES:

- Pierce Regional Support Network P&P: QA-01 - *QA/PI Program Description and Work Plan*
- Pierce Regional Support Network P&P: QA-02 - *QA/PI Program Annual Evaluation*
- Pierce Regional Support Network P&P: QA-03 - *QA/PI Performance Improvement Projects*
- Pierce Regional Support Network P&P: QA-04 - *QA/PI Monitoring Important Aspects of Care and Service*
- Pierce Regional Support Network P&P: QA-05 - *External Audit Preparation*
- Pierce Regional Support Network P&P: QA-06 - *QA/PI Committee Structure*
- Pierce Regional Support Network P&P: QA-09 - *Quality Review Team*

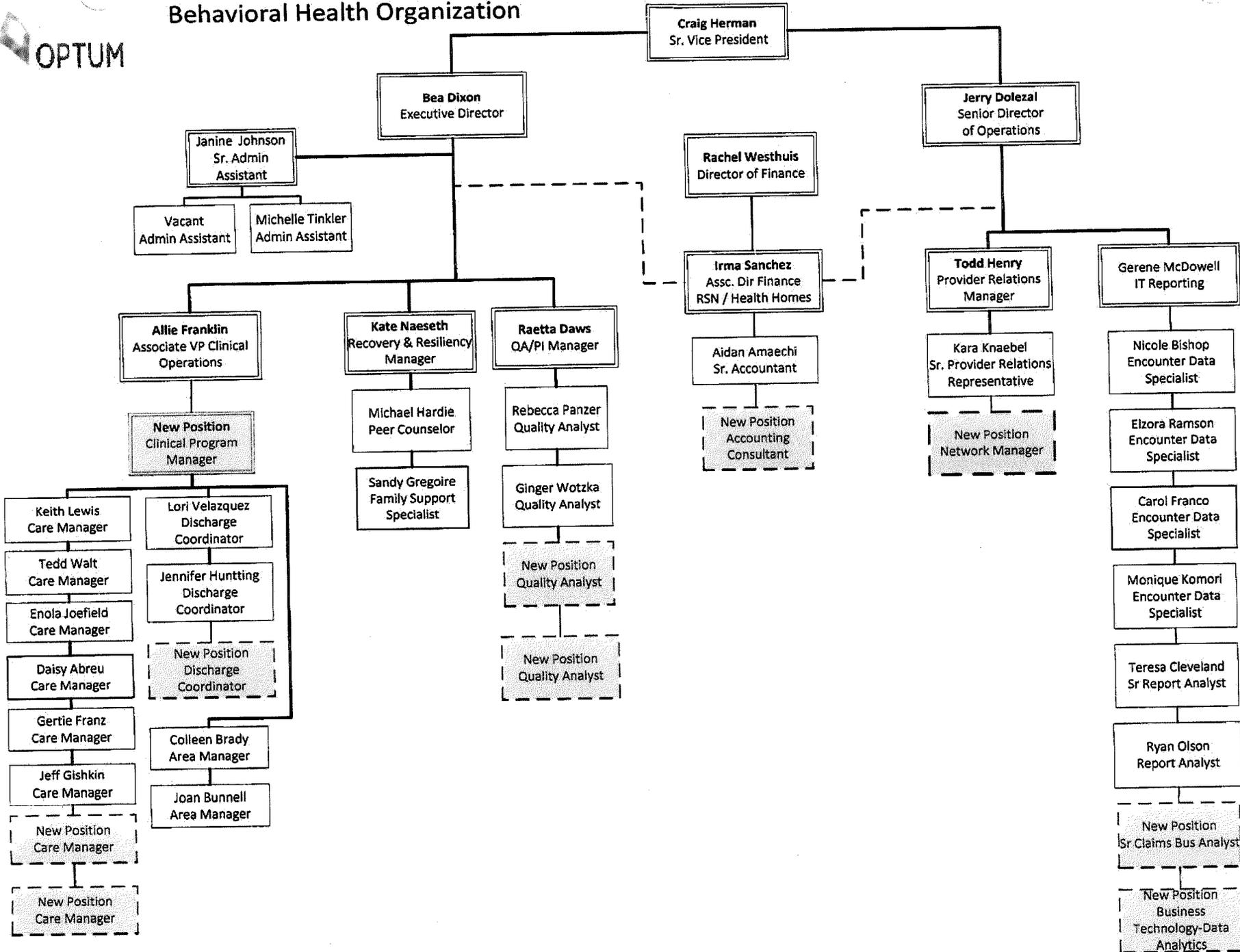
APPROVAL HISTORY:

- Policy and Procedure Committee review and approval: 10/26/2009
- Policy and Procedure Committee review and approval: 08/23/2010
- Policy and Procedure Committee review and approval: 09/26/2011

- Policy and Procedure Committee review and approval: 08/27/2012
- Policy and Procedure Committee review and approval: 12/02/2013
- Policy and Procedure Committee review and approval: 12/15/2014



Behavioral Health Organization



**Memorandum of Understanding
Between
OptumHealth Pierce Regional Support Network and the
Children's Long-Term Inpatient Program Administration**

This Memorandum of Understanding, hereinafter referred to as MOU, is made and entered into by OptumHealth Pierce Regional Support Network ("OptumHealth PRSN") and the Children's Long-term Inpatient Program ("CLIP") Administration.

1.0 Purpose

- 1.1.** The agreement is made between OptumHealth PRSN and the CLIP Administration

OptumHealth PRSN is under contract with the Department of Social and Health Services ("DSHS") to coordinate with the CLIP Administration in order to develop resource management guidelines and admissions procedures for CLIP inpatient resources. The intent of this agreement is to clarify expectations, roles, and responsibilities for the resource management of CLIP resources that are funded by DSHS.

All referrals to the CLIP programs must be approved by OptumHealth PRSN and incorporate the perspective of representatives from mental health and child-serving systems and families of children served by these systems (See Attachment A).

All parties wish to acknowledge good faith in the implementation of this agreement.

2.0 Background

2.1. CLIP Administration

The CLIP Administration is responsible for policy and clinical decision making regarding admission to Washington State's four CLIP Programs. It assists the Division of Behavioral Health and Recovery (DBHR) of DSHS with monitoring the care provided by the CLIP Programs.

The CLIP Administration is staffed by children's mental health specialists and administrative staff. Consulting psychiatrists, social workers, and nurses serve as members of the CLIP Certification Team, Placement Team, and/or Inspection of Care Team.

There are three CLIP facilities in community settings around Washington (Spokane, Tacoma, and Seattle), and one state-owned psychiatric hospital, the Child Study and Treatment Center (“CSTC”) in Lakewood, Washington.

CLIP facilities provide 24-hour residential treatment, 24-hour supervision, psychiatric services, individual/family/group therapy, social work and case management services, routine medical care, recreational therapy, nursing services, dietary services, and parent support.

In coordination with RSNs, the CLIP Administration insures that the CLIP Programs admit only those youth who meet Medicaid criteria for medical necessity, and that discharges occur with necessary planning and due consideration of the needs of the youth and family.

2.2. OptumHealth PRSN

OptumHealth PRSN contracts with the Washington State Department of Social and Health Services to serve as a Pre-paid Inpatient Health Plan (PIHP) and to manage community mental health services in Pierce County.

In turn, OptumHealth PRSN contracts with local Community Mental Health Agencies (CMHA) for the provision of mental health services to eligible persons in Pierce County.

OptumHealth PRSN designates the Children’s Alternative Resources Committee (“CARC”), as the referral mechanism for Pierce County residents seeking voluntary CLIP treatment. The CARC is a team of mental health professionals and stakeholders that meet to discuss each potential CLIP referral, before the formal referral to the CLIP Administration is made. The Committee will serve as OptumHealth PRSN’s agent to: determine whether appropriate less restrictive services are available for adolescents hospitalized involuntarily; assess/coordinate the Juvenile Rehabilitation Administration (“JRA”) transfers or children on 10.77; and integrate resource management of all children admitted to CLIP.

3.0 Roles of the Parties

3.1. OptumHealth PRSN

3.1.1. OptumHealth PRSN will integrate all regional assessment and CLIP referral activities, including:

3.1.1.1. Designating a mechanism to assess the needs of children being considered for voluntary admission, and coordinate referrals to the CLIP Administration. (see Attachment A)

3.1.1.2. Assessing the needs of involuntarily committed (ITA’d) adolescents (180 day restrictive orders) prior to their assignment and admission to a CLIP program.

- 3.1.1.3. Designating an agent(s) to participate in the CLIP Placement Team assignment of ITA'd adolescents.
- 3.1.1.4. Designating a mechanism to assess the needs of all juveniles transferred for evaluation purposes by the JRA or under RCW 10.77 to CSTC.
- 3.1.1.5. Ensure that all required CLIP application materials are submitted prior to CLIP Administration consideration of referrals.
- 3.1.2. Designated OptumHealth PRSN and provider network staff will participate in timely plan of care development and implementation, including discharge planning.
- 3.1.3. Designated OptumHealth PRSN and provider network staff will participate in concurrent length of stay management and decisions to transfer to another inpatient setting (CLIP or community psychiatric hospital) in accord with the CLIP Policies and Procedures.
- 3.1.4. OptumHealth PRSN will designate a single contact person who will monitor OptumHealth PRSN's performance in accord with the terms of this agreement and coordinate with the CLIP Administration as needed.
- 3.1.5. OptumHealth and/or its designee(s) will make good faith efforts to coordinate with the Department of Children and Family Services (DCFS) on shared children in furtherance of the goals of the CLIP Administration and its programs.

3.2. CLIP Administration

- 3.2.1. CLIP Administration will provide information to the OptumHealth PRSN network regarding the CLIP programs, application processes, admission criteria, waiting lists, and specialized services.
- 3.2.2. CLIP Administration will serve as a statewide resource that offers technical assistance upon request to OptumHealth PRSN regarding CLIP resource management.
- 3.2.3. CLIP Administration will serve as the contact for OptumHealth PRSN regarding all referrals for inpatient care in the CLIP programs.
- 3.2.4. CLIP Administration will respond to inquiries from individuals regarding the CLIP programs and refer those wishing further information to OptumHealth PRSN.
- 3.2.5. CLIP Administration will manage all referrals from the identified OptumHealth PRSN mechanism in accord with this agreement and the CLIP Policies and Procedures.
- 3.2.6. CLIP Administration will coordinate the activities of the CLIP Certification and Placement Teams.
- 3.2.7. CLIP Administration will broker the statewide CLIP waiting list.
- 3.2.8. CLIP Administration will monitor CLIP program services as directed by and in coordination with DSHS and in accordance with applicable federal laws, state RCW and WAC sections, and CLIP Administration Policies and Procedures.

- 3.2.9. CLIP Administration will provide monthly utilization information to OptumHealth PRSN.
- 3.2.10. CLIP Administration will notify OptumHealth PRSN when contacted regarding an ITA to allow for exploration of appropriate less restrictive services.
- 3.2.11. CLIP Administration will notify OptumHealth PRSN when a youth from Pierce County is being sent to Child Study and Treatment Center under RCW 10.77 for competency restoration.
- 3.2.12. CLIP Administration will follow the CLIP Policies and Procedures for appeals and dispute resolution as requested.
- 3.2.13. CLIP Administration will provide a single contact person who will monitor the terms of this agreement and coordinate with OptumHealth PRSN as needed.

4.0 Plan of Care and Discharge Planning

- 4.1. OptumHealth PRSN will ensure that designated OptumHealth PRSN and provider network staff will participate in timely plan of care development and implementation, including discharge planning.
- 4.2. For children in a CLIP facility who are not already involved with DCFS services and are recommended by OptumHealth PRSN, their agents, or the CLIP facility for discharge to other than their immediate or extended family, the OptumHealth Care Manager will help the legal guardian or child identify other kinship placement or treatment options.
- 4.3. Dispute Resolution
 - 4.3.1. If OptumHealth PRSN, on behalf of the child's community team, disagrees with the treatment plan and/or discharge plan recommendations developed and/or implemented by the CLIP program, they may file a formal grievance with that CLIP Program. If OptumHealth PRSN and the CLIP program cannot come to an agreement, OptumHealth PRSN may submit a formal request for dispute resolution by the CLIP Administration. Dispute resolution will occur in accord with the CLIP Policies and Procedures.

5.0 Limitation of MOU

- 5.1. It is understood among the parties that this MOU is not a contract and is not binding on the parties.
- 5.2. Violation of any terms cannot be a basis for a claim of damages against parties or their employees, interns or volunteers.

6.0 Dispute Resolution

6.1. All disputes occurring between the parties of this MOU shall be resolved in informal negotiation between the parties.

7.0 Relationship of the Parties

7.1. No agent or employee of the identified parties shall be deemed an agent or employee of the other party.

7.2. Each party will solely and entirely be responsible for the acts of its agents, employees, interns, or volunteers.

7.3. This MOU is executed for the benefit of the Parties and the public. It is not intended, nor may it be construed, to create any third party beneficiaries.

8.0 Hold Harmless

8.1. Regardless of any verbal statements made prior to or following signature on this MOU, nothing in this MOU is intended to establish a legally binding agreement between the parties.

8.2. The parties to this MOU will hold one another harmless for failure to perform any of the roles in section 3 of this document, including termination of this MOU with or without advance notice.

8.3. There shall be no remedy available to one party for failure by the other party, or a third party, to perform any role in section 3 of this document.

9.0 Communication

Unless otherwise stated in this MOU, the following will be contacts for this MOU:

OptumHealth PRSN Contacts

MOU Negotiations/Updates – Ingrid Jean-Baptiste, Provider Relations Liaison – ingrid.jeanbaptiste@optumhealth.com

Clinical and Consumer Care – Mark Nelson, OptumHealth Care Manager – mark.nelson@optumhealth.com

CLIP Administration Contact

CLIP Coordinator - Lisa Daniels

CLIP Program Administrator – Rebecca Kelly

10.0 Term

The term of this MOU begins when both parties have signed. The MOU is of indefinite duration.

11.0 Amendment

This MOU may be amended at any time by written agreement of the parties.

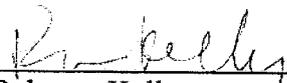
12.0 Termination

12.1. Each party retains the right to terminate this MOU at any time.

13.0 Entire MOU

This MOU contains all the terms and conditions agreed to by the parties. No other understanding, oral or otherwise, regarding the subject matter of this MOU shall be deemed to exist or to bind any of the parties hereto.

IN WITNESS WHEREOF, the parties hereto have caused this Memorandum of Understanding, consisting of six (6) pages, to be executed by the dates and signatures herein under affixed. The persons signing this MOU on behalf of the parties represent that each has authority to execute the MOU on behalf of the party entering this MOU.



Rebecca Kelly
CLIP Program Administrator, DBHR



Cheri Dolezal
Executive Director, OptumHealth Pierce RSN
3315 South 23rd Street, Suite 310
Tacoma, WA 98405

General Phone:
(360)725-1291
FAX:
(360) 586-0341

General Phone:
(253)292-4200
FAX:
(253)292-4219

Date: 1/15/2010

Date: 1-8-2010

Memorandum of Understanding

Children's Long-term Inpatient Program (CLIP)

Attachment A

Protocol for Referral to CLIP

- **The following procedures will be followed when a CLIP referral packet for voluntary treatment is received by OptumHealth PRSN:**
 - 1.1. When a child is identified as potentially needing long-term inpatient services in a CLIP program, the OptumHealth PRSN Children's Care Manager will make an initial review of the packet materials. All referrals must include the findings of a mental health intake evaluation.
 - 1.2. DCFS referrals
 - 1.2.1. The DCFS social worker will be involved in the referral to CLIP for any child receiving services from DCFS and will be invited to all staffings, as would a parent or legal guardian, in which CLIP treatment is being considered. These staffings will review the mental health status and behavior of the child. The staffings will also review the abilities of the immediate and extended family to care for the child and what supports are needed to enable them to provide a safe and nurturing environment for the child.
 - 1.3. All referrals to CLIP will include the goals for mental health treatment in CLIP and the transition and discharge plan when those goals have been achieved. The transition and discharge plan will include recovery and resiliency oriented community-based mental health care, supports to the child and child's proposed caregiver, safety/crisis plan, and involvement with other agencies and support services.
 - 1.4. Completed referral packets will be discussed at the cross-system Children's Alternative Resources Committee (CARC) meetings, which will be facilitated by an OptumHealth PRSN staff member.
 - 1.5. The CARC will make its final recommendation at the conclusion of the meeting.
 - 1.6. The recommendations and rationale of the CARC will be forwarded to the CLIP Administration by an OptumHealth Care Manager when a CLIP referral has been approved.
 - 1.6.1. Rejection of referral
 - 1.6.1.1. If the referral is rejected, the OptumHealth Care Manager will notify the referent and provide the recommended recovery and resiliency oriented mental health care and community alternatives. The CARC will offer to meet with the referent to review the decision and discuss the recommended recovery and resiliency oriented community-based services.
 - 1.6.2. Approval of referral

- 1.6.2.1. If the CARC recommends admission of a child to a CLIP program, the committee will forward the completed application to the CLIP Administration in order to access statewide inpatient resources.
 - 1.6.2.2. The OptumHealth Care Manager will ensure that all required CLIP application materials are submitted prior to CLIP Administration consideration of the CARC's recommendation.
 - 1.7. When a child is approved for admission (or Court-ordered) to a CLIP, and there is not a bed immediately available, the following must occur:
 - 1.7.1. The OptumHealth Care Manager will continue to work with the child/family team to build a strong community placement option and plan of care.
 - 1.7.2. As appropriate, the Pierce FAST team will be involved.
 - 1.8. When a child is approved for admission (or Court-ordered) to a CLIP and it is determined that the child no longer requires CLIP-level services, the following must occur:
 - 1.8.1. A community support and service plan must be implemented.
 - 1.8.2. The OptumHealth Care Manager will continue to stay involved with the child/family team and service providers to support the ongoing delivery of community-services and supports and to monitor the child's progress and additional service needs.
 - 1.8.3. The OptumHealth Care Manager will coordinate with the CLIP Coordinator regarding the status of the CLIP application.
- 2.0 Dispute Resolution
 - 2.1. If any individual disagrees with the formal CARC decision that a child does or does not need admission to a CLIP program, that individual may appeal the decision. OptumHealth PRSN will utilize its standard procedures for review of appeals. Appeals will also be in accordance with the existing local cross system protocols for children served by DSHS.
 - 2.2. If the appellant is not satisfied with the outcome of their appeal s/he may appeal to the CLIP Administration in accord with the CLIP Policies and Procedures. Any appeal to the CLIP Administration must represent the perspectives of both OptumHealth PRSN and the appellant.

- **The following procedures will be followed when a CLIP referral packet for involuntary treatment is received by OptumHealth PRSN:**

- 1.1. For adolescents detained involuntarily in an acute psychiatric setting, CLIP Administration will notify OptumHealth PRSN and a OptumHealth Care Manager will coordinate with the inpatient facility and evaluate the potential for less restrictive services.
- 1.2. The adolescent's name is placed on the waiting list based upon the date of their 180-day order.
- 1.3. OptumHealth PRSN will share the community and/or family recommendations for CLIP program assignment for committed adolescents with the Placement Team.

Pierce County Administrative Manual Review Checklist
WAC 388-877-0400, WAC 388-877-0410 WAC 388-877-0420 and 388-877-0430

Agency Name:

Date of Review:

Each service provider must have and adhere to an administrative manual that contains at a minimum:	YES	NO	COMMENTS
AGENCY ADMINISTRATION - GOVERNING BODY REQUIREMENTS WAC 388-877-0400			
Governing Body is responsible for the conduct and quality of the behavioral health services provided. The agency's governing body must:			
(1) Assure there is an administrator responsible for the day-to-day operation of services			
(2) Maintain a current job description for the administrator, including the administrator's authority and duties.			
(3) Approve the mission statement and quality management plan/process for the services provided.			
(4) Notify the department within 30 days of changes of the administrator.			
AGENCY ADMINISTRATION - ADMINISTRATOR KEY RESPONSIBILITIES WAC 388-877-0410			
(1) The agency's administrator is responsible for the day-to-day operation of the licensed or certified behavioral health treatment services, including:			
(a) All administrative matters;			
(b) Individual care services; and			
(c) Meeting all applicable rules, policies, and ethical standards.			
(2) The administrator must:			
(a) Delegate to staff person the duty and responsibility to act in the administrator's behalf when the administrator is not on duty or on call;			
(b) Ensure administrative, personnel and clinical policies and procedures are adhered to & kept current to be in compliance w/the rules in this chapter.			
(c) Employ sufficient qualified personnel to provide adequate treatment svcs and facility security.			
(d) Ensure all persons providing clinical services are credentialed for their scope of practice as required by DOH.			
(e) Identify at least one person to be responsible for clinical supervision duties.			
(f) Ensure that there is an up-to-date personnel file for each employee, trainee, student, volunteer, and for each contract staff person who provides or supervises an individual's care.			

WAC 388-877-0410 (Continued)	YES	NO	COMMENTS
(g) Ensure that personnel records document that WA State patrol background checks consistent w/RCW 43.43.830 through 43.43.834 have been completed for each employee in contact with individuals receiving services.			
(3) The administrator must ensure the agency develops and maintains a written internal quality management plan/process that:			
(a) addresses the clinical supervision and training of clinical staff;			
(b) Monitors compliance with the rules in this chapter, and other state and federal rules & laws that govern agency licensing & certification requirements; &			
(c) Continuously improves the quality of care in all of the following:			
(i) Cultural competency			
(ii) Use of evidence based and promising practices; and			
(iii) In response to:			
* Critical incidents;			
* Complaints; and			
* Grievances.			
AGENCY ADMINISTRATION POLICIES AND PROCEDURES			
WAC 388-877-0420			
(1) Ownership: Documentation of agency's governing body, including a description of membership and authorities, and documentation of agency's:			
(a) Articles and certificate of incorporation if the owner is a corporation			
(b) Partnership agreement if the owner is a partnership; or			
(c) Sole proprietorship if one person is the owner			
(2) Licensure: Copies of a current master license that authorizes the organization to do business in WA State that:			
(a) Includes the entity name, firm name, or registered trade name; and			
(b) Lists all addresses where the entity performs services.			
(3) Organizational Description: Detailing all positions and associated licensure or certification, updated as needed.			
(4) Agency staffing and supervision: Documentation that shows the agency has staff members			
(a) Adequate in number to provide program-specific certified services to serve the agency's caseload of individuals; and			
(b) Who provide tx in accordance to regulations relevant to their specialty and registration, certification, licensing, and trainee or volunteer status.			

WAC 388-877-0420 (Continued)	YES	NO	COMMENTS
(5) Interpreter services for individuals with Limited English Proficiency (LEP) and individuals who have sensory disabilities.. Documentation that demonstrates the agency's ability to provide or coordinate svcs for individuals who have sensory disabilities.			
(a) Certified interpreters or other interpreter svcs must be available for individuals with LES proficiency and individuals who have sensory disabilities; or			
(b) The agency must have the ability to effectively provide, coordinate or refer individuals in these populations for appropriate assessment or treatment.			
(6) Reasonable access for individuals with disabilities. A description of how reasonable accommodations will be provided to individuals with disabilities.			
(7) Nondiscrimination. A description of how the agency complies with all state and federal nondiscrimination laws, rules, and plans.			
(8) Fee Schedules: A copy of current fee schedules for all services must be available on request.			
(9) Funding options for treatment costs. A description of how the agency works with individuals to address the funding of an individual's treatment costs, including a mechanism to address changes in the individuals ability to pay.			
(10) State/Federal rules on confidentiality. A description of how the agency implements State & Federal rules on individual's confidentiality consistent with the service or services being provided.			
(11) Report & document suspected abuse, neglect, or exploitation. A description in how the agency directs staff to report and document suspected abuse, neglect or exploitation of a child or vulnerable adult consistent with chapters 26.44 and 74.34 RCW..			
(12) Protection of Youth. Documentation of how the agency addresses compliance with program-specific rules and the protection of youth participating in group or residential treatment with adults.			
(13) Reporting the death of an individual seeking or receiving services. A description of how the agency directs staff to report to the department or RSN within one business day the death of any individual which occurs on the premises of a licensed agency.			
(14) Reporting critical incidents. A description of how the agency directs staff to report to the department of RSN, within one business day of any critical incident that occurs involving an individual, and actions taken as a result of the incident.			

WAC 388-877-0420 (Continued)	YES	NO	COMMENTS
(15) A smoking policy Documentation that a smoking policy consistent with Washington Clean Indoor Air Act, chapter 70.160 RCW is in place.			
(16) Outpatient Evacuation Plan. For a nonresidential provider, an evacuation plan for use in the event of a disaster or emergency addressing:			
(a) Different types of disasters;			
(b) Placement of posters showing routes of exit; and Drug Free Work			
(c) The need to mention evacuation routes at public meetings.			
(d) Communication methods for patients, staff, and visitors including persons with a visual or hearing impairment or limitation;			
(e) Evacuation of mobility-impaired persons;			
(f) Evacuation of children if child care is offered;			
(17) Individual rights. A description of how the agency has individual participation rights and policies consistent with WAC 388-877-0600.			
(18) Individual complaints and grievances. A description of how the agency addresses an individual's complaints and/or grievances.			
TREATMENT FACILITY REQUIREMENTS WAC 388-877-0430			
Each agency licensed by the department to provide any behavioral health service must ensure that its treatment facility:			
(1) Is suitable for the purposes intended;			
(2) Is not a personal residence;			
(3) Is accessible to an individual with a disability;			
(4) Has a reception area separate from living and therapy areas;			
(5) Has adequate private space for personal consultation with an individual, staff charting, and therapeutic and social activities, as appropriate;			
(6) Has a secure storage of active or closed confidential records; and			
(7) Has separate secure, locked storage of poisonous external chemical and caustic materials.			

Additional Observations/Notations:

PERSONNEL MANUAL

WAC 388-877-0500, WAC 388-877-0520, and WAC 388-877-0530

Agency Name:

Date of Review:

PERSONNEL - AGENCY POLICIES AND PROCEDURES WAC 388-877-0500	YES	NO	COMMENTS
The Agency must meet the minimum requirements and include the following:			
(1) Hiring Practices. Identification of how the agency:			
(a) Ensures all persons providing or supervising clinical services have an active registration, certification, or license granted by the dept. of health consistent with the services provided; and			
(b) Ensures the requirements of WAC 388-06-0170 are met if the agency provides services to youth.			
(2) Background Checks. Identification of how the agency conducts WA State background checks on each agency employee contact with individuals receiving services, consistent with RCW 43.43.830 through 43.43.842.			
(3) Excluded provider list. A description of how the agency conducts a review of the listing of excluded individuals/entities (LEIE) searchable database (found on the Office of Inspector General, U.S. Dept. of Health and Human Services website at http://oig.hhs.gov) for each employee in contact with individuals receiving svcs. to include a procedures on how the agency:			NEW
(a) Reviewed the LEIE database at the time of employee's hire and annually thereafter; and			
(b) Assured the employee is not currently debarred, suspended, proposed for debarment, declared ineligible, or voluntary excluded from participating in transactions involving certain federal funds.			
(4) Drug free workplace. Identification of how the agency provides for a drug free workplace that includes:			
(a) Agency standards of prohibited conduct; and			
(b) Actions to be taken in the event a staff member misuses alcohol or other drugs.			
(5) Supervision. Identification of how supervision is provided to assist program staff and volunteers to increase their skills, improve quality of services to individuals and families.			
(6) Staff Training. A description of how the agency provides training within 30 of an employee's hire date and annually thereafter;			
(a) Consistent with the agency's certified services.			

WAC 388-877-0500 (Continued)	YES	NO	COMMENTS
(b) On cultural competency that assists staff in recognizing when cultural barriers interfere with clinical care that includes a review of:			
(i) Populations specific to the agency's geographic service area; and			
(ii) Applicable available community resources			
(c) On procedures for how to respond to individuals in crisis that includes a review of:			
(i) Emergency procedures;			
(ii) Program policies and procedures; and			
(iii) Rights for individuals receiving services and supports.			
(d) That addresses the requirements of this chapter.			
SUPERVISION REQUIREMENTS WAC 388-877-0520			
1. Each trainee and intern who received training at a agency must be assigned a supervisor who has been approved by the agency administrator or designee.			
2. The assigned supervisor:			
(a) Must be credentialed by the DOH for their scope of practices;			
(b) Is responsible for all individuals assigned to the trainee or intern they supervise; and			
(c) Must review clinical documentation with the trainee or intern as part of the supervision process.			
VOLUNTEERS AND STUDENT PRACTICUM REQUIREMENTS WAC 388-877-0530			
1. Each volunteer meets the qualification of the position they are assigned.			
2. Each student who uses the agency as a setting for student practicum is supported by an educational institution.			
(a) The agency and the educational institution must have a written agreement that describes:			
(i) The nature and scope of student activity at the treatment setting; and			
(ii) The plan for supervision of student activities.			
(b) The agency must obtain and retain a confidentiality statement signed by the student and the student's academic supervisor.			

Additional Observations/Notations:

Pierce County Clinical Manual Review Checklist
WAC 388-877B-0300 through -0370 and WAC 388-877-0600 through -0650

Date of On-Site Review:

Agency Name:

CHEMICAL DEPENDENCY TREATMENT SERVICES - GENERAL WAC 388-877B-0400	YES	NO	COMMENTS
All Agencies must fully comply with the following:			
(1) Opiate substitution treatment services include the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical,			
(2) An agency must meet all the certification requirements in 877B-0405 in order to provide opiate substitution treatment services and:			
(a) Be licensed by the department as a behavioral health agency;			
(b) Meet the applicable behavioral health agency licensure, certification, administration, personnel, and clinical requirements in chapter 388-877 WAC, Behavioral Health Services Administrative requirements; and			
(c) Have policies and procedures to support and implement the:			
(i) General requirements in chapter 388-877 WAC; and			
(ii) Specific applicable requirements in WAC 388-877B-0400 through 388-877B-0450.			
(3) An agency providing opiate substitution treatment services must ensure that the agency's individual record system complies with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction			
(4) An Agency must:			
(a) Use the PPC for admission, continued services, and discharge planning and decisions.			
(b) Provide education to each individual admitted to the treatment facility on:			
(i) Alcohol, other drugs, and/or chemical dependency;			
(ii) Relapse prevention;			
(iii) Blood borne pathogens; and			
(iv) Tuberculosis (TB)			
(c) Provide education or information to each individual admitted on:			
(i) Emotional, physical, and sexual abuse;			
(ii) Nicotine addiction;			

(iii) The impact of chemical use during pregnancy, risks of the fetus, and the importance of informing medical practitioners of chemical use during pregnancy; and			
(iv) Family planning.			
(d) Have written procedures for:			
(i) Diversion control that contains specific measures to reduce the possibility of the diversion of controlled substances from legitimate treatment use, and assign specific responsibility to the medical and administrative staff members for carrying out the described diversion control measures and functions.			
(ii) Urinalysis and drug testing, to include obtaining:			
A. Specimen samples from each individual, at least eight times within twelve consecutive months.			
B. Random samples, without notice to the individual.			
C. Samples in a therapeutic manner that minimizes falsification.			
D. Observed samples, when clinically appropriate.			
E. Samples handled through proper chain of custody techniques.			
(iii) Laboratory testing.			
(iv) The response to medical and psychiatric emergencies.			
(v) Verifying the identity of an individual receiving treatment services, including maintaining a file in the dispensary with a photograph of the individual and updating the photographs when the individual's physical appearance changes significantly.			
(5) An agency must ensure that an individual is not admitted to opiate substitution treatment detoxification services more than two times in a twelve-month period following admission to services.			
(6) An agency that provides services to a pregnant woman must have a written procedure to address specific issues regarding a woman's pregnancy and prenatal care needs; and to provide referral information to applicable resources.			
(7) An agency that provides youth opiate treatment services must:			
(a) Have a written procedure to assess and refer an individual to the department's child welfare services when applicable; and			
(b) Ensure that counseling sessions with nine to twelve youths include a second adult staff member.			

<p>(c) Ensure that before admission the youth has had two documented attempts at short-term detoxification or drug-free treatment within a twelve-month period, with a waiting period of no less than seven days between the first and second short-term detoxification treatment.</p>			
<p>(d) Ensure that when a youth is admitted for maintenance treatment, written consent by a parent or if applicable, legal guardian or responsible adult designated by the relevant state authority, is obtained.</p>			
<p>(8) An agency providing opiate substitution treatment services must ensure:</p>			
<p>(a) That notification to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the department is made within three weeks of any replacement or other change in the status of the program, program sponsor (as defined in 42 C.F.R. Part 8), or medical director.</p>			
<p>(b) Treatment is provided to an individual in compliance with 42 CFR Part 8.</p>			
<p>(c) The number of individuals receiving treatment services does not exceed three hundred fifty unless authorized by the county, city, or tribal legislative authority in which the program is located.</p>			
<p>(d) The individual record system complies with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction.</p>			
<p>(e) The death of an individual enrolled in OST is reported to the department within one business day.</p>			

(b) The Agency maintains a written procedure of:	YES	NO	COMMENTS
(i) How confidentiality will be maintained at each off-site location, including how confidential information and individual records will be transported between the certified facility and the off-site location; and			
(ii) How services will be offered in a manner that promotes individual and agency staff safety.			
(c) The agency is certified to provide the type of service offered at its main location.			
(d) Chemical dependency assessment or treatment is not the primary purpose of the location where the individual is served (such as in a school, hospital, or correctional facility).			
(e) Services are provided in a private, confidential setting w/i the off-site location.			
(10) Minimum treatment requirements for deferred prosecution are established in chapter 10.05 RCW.			
AGENCY STAFF REQUIREMENTS WAC 388-877B-0405			
An agency providing OST services must:			
(1) Submit to the department documentation that the agency has communicated with the county legislative authority and if applicable, the city legislative authority or tribal legislative authority, in order to secure a location for the new opiate substitution treatment program that meets county, tribal or city land use ordinances.			
(2) Ensure that a community relations plan developed and completed in consultation with the county, city, or tribal legislative authority or their designee, in order to minimize the impact of the opiate substitution treatment programs upon the business and residential neighborhoods in which the program is located. The plan must include:			
(a) Documentation of the strategies used to:			
(i) Obtain stakeholder input regarding the proposed location; (ii) Address any concerns identified by stakeholders; and (iii) Develop an ongoing community relations plan to address new concerns expressed by stakeholders.			
(b) Documentation that transportation systems will provide reasonable opportunities to persons in need of treatment to access the services of the program.			
(c) A copy of the application for:			

(i) A registration certificate from the Washington state board of pharmacy. (ii) Licensure to the federal Drug Enforcement Administration. (iii) Certification to the federal Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). (iv) Accreditation from a federal CSAT/SAMHSA-approved opioid treatment program accreditation body.			
(d) A declaration to limit the number of individual program participants to three hundred fifty as specified in RCW 70.96A.410 (1)(e).			
(e) For new applicants who operate opiate substitution treatment programs in another state, copies of all survey reports written by their national accreditation body and state certification, if applicable, within the past six years.			
(3) Have concurrent approval to provide opiate substitution treatment by:			
(a) The Washington State department of health board of pharmacy; (b) The Federal CSAT SAMHSA, as required by 42 C.F.R. Part 8 for certification as an opioid treatment program; and (c) The federal Drug Enforcement Administration.			
(4) An agency must ensure that opiate substitution treatment is provided to an individual in compliance with the applicable requirements in 42 C.F.R. Part 8 and 21 C.F.R. Part 1301.			
(5) The department may deny an application for certification when:			
(a) There is not a demonstrated need in the community where the applicant proposes to locate the program. (b) There is sufficient availability, access, and capacity of other certified programs near the area where the applicant is proposing to locate the program. (c) The applicant has not demonstrated in the past, the capability to provide the appropriate services to assist individuals using the program to meet goals established by the legislature.			
AGENCY STAFF REQUIREMENTS WAC 388-877B-0410			
An agency providing OST services must ensure:			
(1) Appoint a program sponsor, as defined in 42 C.F.R. Part 8, who is responsible for notifying the federal Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), the federal Drug Enforcement Administration (DEA), the department, and the Washington State board of pharmacy of any theft or significant loss of a controlled substance.			

(2) Ensure there is an appointed medical director who:			
(a) Is licensed by DOH to practice medicine and practices within their scope of practice.			
(b) Is responsible for all medical services performed. See the program physician responsibilities in WAC 388-877B-0440.			
(c) Ensures all medical services provided are in compliance with applicable federal, state, and local rules and laws.			
(3) Ensure all medical services provided are provided by an appropriate DOH-credentialed medical provider practicing within their scope of practice.			
(4) Ensure all chemical dependency assessment and counseling services are provided by a DOH-credentialed chemical dependency professional (CDP), or a CDP trainee (CDPT) under the supervision of an approved supervisor.			
(c) Is responsible for monitoring the continued competency of each CDP in assessment, tx, continuing care, transfer, and d/c. The monitoring must include a semi-annual review of a sample of the clinical records kept by the CDP; and			
(d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180.			
(4) Each chemical dependency professional trainee has at least one approved supervisor who meets the qualifications in WAC 246-811-049. An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.			
(5) Ensure there is a designated and identified clinical supervisor who:			
(a) Is a CDP			
(b) Has documented competency in clinical supervision			
(c) Is responsible for monitoring the continued competency of each CDP in assessment, treatment, continuing care, transfer, and discharge. This monitoring must include a semi-annual review of a sample of each CDP's clinical records.			
(d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180.			

(6) Ensure an agency using CDPTs has at least one approved supervisor that meets the qualification in WAC 246-811-049. An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.

(7) ensure at least one staff memeber has documened training in:

(a) Family planning; (b) Prenatal health care; and (c) Parenting skills.			
(a) Family planning; (b) Prenatal health care; and (c) Parenting skills.			
(8) Ensure that at least one staff member is on duty at all times who has documented training in:			
(a) Cardiopulmonary resuscitation (CPR); and (b) Management of opiate overdose.			
(9) Ensure that a personnel file for a staff member providing individual care includes a copy of an initial tuberculosis (TB) screen and subsequent screening as appropriate.			
(10) Provide and ensure all staff members receive annual training on:			
(a) The prevention and control of communicable disease, blood borne pathogens and TB; and			
(b) Opiate dependency clinical and medical best practice, specific to the staff member's scope of practice and job function.			
CLINICAL RECORD CONTENT AND DOCUMENTATION WAC 388-877B-0420			
An agency providing chemical dependency outpatient treatment services must ensure:			
(1) The clinical record must contain:			
(a) Documentation the individual was informed of federal confidentiality requirements and received a copy of the individual notice required under 42 C.F.R. Part 2.			
START HERE (b) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanctions.			
(c) Documentation that the initial individual service plan was completed before treatment services are received.			
(d) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			

(e) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:			
(i) The individual's demographic information; and			
(ii) The diagnostic assessment statement and other assessment information to include:			
(A) Documentation of the HIV/AIDS intervention.			
(B) Tuberculosis (TB) screen or test result.			
(C) A record of the individual's detoxification and treatment history.			
(D) The reason for the individual's transfer.			
(E) Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.			
(F) A discharge summary and continuing care plan.			
(f) Justification for the change in the level of care when transferring an individual from one certified treatment service to another within the same agency, at the same location.			

(g) Documentation that staff members met with each individual at the time of discharge, unless the individual left without notice, to:	YES	NO	COMMENTS
(i) Determine the appropriate recommendation for care and finalize a continuing care plan.			
(ii) Assist the individual in making contact with necessary agencies or services.			
(iii) Provide and document the individual was provided with a copy of the plan.			
(h) Documentation that a discharge summary was completed within seven days of the individual's discharge, including the date of discharge, a summary of the			
(2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:			
(a) Be personalized to the individual's unique treatment needs;			
(b) Include individual needs identified in the diagnostic and periodic reviews, addressing:			
(i) All substance use needing treatment, including tobacco, if necessary;			
(ii) The individual's bio-psychosocial problems;			
(iii) Treatment goals;			
(iv) Estimated dates or conditions for completion of each treatment goal; and			
(v) Approaches to resolve the problem.			
(c) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.			
(d) Document that the plan was updated to reflect any changes in the individual's treatment needs, or as requested by the individual, at least once per month for the first three months, and at least quarterly thereafter.			
(e) Document that the plan has been reviewed with the individual.			
ADDITIONAL ASSESSMENT STANDARDS			
WAC 388-877B-0330			
The Agency must ensure the Assessment include:			
(1) A face-to-face diagnostic interview with the individual in order to obtain, review, evaluate, and document a history of the individual's involvement with alcohol and other drugs, including:			
(a) The type of substances used, including tobacco;			
(b) The route of administration; and			
(c) The amount, frequency, and duration of use.			
(2) A history of alcohol or other drug treatment or education.			
(3) The individual's self-assessment of use of alcohol and other drugs.			

WAC 388-877B-0330 (Continued)	YES	NO	COMMENTS
(4) A history of relapse.			
(5) A history of self-harm.			
(6) A history of legal involvement.			
(7) A statement regarding the provide of an HIV/AIDS brief risk intervention, and any referral made.			
(8) A diagnostic assessment statement, including sufficient information to determine the individual's diagnosis using:			
(a) Diagnostic and Statistical Manual (DSM IV TR, 2000) as it existed on the effective date of this section; then			
(b) DSM-5 as it exists when published and released in 2013, consistent with the purposes of this section. Information regarding the publication date and release of the DSM-5 is posted on the American Psychiatric Association's public website at www.DSM5.org .			
(9) A placement decision, using PPC dimensions when the assessment indicates the individual is in need of services.			
(10) Evidence the individual was notified of the assessment results and documentation of the treatment options provided and the individual's choice. If the individual was not notified of the results and advised of referral options, the reason must be documented.			
(11) The additional requirements outlined under WAC 388-877B-0550 for driving under the influence (DUI) assessments, for an agency providing services to an individual under RCW 46.61.5056.			
(12) Documented attempts to obtain the following information when assessing youth:			
(a) Parental and sibling use of alcohol and other drugs.			
(b) A history of school assessments for learning disabilities or other problems, which may affect ability to understand written materials.			
(c) Past and present parent/guardian custodial status, including a history of running away and out-of-home placements.			
(d) A history of emotional or psychological problems.			
(e) A history of child or adolescent developmental problems.			
(f) The ability of parents, or if applicable, a legal guardian to participate in treatment.			

NON COMPLIANCE REPORTING REQUIREMENTS WAC 388-877B-0340	YES	NO	COMMENTS
An agency providing treatment to a court-mandated individual, including deferred prosecution, must develop procedures addressing individual noncompliance and reporting requirements, including:			
(1) Completing an authorization to release confidential information form that meets the requirements of 42 C.F.R. Part 2 and 45 C.F.R. Parts 160 and 164 or through a court order authorizing the disclosure pursuant to 42 C.F.R. Part 2, Sections 2.63			
(2) Notifying the designated chemical dependency specialist within three working days from obtaining information of any violation of the terms of the court order for purposes of revocation of the individual's conditional release, or department of corrections (DOC) if the individual is under DOC supervision.			
(3) Reporting and recommending action for emergency noncompliance to the court or other appropriate jurisdiction(s) within three working days from obtaining information on:			
(a) An individual's failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by individual's self-report, identified third party report confirmed by the agency, or blood alcohol content or other laboratory test.			
(b) An individual's report of subsequent alcohol and/or drug related arrests.			
(c) An individual leaving the program against program advice or an individual discharged for rule violation.			
(4) Reporting and recommending action for nonemergent, noncompliance to the court or other appropriate jurisdiction(s) within ten working days from the end of each reporting period, upon obtaining information on:			
(a) An individual's unexcused absences or failure to report, including failure to attend mandatory self-help groups.			
(b) An individual's failure to make acceptable progress in any part of the treatment plan.			
(5) Transmitting noncompliance or other significant changes as soon as possible, but no longer than ten working days from the date of the noncompliance, when the court does not wish to receive monthly reports.			
(6) Reporting compliance status of persons convicted under chapter 46.61 RCW to the department of licensing.			

LEVEL II INTENSIVE OUTPATIENT SERVICES WAC 388-877B-0350	YES	NO	COMMENTS
An agency providing Level II intensive outpatient treatment services must:			
(1) Develop an pt. service plan prior to the individual's participation in tx.			
(2) Provide patient cd counseling sessions with each individual at least once a month or more if clinically indicated.			
(3) Documentation of progress in a timely manner & before any subsequent scheduled appointments of the same type of service session or group type occur, or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
(4) Conduct and document a review of each individual's service plan in individual counseling sessions, at least once a month, to assess adequacy and attainment of goals.			
(5) Refer for ongoing tx or support upon completion of intensive op tx, as necessary,.			
(6) Ensure that patients admitted under a deferred prosecution order under Chapter 10.05 RCW:			
(a) Receive a minimum of 72 hours of tx services w/i a maximum of 12 weeks, which consist of the following during the first four weeks of treatment:			
(i) At least 3 sessions each week, with each session occurring on separate days of the week.			
(ii) Group sessions must last at least one hour.			
(b) Attend self-help groups in addition to the 72 hours of treatment services.			
(c) Have approval, in writing, by the court having jurisdiction in the case, when there is any exception to the requirements in this subsection.			
LEVEL I OUTPATIENT TREATMENT SERVICES WAC 388-877B-0360			
An agency providing Level I outpatient treatment services must:			
(1) Develop an initial individual service plan before the individual's participation in treatment.			
(2) Conduct group or individual chemical dependency counseling sessions for each individual, each month, according to an individual service plan.			
(3) Conduct and document an individual service plan review for each individual once a month for the first three months and quarterly thereafter or sooner if required by other laws.			

WAC 388-877B-0360 (Continued)	YES	NO	COMMENTS
(4) Document progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur, or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
PROGRAM-SPECIFIC CERTIFICATION WAC 388-877B-0370			
An agency providing services subject to 46.61.5056 must ensure the following:			
(1) Treatment during the first sixty days must include:			
(a) Weekly group or individual chemical dependency counseling sessions according to the individual service plan.			
(b) One individual chemical dependency counseling session of not less than thirty minutes duration, excluding the time taken for a chemical dependency assessment, for each individual, according to the individual service plan.			
(c) Alcohol and drug basic education for each individual.			
(d) Participation in self-help groups for an individual with a diagnosis of substance dependence. Participation must be documented in the individual's clinical record.			
(e) The balance of the sixty-day time period for individuals who complete intensive inpatient chemical dependency treatment services must include, at a minimum, weekly outpatient counseling sessions according to the individual service plan.			
(2) The next one hundred twenty days of treatment includes:			
(a) Group or individual chemical dependency counseling sessions every two weeks according to the individual service plan.			
(b) One individual chemical dependency counseling session of not less than thirty minutes duration, every sixty days according to the individual service plan.			
(c) Referral of each individual for ongoing treatment or support, as necessary, using PPC, upon completion of one hundred eighty days of treatment.			
(3) For an individual who is assessed with insufficient evidence of a substance use disorder, a chemical dependency professional (CDP) must refer the individual to alcohol/drug information school.			

INDIVIDUAL RIGHTS WAC 388-877-0600	YES	NO	COMMENTS
An agency must provide the following:			
(1) Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 70.96A, 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:			
(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;			
(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;			
(c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;			
(d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the			
(e) Be free of any sexual harassment;			
(f) Be free of exploitation, including physical and financial exploitation;			
(g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;			
(h) Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;			
(j) File a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.			
(2) Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:			
(a) Provided in writing to each individual on or before admission;			
(b) Available in alternative formats for individuals who are blind;			
(c) Translated to the most commonly used languages in the agency's service area;			
(d) Posted in public areas; and			
(e) Available to any participant upon request.			

WAC 388-877-0600 (Continued)	YES	NO	COMMENTS
(3) Each agency must ensure all research concerning an individual whose cost of care is publicly funded is done in accordance with chapter 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.			
(4) In addition to the requirements in this section, each agency enrolled as a medicare and/or medicaid provider must ensure an individual seeking or participating in behavioral health treatment services, or the person legally responsible for the individual is informed of their medicaid rights at time of admission and in a manner that is understandable to the individual or legally responsible person.			
INITIAL ASSESSMENT WAC 388-877-0610			
Each Agency is responsible for an individual initial assessment			
(1) The initial assessment must be:			
(a) Conducted in person; and			
(b) Completed by a professional appropriately credentialed or qualified to provide chemical dependency, mental health, and/or problem and pathological gambling services as determined by state law.			
(2) The initial assessment must include and document the individual's:			
(a) Identifying information;			
(b) Presenting issues;			
(c) Medical provider's name or medical providers' names;			
(d) Medical concerns;			
(e) Medications currently taken;			
(f) Brief mental health history;			
(g) Brief substance use history, including tobacco;			
(h) Brief problem and pathological gambling history;			
(i) The identification of any risk of harm to self and others, including suicide and/or homicide;			
(j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;			
(k) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and			
(l) Treatment recommendations or recommendations for additional program-specific assessment.			

INDIVIDUAL SERVICE PLAN WAC 388-877-0620	YES	NO	COMMENTS
Each Agency is responsible for an individual's service plan as follows:			
(1) The individual service plan must:			
(a) Be completed or approved by a professional appropriately credentialed or qualified to provide mental health, chemical dependency, and/or problem and			
(b) Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.			
(c) Be in a terminology that is understandable to the individual and the individual's family.			
(d) Document that the plan was mutually agreed upon and a copy was provided to the individual.			
(e) Demonstrate the individual's participation in the development of the plan.			
(f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.			
(g) Be strength-based.			
(h) Contain measurable goals or objectives, or both.			
(i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.			
(2) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.			
INDIVIDUAL CLINICAL RECORD SYSTEM WAC 388-877-0630			
Each Agency is responsible for the following:			
(1) Maintain a comprehensive clinical record system that includes policies and procedures that protect an individual's personal health information; and			
(2) Ensure that the individual's personal health information is shared or released only in compliance with applicable state and federal law.			
(3) If maintaining electronic individual clinical records:			
(a) Provide secure, limited access through means that prevent modification or deletion after initial preparation;			
(b) Provide for a backup of records in the event of equipment, media, or human error; and			
(c) Provide for protection from unauthorized access, including network and internet access.			
(4) Retain an individual's clinical record, including an electronic record, for a minimum of six years after the discharge or transfer of any individual.			

WAC 388-877-0630 (Continued)	YES	NO	COMMENTS
(5) Retain a youth's or child's individual clinical record, including an electronic record, for at least six years after the most recent discharge, or at least three years following the youth's or child's eighteenth birthday.			
(6) Meet the access to clinical records requirements in WAC 388-877-0650.			
CLINICAL RECORD CONTENT WAC 388-877-0640			
Each Agency is responsible for the individual's clinical record that must include:			
(1) Documentation the individual received a copy of counselor disclosure requirements established under RCW 18.19.060.			
(2) Demographic information.			
(3) An initial assessment.			
(4) Documentation of the individual's response when asked if:			
(a) The individual is under department of corrections (DOC) supervision.			
(b) The individual is under civil or criminal court ordered mental health or chemical dependency treatment.			
(c) There is a court order exempting the individual participant from reporting requirements. A copy of the court order must be included in the record if the participant claims exemption from reporting requirements.			
(5) Documentation that the agency met all the following requirements when an individual informs the agency that the individual is under supervision by DOC due to a less restrictive alternative or DOC order for treatment:			
(a) The agency notified DOC orally or in writing. The agency must confirm an oral notification with a written notice by electronic mail or fax.			
(b) The agency obtained a copy of the court order from the individual and placed it in the record when the individual has been given relief from disclosure by the committing court.			
(c) When appropriate, the agency requested an evaluation by a designated mental health professional when the provider becomes aware of a violation of the court-			
(6) The initial and any subsequent individual service plan that include:			
(a) All revisions to the plan, consistent with the service(s) the individual receives; and			
(b) Documentation of objective progress towards established goals as outlined in the plan.			
(7) Documentation the individual was informed of applicable federal and state confidentiality requirements.			

WAC 388-877-0640 (Continued)	YES	NO	COMMENTS
(8) Documentation of confidential information that has been released without the consent of the individual under RCW 70.02.050, 71.05.390, and 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA).			
(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred.			
(10) If treatment is not court-ordered, documentation of informed consent to treatment by the individual or individual's parent, or other legal representative.			
(11) If treatment is court-ordered, a copy of the detention or involuntary tx order.			
(12) Documentation of coordinator of care, as needed.			
(13) Documentation of all service encounters.			
(14) Medication records, if applicable.			
(15) Laboratory reports, if applicable.			
(16) Properly completed authorizes for release of information, If applicable.			
(17) Copies of applicable correspondence.			
(18) Discharge Information.			
CLINICAL RECORD ACCESS WAC 388-877-0650			
(1) Each Agency must provide access to an individual's clinical record at the request of the individual or, if applicable, the individual's designated representative, and/or legal representative. The agency must:			
(a) Review the clinical record before making the record available in order to identify and remove:			
(i) Any material confidential to another person, agency, or provider; and			
(ii) Reports not originated by the agency.			
(b) Make the clinical rec available to the requester w/i 15 days of the request.			
(c) Allow appropriate time and privacy for the review.			
(d) Have a clinical staff member available to answer questions.			
(e) Charge for copying at a rate not higher than defined in RCW 70.02.010(12).			
(f) Meet the individual clinical record system criteria in WAC 388-877-0630.			
(2) Make an individual's clinical record available to department staff as required for department program review.			
(3) If the agency maintains electronic individual clinical records, the agency must:			
(a) Make the clinical record available in paper form; and			
(b) Meet the criteria in (1) and (2) of this section.			

**Pierce County Clinical Manual Review Checklist
WAC 388-877B-**

Date of On-Site Review:
Agency Name:

CHEMICAL DEPENDENCY TREATMENT SERVICES - GENERAL WAC 388-877B-0400	YES	NO	COMMENTS
All Agencies must fully comply with the following:			
(1) Opiate substitution treatment services include the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical,			
(2) An agency must meet all the certification requirements in 877B-0405 in order to provide opiate substitution treatment services and:			
(a) Be licensed by the department as a behavioral health agency;			
(b) Meet the applicable behavioral health agency licensure, certification, administration, personnel, and clinical requirements in chapter 388-877 WAC, Behavioral Health Services Administrative requirements; and			
(c) Have policies and procedures to support and implement the:			
(i) General requirements in chapter 388-877 WAC; and			
(ii) Specific applicable requirements in WAC 388-877B-0400 through 388-877B-0450.			
(3) An agency providing opiate substitution treatment services must ensure that the agency's individual record system complies with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction			
(4) An Agency must:			
(a) Use the PPC for admission, continued services, and discharge planning and decisions.			
(b) Provide education to each individual admitted to the treatment facility on:			
(i) Alcohol, other drugs, and/or chemical dependency;			
(ii) Relapse prevention;			
(iii) Blood borne pathogens; and			
(iv) Tuberculosis (TB)			
(c) Provide education or information to each individual admitted on:			
(i) Emotional, physical, and sexual abuse;			
(ii) Nicotine addiction;			

(iii) The impact of chemical use during pregnancy, risks of the fetus, and the importance of informing medical practitioners of chemical use during pregnancy; and			
(iv) Family planning.			
(d) Have written procedures for:			
(i) Diversion control that contains specific measures to reduce the possibility of the diversion of controlled substances from legitimate treatment use, and assign specific responsibility to the medical and administrative staff members for carrying out the described diversion control measures and functions.			
(ii) Urinalysis and drug testing, to include obtaining:			
A. Specimen samples from each individual, at least eight times within twelve consecutive months.			
B. Random samples, without notice to the individual.			
C. Samples in a therapeutic manner that minimizes falsification.			
D. Observed samples, when clinically appropriate.			
E. Samples handled through proper chain of custody techniques.			
(iii) Laboratory testing.			
(iv) The response to medical and psychiatric emergencies.			
(v) Verifying the identity of an individual receiving treatment services, including maintaining a file in the dispensary with a photograph of the individual and updating the photographs when the individual's physical appearance changes significantly.			
(5) An agency must ensure that an individual is not admitted to opiate substitution treatment detoxification services more than two times in a twelve-month period following admission to services.			
(6) An agency that provides services to a pregnant woman must have a written procedure to address specific issues regarding a woman's pregnancy and prenatal care needs; and to provide referral information to applicable resources.			
(7) An agency that provides youth opiate treatment services must:			
(a) Have a written procedure to assess and refer an individual to the department's child welfare services when applicable; and			
(b) Ensure that counseling sessions with nine to twelve youths include a second adult staff member.			

(c) Ensure that before admission the youth has had two documented attempts at short-term detoxification or drug-free treatment within a twelve-month period, with a waiting period of no less than seven days between the first and second short-term detoxification treatment.			
(d) Ensure that when a youth is admitted for maintenance treatment, written consent by a parent or if applicable, legal guardian or responsible adult designated by the relevant state authority, is obtained.			
(8) An agency providing opiate substitution treatment services must ensure:			
(a) That notification to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the department is made within three weeks of any replacement or other change in the status of the program, program sponsor (as defined in 42 C.F.R. Part 8), or medical director.			
(b) Treatment is provided to an individual in compliance with 42 CFR Part 8.			
(c) The number of individuals receiving treatment services does not exceed three hundred fifty unless authorized by the county, city, or tribal legislative authority in which the program is located.			
(d) The individual record system complies with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction.			
(e) The death of an individual enrolled in OST is reported to the department within one business day.			
(b) The Agency maintains a written procedure of:	YES	NO	COMMENTS
(i) How confidentiality will be maintained at each off-site location, including how confidential information and individual records will be transported between the certified facility and the off-site location; and			
(ii) How services will be offered in a manner that promotes individual and agency staff safety.			
(c) The agency is certified to provide the type of service offered at its main location.			
(d) Chemical dependency assessment or treatment is not the primary purpose of the location where the individual is served (such as in a school, hospital, or correctional facility).			
(e) Services are provided in a private, confidential setting w/i the off-site location.			
(10) Minimum treatment requirements for deferred prosecution are established in chapter 10.05 RCW.			
AGENCY STAFF REQUIREMENTS WAC 388-877B-0405			

An agency providing OST services must:			
(1) Submit to the department documentation that the agency has communicated with the county legislative authority and if applicable, the city legislative authority or tribal legislative authority, in order to secure a location for the new opiate substitution treatment program that meets county, tribal or city land use ordinances.			
(2) Ensure that a community relations plan developed and completed in consultation with the county, city, or tribal legislative authority or their designee, in order to minimize the impact of the opiate substitution treatment programs upon the business and residential neighborhoods in which the program is located. The plan must include:			
(a) Documentation of the strategies used to:			
(i) Obtain stakeholder input regarding the proposed location; (ii) Address any concerns identified by stakeholders; and (iii) Develop an ongoing community relations plan to address new concerns expressed by stakeholders.			
(b) Documentation that transportation systems will provide reasonable opportunities to persons in need of treatment to access the services of the program.			
(c) A copy of the application for:			
(i) A registration certificate from the Washington state board of pharmacy. (ii) Licensure to the federal Drug Enforcement Administration. (iii) Certification to the federal Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). (iv) Accreditation from a federal CSAT/SAMHSA-approved opioid treatment program accreditation body.			
(d) A declaration to limit the number of individual program participants to three hundred fifty as specified in RCW 70.96A.410 (1)(e).			
(e) For new applicants who operate opiate substitution treatment programs in another state, copies of all survey reports written by their national accreditation body and state certification, if applicable, within the past six years.			
(3) Have concurrent approval to provide opiate substitution treatment by:			

(a) The Washington State department of health board of pharmacy; (b) The Federal CSAT SAMHSA, as required by 42 C.F.R. Part 8 for certification as an opioid treatment program; and (c) The federal Drug Enforcement Administration.			
(4) An agency must ensure that opiate substitution treatment is provided to an individual in compliance with the applicable requirements in 42 C.F.R. Part 8 and 21 C.F.R. Part 1301.			
(5) The department may deny an application for certification when:			
(a) There is not a demonstrated need in the community where the applicant proposes to locate the program. (b) There is sufficient availability, access, and capacity of other certified programs near the area where the applicant is proposing to locate the program. (c) The applicant has not demonstrated in the past, the capability to provide the appropriate services to assist individuals using the program to meet goals established by the legislature.			
AGENCY STAFF REQUIREMENTS WAC 388-877B-0410			
An agency providing OST services must ensure:			
(1) Appoint a program sponsor, as defined in 42 C.F.R. Part 8, who is responsible for notifying the federal Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), the federal Drug Enforcement Administration (DEA), the department, and the Washington State board of pharmacy of any theft or significant loss of a controlled substance.			
(2) Ensure there is an appointed medical director who:			
(a) Is licensed by DOH to practice medicine and practices within their scope of practice.			
(b) Is responsible for all medical services performed. See the program physician responsibilities in WAC 388-877B-0440.			
(c) Ensures all medical services provided are in compliance with applicable federal, state, and local rules and laws.			
(3) Ensure all medical services provided are provided by an appropriate DOH-credentialed medical provider practicing within their scope of practice.			

(4) Ensure all chemical dependency assessment and counseling services are provided by a DOH-credentialed chemical dependency professional (CDP), or a CDP trainee (CDPT) under the supervision of an approved supervisor.			
(c) Is responsible for monitoring the continued competency of each CDP in assessment, tx, continuing care, transfer, and d/c. The monitoring must include a semi-annual review of a sample of the clinical records kept by the CDP; and			
(d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180.			
(4) Each chemical dependency professional trainee has at least one approved supervisor who meets the qualifications in WAC 246-811-049. An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.			
(5) Ensure there is a designated and identified clinical supervisor who:			
(a) Is a CDP			
(b) Has documented competency in clinical supervision			
(c) Is responsible for monitoring the continued competency of each CDP in assessment, treatment, continuing care, transfer, and discharge. This monitoring must include a semi-annual review of a sample of each CDP's clinical records.			
(d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180.			
(6) Ensure an agency using CDPTs has at least one approved supervisor that meets the qualification in WAC 246-811-049. An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.			
(7) ensure at least one staff member has documented training in:			
(a) Family planning; (b) Prenatal health care; and (c) Parenting skills.			
(a) Family planning; (b) Prenatal health care; and (c) Parenting skills.			

(8) Ensure that at least one staff member is on duty at all times who has documented training in:			
(a) Cardiopulmonary resuscitation (CPR); and (b) Management of opiate overdose.			
(9) Ensure that a personnel file for a staff member providing individual care includes a copy of an initial tuberculosis (TB) screen and subsequent screening as appropriate.			
(10) Provide and ensure all staff members receive annual training on:			
(a) The prevention and control of communicable disease, blood borne pathogens and TB; and			
(b) Opiate dependency clinical and medical best practice, specific to the staff member's scope of practice and job function.			
CLINICAL RECORD CONTENT AND DOCUMENTATION WAC 388-877B-0420			
An agency providing chemical dependency outpatient treatment services must ensure:			
(1) The clinical record must contain:			
(a) Documentation the individual was informed of federal confidentiality requirements and received a copy of the individual notice required under 42 C.F.R. Part 2.			
START HERE (b) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanctions.			
(c) Documentation that the initial individual service plan was completed before treatment services are received.			
(d) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
(e) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:			
(i) The individual's demographic information; and			
(ii) The diagnostic assessment statement and other assessment information to include:			
(A) Documentation of the HIV/AIDS intervention.			
Clinical Manual - OST			

(B) Tuberculosis (TB) screen or test result.			
(C) A record of the individual's detoxification and treatment history.			
(D) The reason for the individual's transfer.			
(E) Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.			
(F) A discharge summary and continuing care plan.			
(f) Justification for the change in the level of care when transferring an individual from one certified treatment service to another within the same agency, at the same location.			
(g) Documentation that staff members met with each individual at the time of discharge, unless the individual left without notice, to:	YES	NO	COMMENTS
(i) Determine the appropriate recommendation for care and finalize a continuing care plan.			
(ii) Assist the individual in making contact with necessary agencies or services.			
(iii) Provide and document the individual was provided with a copy of the plan.			
(h) Documentation that a discharge summary was completed within seven days of the individual's discharge, including the date of discharge, a summary of the individual's			
(2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:			
(a) Be personalized to the individual's unique treatment needs;			
(b) Include individual needs identified in the diagnostic and periodic reviews, addressing:			
(i) All substance use needing treatment, including tobacco, if necessary;			
(ii) The individual's bio-psychosocial problems;			
(iii) Treatment goals;			
(iv) Estimated dates or conditions for completion of each treatment goal; and			
(v) Approaches to resolve the problem.			
(c) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.			
(d) Document that the plan was updated to reflect any changes in the individual's treatment needs, or as requested by the individual, at least once per month for the first three months, and at least quarterly thereafter.			
(e) Document that the plan has been reviewed with the individual.			
ADDITIONAL ASSESSMENT STANDARDS			
WAC 388-877B-0330			
The Agency must ensure the Assessment include:			
(1) A face-to-face diagnostic interview with the individual in order to obtain, review, evaluate, and document a history of the individual's involvement with alcohol and other drugs, including:			

(a) The type of substances used, including tobacco;			
(b) The route of administration; and			
(c) The amount, frequency, and duration of use.			
(2) A history of alcohol or other drug treatment or education.			
(3) The individual's self-assessment of use of alcohol and other drugs.			
WAC 388-877B-0330 (Continued)	YES	NO	COMMENTS
(4) A history of relapse.			
(5) A history of self-harm.			
(6) A history of legal involvement.			
(7) A statement regarding the provide of an HIV/AIDS brief risk intervention, and any referral made.			
(8) A diagnostic assessment statement, including sufficient information to determine the individual's diagnosis using:			
(a) Diagnostic and Statistical Manual (DSM IV TR, 2000) as it existed on the effective date of this section; then			
(b) DSM-5 as it exists when published and released in 2013, consistent with the purposes of this section. Information regarding the publication date and release of the DSM-5 is posted on the American Psychiatric Association's public website at www.DSM5.org .			
(9) A placement decision, using PPC dimensions when the assessment indicates the individual is in need of services.			
(10) Evidence the individual was notified of the assessment results and documentation of the treatment options provided and the individual's choice. If the individual was not notified of the results and advised of referral options, the reason must be documented.			
(11) The additional requirements outlined under WAC 388-877B-0550 for driving under the influence (DUI) assessments, for an agency providing services to an individual under RCW 46.61.5056.			
(12) Documented attempts to obtain the following information when assessing youth:			
(a) Parental and sibling use of alcohol and other drugs.			
(b) A history of school assessments for learning disabilities or other problems, which may affect ability to understand written materials.			
(c) Past and present parent/guardian custodial status, including a history of running away and out-of-home placements.			
(d) A history of emotional or psychological problems.			
(e) A history of child or adolescent developmental problems.			
(f) The ability of parents, or if applicable, a legal guardian to participate in treatment.			

NON COMPLIANCE REPORTING REQUIREMENTS WAC 388-877B-0340	YES	NO	COMMENTS
An agency providing treatment to a court-mandated individual, including deferred prosecution, must develop procedures addressing individual noncompliance and reporting requirements, including:			
(1) Completing an authorization to release confidential information form that meets the requirements of 42 C.F.R. Part 2 and 45 C.F.R. Parts 160 and 164 or through a court order authorizing the disclosure pursuant to 42 C.F.R. Part 2, Sections 2.63 through 2.67.			
(2) Notifying the designated chemical dependency specialist within three working days from obtaining information of any violation of the terms of the court order for purposes of revocation of the individual's conditional release, or department of corrections (DOC) if the individual is under DOC supervision.			
(3) Reporting and recommending action for emergency noncompliance to the court or other appropriate jurisdiction(s) within three working days from obtaining information on:			
(a) An individual's failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by individual's self-report, identified third party report confirmed by the agency, or blood alcohol content or other laboratory test.			
(b) An individual's report of subsequent alcohol and/or drug related arrests.			
(c) An individual leaving the program against program advice or an individual discharged for rule violation.			
(4) Reporting and recommending action for nonemergent, noncompliance to the court or other appropriate jurisdiction(s) within ten working days from the end of each reporting period, upon obtaining information on:			
(a) An individual's unexcused absences or failure to report, including failure to attend mandatory self-help groups.			
(b) An individual's failure to make acceptable progress in any part of the treatment plan.			
(5) Transmitting noncompliance or other significant changes as soon as possible, but no longer than ten working days from the date of the noncompliance, when the court does not wish to receive monthly reports.			
(6) Reporting compliance status of persons convicted under chapter 46.61 RCW to the department of licensing.			
LEVEL II INTENSIVE OUTPATIENT SERVICES WAC 388-877B-0350	YES	NO	COMMENTS
An agency providing Level II intensive outpatient treatment services must:			
(1) Develop an pt. service plan prior to the individual's participation in tx.			

(2) Provide patient cd counseling sessions with each individual at least once a month or more if clinically indicated.			
(3) Documentation of progress in a timely manner & before any subsequent scheduled appointments of the same type of service session or group type occur, or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
(4) Conduct and document a review of each individual's service plan in individual counseling sessions, at least once a month, to assess adequacy and attainment of goals.			
(5) Refer for ongoing tx or support upon completion of intensive op tx, as necessary,.			
(6) Ensure that patients admitted under a deferred prosecution order under Chapter 10.05 RCW:			
(a) Receive a minimum of 72 hours of tx services w/i a maximum of 12 weeks, which consist of the following during the first four weeks of treatment:			
(i) At least 3 sessions each week, with each session occurring on separate days of the week.			
(ii) Group sessions must last at least one hour.			
(b) Attend self-help groups in addition to the 72 hours of treatment services.			
(c) Have approval, in writing, by the court having jurisdiction in the case, when there is any exception to the requirements in this subsection.			
LEVEL I OUTPATIENT TREATMENT SERVICES WAC 388-877B-0360			
An agency providing Level I outpatient treatment services must:			
(1) Develop an initial individual service plan before the individual's participation in treatment.			
(2) Conduct group or individual chemical dependency counseling sessions for each individual, each month, according to an individual service plan.			
(3) Conduct and document an individual service plan review for each individual once a month for the first three months and quarterly thereafter or sooner if required by other laws.			
WAC 388-877B-0360 (Continued)	YES	NO	COMMENTS
(4) Document progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur, or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			

PROGRAM-SPECIFIC CERTIFICATION WAC 388-877B-0370			
An agency providing services subject to 46.61.5056 must ensure the following:			
(1) Treatment during the first sixty days must include:			
(a) Weekly group or individual chemical dependency counseling sessions according to the individual service plan.			
(b) One individual chemical dependency counseling session of not less than thirty minutes duration, excluding the time taken for a chemical dependency assessment, for each individual, according to the individual service plan.			
(c) Alcohol and drug basic education for each individual.			
(d) Participation in self-help groups for an individual with a diagnosis of substance dependence. Participation must be documented in the individual's clinical record.			
(e) The balance of the sixty-day time period for individuals who complete intensive inpatient chemical dependency treatment services must include, at a minimum, weekly outpatient counseling sessions according to the individual service plan.			
(2) The next one hundred twenty days of treatment includes:			
(a) Group or individual chemical dependency counseling sessions every two weeks according to the individual service plan.			
(b) One individual chemical dependency counseling session of not less than thirty minutes duration, every sixty days according to the individual service plan.			
(c) Referral of each individual for ongoing treatment or support, as necessary, using PPC, upon completion of one hundred eighty days of treatment.			
(3) For an individual who is assessed with insufficient evidence of a substance use disorder, a chemical dependency professional (CDP) must refer the individual to alcohol/drug information school.			
INDIVIDUAL RIGHTS WAC 388-877-0600	YES	NO	COMMENTS
An agency must provide the following:			
(1) Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 70.96A, 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:			
(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;			

(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;			
(c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;			
(d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the			
(e) Be free of any sexual harassment;			
(f) Be free of exploitation, including physical and financial exploitation;			
(g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;			
(h) Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;			
(j) File a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.			
(2) Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:			
(a) Provided in writing to each individual on or before admission;			
(b) Available in alternative formats for individuals who are blind;			
(c) Translated to the most commonly used languages in the agency's service area;			
(d) Posted in public areas; and			
(e) Available to any participant upon request.			
WAC 388-877-0600 (Continued)	YES	NO	COMMENTS
(3) Each agency must ensure all research concerning an individual whose cost of care is publicly funded is done in accordance with chapter 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.			
(4) In addition to the requirements in this section, each agency enrolled as a medicare and/or medicaid provider must ensure an individual seeking or participating in behavioral health treatment services, or the person legally responsible for the individual is informed of their medicaid rights at time of admission and in a manner that is understandable to the individual or legally responsible person.			
INITIAL ASSESSMENT			
WAC 388-877-0610			
Each Agency is responsible for an individual initial assessment			
(1) The initial assessment must be:			
(a) Conducted in person; and			

(b) Completed by a professional appropriately credentialed or qualified to provide chemical dependency, mental health, and/or problem and pathological gambling services as determined by state law.			
(2) The initial assessment must include and document the individual's:			
(a) Identifying information;			
(b) Presenting issues;			
(c) Medical provider's name or medical providers' names;			
(d) Medical concerns;			
(e) Medications currently taken;			
(f) Brief mental health history;			
(g) Brief substance use history, including tobacco;			
(h) Brief problem and pathological gambling history;			
(i) The identification of any risk of harm to self and others, including suicide and/or homicide;			
(j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;			
(k) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and			
(l) Treatment recommendations or recommendations for additional program-specific assessment.			
INDIVIDUAL SERVICE PLAN WAC 388-877-0620	YES	NO	COMMENTS
Each Agency is responsible for an individual's service plan as follows:			
(1) The individual service plan must:			
(a) Be completed or approved by a professional appropriately credentialed or qualified to provide mental health, chemical dependency, and/or problem and pathological gambling			
(b) Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.			
(c) Be in a terminology that is understandable to the individual and the individual's family.			
(d) Document that the plan was mutually agreed upon and a copy was provided to the individual.			
(e) Demonstrate the individual's participation in the development of the plan.			
(f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.			
(g) Be strength-based.			
(h) Contain measurable goals or objectives, or both.			
(i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.			

(2) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.			
INDIVIDUAL CLINICAL RECORD SYSTEM WAC 388-877-0630			
Each Agency is responsible for the following:			
(1) Maintain a comprehensive clinical record system that includes policies and procedures that protect an individual's personal health information; and			
(2) Ensure that the individual's personal health information is shared or released only in compliance with applicable state and federal law.			
(3) If maintaining electronic individual clinical records:			
(a) Provide secure, limited access through means that prevent modification or deletion after initial preparation;			
(b) Provide for a backup of records in the event of equipment, media, or human error; and			
(c) Provide for protection from unauthorized access, including network and internet access.			
(4) Retain an individual's clinical record, including an electronic record, for a minimum of six years after the discharge or transfer of any individual.			
WAC 388-877-0630 (Continued)	YES	NO	COMMENTS
(5) Retain a youth's or child's individual clinical record, including an electronic record, for at least six years after the most recent discharge, or at least three years following the youth's or child's eighteenth birthday.			
(6) Meet the access to clinical records requirements in WAC 388-877-0650.			
CLINICAL RECORD CONTENT WAC 388-877-0640			
Each Agency is responsible for the individual's clinical record that must include:			
(1) Documentation the individual received a copy of counselor disclosure requirements established under RCW 18.19.060.			
(2) Demographic information.			
(3) An initial assessment.			
(4) Documentation of the individual's response when asked if:			
(a) The individual is under department of corrections (DOC) supervision.			
(b) The individual is under civil or criminal court ordered mental health or chemical dependency treatment.			
(c) There is a court order exempting the individual participant from reporting requirements. A copy of the court order must be included in the record if the participant claims exemption from reporting requirements.			

(5) Documentation that the agency met all the following requirements when an individual informs the agency that the individual is under supervision by DOC due to a less restrictive alternative or DOC order for treatment:			
(a) The agency notified DOC orally or in writing. The agency must confirm an oral notification with a written notice by electronic mail or fax.			
(b) The agency obtained a copy of the court order from the individual and placed it in the record when the individual has been given relief from disclosure by the committing court.			
(c) When appropriate, the agency requested an evaluation by a designated mental health professional when the provider becomes aware of a violation of the court-ordered			
(6) The initial and any subsequent individual service plan that include:			
(a) All revisions to the plan, consistent with the service(s) the individual receives; and			
(b) Documentation of objective progress towards established goals as outlined in the plan.			
(7) Documentation the individual was informed of applicable federal and state confidentiality requirements.			
WAC 388-877-0640 (Continued)	YES	NO	COMMENTS
(8) Documentation of confidential information that has been released without the consent of the individual under RCW 70.02.050, 71.05.390, and 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA).			
(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred.			
(10) If treatment is not court-ordered, documentation of informed consent to treatment by the individual or individual's parent, or other legal representative.			
(11) If treatment is court-ordered, a copy of the detention or involuntary tx order.			
(12) Documentation of coordinator of care, as needed.			
(13) Documentation of all service encounters.			
(14) Medication records, if applicable.			
(15) Laboratory reports, if applicable.			
(16) Properly completed authorizes for release of information, If applicable.			
(17) Copies of applicable correspondence.			
(18) Discharge Information.			
CLINICAL RECORD ACCESS WAC 388-877-0650			
(1) Each Agency must provide access to an individual's clinical record at the request of the individual or, if applicable, the individual's designated representative, and/or legal representative. The agency must:			

(a) Review the clinical record before making the record available in order to identify and remove:			
(i) Any material confidential to another person, agency, or provider; and			
(ii) Reports not originated by the agency.			
(b) Make the clinical rec available to the requester w/i 15 days of the request.			
(c) Allow appropriate time and privacy for the review.			
(d) Have a clinical staff member available to answer questions.			
(e) Charge for copying at a rate not higher than defined in RCW 70.02.010(12).			
(f) Meet the individual clinical record system criteria in WAC 388-877-0630.			
(2) Make an individual's clinical record available to department staff as required for department program review.			
(3) If the agency maintains electronic individual clinical records, the agency must:			
(a) Make the clinical record available in paper form; and			
(b) Meet the criteria in (1) and (2) of this section.			

Pierce County Clinical Manual Review Checklist
WAC 388-877B-0200 through -0280 and WAC 388-877-0600 through -0650

Date:

CHEMICAL DEPENDENCY TREATMENT SERVICES - GENERAL WAC 388-877B-0200	YES	NO	COMMENTS
All Agencies must fully comply with the following:			
(1) Residential treatment services provide chemical dependency treatment for an individual and include room and board in a facility with twenty-four hours a day supervision			
(2) Residential treatment services require additional program-specific certification by the department's division of behavioral health and recovery and include:			
(a) Intensive Inpatient services (WAC 388-877B-0250)			
(b) Recovery House treatment services (see WAC 388-877B-0260)			
(c) Long-Term Residential (see WAC 388-877B-0270)			
(d) Youth residential (see WAC 388-877B-0280)			
(3) An agency providing residential treatment services to an individual must:			
(a) Be licensed by the department of health and meet the criteria under one of the following DOH chapters:			
(i) Hospital licensing regulations			
(ii) Private psychiatric and alcoholism hospital			
(iii) Private alcohol and drug hospitals			
(iv) Residential Treatment facility (chapter 246-337 WAC);			
(b) Be licensed by DBHR			
(c) Meet the applicable behavioral health agency licensure, certification, administration, personnel, and clinical requirements in chapter 388-877 WAC, Behavioral Health Services Administrative requirements; and			
(d) Have policies and procedures to support and implement the:			
(i) General requirements in chapter 388-877 WAC; and			
(ii) Specific applicable requirements in WAC 388-877B-0200 through 388-877B-0280.			
(4) An Agency must:			
(a) Use the PPC for admission, continued services, and discharge planning and decisions.			
(b) Provide education to each individual admitted to the treatment facility on:			

(i) Alcohol, other drugs, and/or chemical dependency;			
(ii) Relapse prevention;			
(iii) Blood borne pathogens; and			
(iv) Tuberculosis (TB)			
(c) Provide education or information to each individual admitted on:			
(i) Emotional, physical, and sexual abuse;			
(ii) Nicotine addiction; and			
(iii) The impact of chemical use during pregnancy, risks of the fetus, and the importance of informing medical practitioners of chemical use during pregnancy.			
(d) Maintain a list of resources, including self-help groups, and referral options that can be used by staff members to refer an individual to appropriate services.			
(e) Screen for the prevention and control of tuberculosis.			
(f) Limit the size group counseling sessions to no more than 12 individuals.			
(g) Have written procedures for:			
(i) Urinalysis and drug testing, including laboratory testing; and			
(ii) How agency staff members respond to medical and psychiatric emergencies.			
(5) An agency that provides services to a pregnant woman must:			
(a) Have a written procedure to address specific issues regarding a woman's pregnancy and prenatal care needs; and			
(b) Provide referral information to applicable resources.			
(6) An agency that provides a DUI assessment to an individual under RCW 46.61.5056 must also be certified by the department under WAC 388-877B-0550			
AGENCY STAFF REQUIREMENTS WAC 388-877B-0210			
In addition to meeting the agency admin. and personnel requirements in WAC 388-877-0400 through 388-877-0530, an agency providing residential treatment services must ensure all assessment and counseling services are provided by a CDP, or a CDPT under the supervision of an approved supervisor. The agency must ensure:			
(1) There is a designated clinical supervisor who:			
(a) Is a CDP;			
(b) Has documented competency in clinical supervision;			
(c) Is responsible for monitoring the continued competency of each CDP in assessment, tx, continuing care, transfer, and d/c. The monitoring must include a semi-annual review of a sample of the clinical records kept by the CDP; and			
(d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180.			

(2) Each chemical dependency professional trainee has at least one approved supervisor who meets the qualifications in WAC 246-811-049. An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.			
(3) All staff members are provided annual training on the prevention and control of communicable disease, blood borne pathogens and TB, and document the training in the personnel file.			
(3) Each staff member that provides individual care has a copy of an initial TB screen or test and any subsequent screenings or testing in their personnel file.			
CLINICAL RECORD CONTENT AND DOCUMENTATION WAC 388-877B-0320			
An agency providing chemical dependency outpatient treatment services must ensure:			
(1) The clinical record must contain:			
(a) Documentation the individual was informed of federal confidentiality requirements and received a copy of the individual notice required under 42 C.F.R. Part 2.			
(b) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanctions.			
(c) Justification for the change in the level of care when transferring an individual from one certified treatment service to another within the same agency at the same location.			
(d) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
(e) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:			
(i) The individual's demographic information; and			
(ii) The diagnostic assessment statement and other assessment information to include:			
(A) Documentation of the HIV/AIDS intervention.			
(B) Tuberculosis (TB) screen or test result.			
(C) A record of the individual's detoxification and treatment history.			
(D) The reason for the individual's transfer.			
(E) Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.			

(F) A discharge summary and continuing care plan.			
(f) Documentation that staff members met with each individual at the time of discharge, unless the individual left without notice, to:	YES	NO	COMMENTS
(i) Determine the appropriate recommendation for care and finalize a continuing care plan.			
(ii) Assist the individual in making contact with necessary agencies or services.			
(iii) Provide and document the individual was provided with a copy of the plan.			
(g) Documentation that a discharge summary was completed within seven days of the individual's discharge, including the date of discharge, a summary of the individual's progress towards each individual service plan goal.			
(2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:			
(a) Be personalized to the individual's unique treatment needs;			
(b) Be initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.			
(c) Include individual needs identified in the diagnostic and periodic reviews, addressing:			
(i) All substance use needing treatment, including tobacco, if necessary;			
(ii) The individual's bio-psychosocial problems;			
(iii) Treatment goals;			
(iv) Estimated dates or conditions for completion of each treatment goal; and			
(v) Approaches to resolve the problem.			
(d) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.			
(d) Document that the plan was updated to reflect any changes in the individual's treatment needs, or as requested by the individual, at least once per month for the first three months, and at least quarterly thereafter.			
(e) Document that the plan has been reviewed with the individual.			
ADDITIONAL ASSESSMENT STANDARDS WAC 388-877B-0230			
The Agency must ensure the Assessment include:			
(1) A face-to-face diagnostic interview with the individual in order to obtain, review, evaluate, and document the following:			
(a) A history of the individual's involvement with alcohol and other drugs including:			
(i) The type of substances used, including tobacco;			
(ii) The route of administration; and			

(iii) The amount, frequency, and duration of use.			
(b) A history of alcohol or other drug treatment or education.			
(c) The individual's self-assessment of use of alcohol and other drugs.			
(d) A history of relapse.			
(e) A history of self-harm.			
(f) A history of legal involvement.			
(g) A statement regarding the provide of an HIV/AIDS brief risk intervention, and any referral made.			
(2) A diagnostic assessment statement, including sufficient information to determine the individual's diagnosis using:			
(a) Diagnostic and Statistical Manual (DSM IV TR, 2000) as it existed on the effective date of this section; then			
(b) DSM-5 as it exists when published and released in 2013, consistent with the purposes of this section. Information regarding the publication date and release of the DSM-5 is posted on the American Psychiatric Association's public website at www.DSM5.org.			
(3) A placement decision, using PPC dimensions when the assessment indicates the individual is in need of services.			
(4) Evidence the individual was notified of the assessment results and documentation of the treatment options provided and the individual's choice. If the individual was not notified of the results and advised of referral options, the reason must be documented.			
(5) The additional requirements outlined under WAC 388-877B-0550 for driving under the influence (DUI) assessments, for an agency providing services to an individual under RCW 46.61.5056.			
(6) Documented attempts to obtain the following information when assessing youth:			
(a) Parental and sibling use of alcohol and other drugs.			
(b) A history of school assessments for learning disabilities or other problems, which may affect ability to understand written materials.			
(c) Past and present parent/guardian custodial status, including a history of running away and out-of-home placements.			
(d) A history of emotional or psychological problems.			
(e) A history of child or adolescent developmental problems.			
(f) The ability of parents, or if applicable, a legal guardian to participate in treatment.			
NON COMPLIANCE REPORTING REQUIREMENTS WAC 388-877B-0240	YES	NO	COMMENTS

An agency providing treatment to a court-mandated individual, including deferred prosecution, must develop procedures addressing individual noncompliance and reporting requirements, including:			
(1) Completing an authorization to release confidential information form that meets the requirements of 42 C.F.R. Part 2 and 45 C.F.R. Parts 160 and 164 or through a court order authorizing the disclosure pursuant to 42 C.F.R. Part 2, Sections 2.63 through 2.67.			
(2) Notifying the designated chemical dependency specialist within three working days from obtaining information of any violation of the terms of the court order for purposes of revocation of the individual's conditional release, or department of corrections (DOC) if the individual is under DOC supervision.			
(3) Reporting and recommending action for emergency noncompliance to the court or other appropriate jurisdiction(s) within three working days from obtaining information on:			
(a) An individual's failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by individual's self-report, identified third party report confirmed by the agency, or blood alcohol content or other laboratory test.			
(b) An individual's report of subsequent alcohol and/or drug related arrests.			
(c) An individual leaving the program against program advice or an individual discharged for rule violation.			
(4) Reporting and recommending action for nonemergent, noncompliance to the court or other appropriate jurisdiction(s) within ten working days from the end of each reporting period, upon obtaining information on:			
(a) An individual's unexcused absences or failure to report, including failure to attend mandatory self-help groups.			
(b) An individual's failure to make acceptable progress in any part of the treatment plan.			
(5) Transmitting noncompliance or other significant changes as soon as possible, but no longer than ten working days from the date of the noncompliance, when the court does not wish to receive monthly reports.			
(6) Reporting compliance status of persons convicted under chapter 46.61 RCW to the department of licensing.			
PROGRAM-SPECIFIC CERTIFICATION WAC 388-877B-0270			
An agency providing Long-Term treatment services must:			
(1) Provide an individual a minimum of two hours each week of individual or group counseling			

(2) Provide an individual a minimum of two hours each week of education regarding alcohol, other drugs, and other addictions.			
(3) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
(4) Provide an individual, during the course of services, with:			
(a) Education on social and coping skills;			
(b) Social and recreational activities;			
(c) Assistance in seeking employment, when appropriate, and;			
(d) Assistance with re-entry living skills to include seeking and obtaining safe housing.			
(5) Conduct and document an individual service plan review at least monthly.			
INDIVIDUAL RIGHTS WAC 388-877-0600	YES	NO	COMMENTS
An agency must provide the following:			Applies to all
(1) Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 70.96A, 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:			
(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;			
(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;			
(c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;			
(d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the			
(e) Be free of any sexual harassment;			
(f) Be free of exploitation, including physical and financial exploitation;			
(g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;			

(h) Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;			
(j) File a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.			
(2) Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:			
(a) Provided in writing to each individual on or before admission;			
(b) Available in alternative formats for individuals who are blind;			
(c) Translated to the most commonly used languages in the agency's service area;			
(d) Posted in public areas; and			
(e) Available to any participant upon request.			
(3) Each agency must ensure all research concerning an individual whose cost of care is publicly funded is done in accordance with chapter 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.			
(4) In addition to the requirements in this section, each agency enrolled as a medicare and/or medicaid provider must ensure an individual seeking or participating in behavioral health treatment services, or the person legally responsible for the individual is informed of their medicaid rights at time of admission and in a manner that is understandable to the individual or legally responsible person.			
INITIAL ASSESSMENT WAC 388-877-0610			Applies to all
Each Agency is responsible for an individual initial assessment			
(1) The initial assessment must be:			
(a) Conducted in person; and			
(b) Completed by a professional appropriately credentialed or qualified to provide chemical dependency, mental health, and/or problem and pathological gambling services as determined by state law.			
(2) The initial assessment must include and document the individual's:			
(a) Identifying information;			
(b) Presenting issues;			
(c) Medical provider's name or medical providers' names;			
(d) Medical concerns;			
(e) Medications currently taken;			
(f) Brief mental health history;			
(g) Brief substance use history, including tobacco;			
(h) Brief problem and pathological gambling history;			

(i) The identification of any risk of harm to self and others, including suicide and/or homicide;			
(j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;			
(k) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and			
(l) Treatment recommendations or recommendations for additional program-specific assessment.			
INDIVIDUAL SERVICE PLAN WAC 388-877-0620	YES	NO	COMMENTS
Each Agency is responsible for an individual's service plan as follows:			Applies to all
(1) The individual service plan must:			
(a) Be completed or approved by a professional appropriately credentialed or qualified to provide mental health, chemical dependency, and/or problem and pathological gambling			
(b) Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.			
(c) Be in a terminology that is understandable to the individual and the individual's family.			
(d) Document that the plan was mutually agreed upon and a copy was provided to the individual.			
(e) Demonstrate the individual's participation in the development of the plan.			
(f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.			
(g) Be strength-based.			
(h) Contain measurable goals or objectives, or both.			
(i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.			
(2) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.			
INDIVIDUAL CLINICAL RECORD SYSTEM WAC 388-877-0630			Applies to all
Each Agency is responsible for the following:			
(1) Maintain a comprehensive clinical record system that includes policies and procedures that protect an individual's personal health information; and			
(2) Ensure that the individual's personal health information is shared or released only in compliance with applicable state and federal law.			
(3) If maintaining electronic individual clinical records:			
(a) Provide secure, limited access through means that prevent modification or deletion after initial preparation;			

(b) Provide for a backup of records in the event of equipment, media, or human error; and			
(c) Provide for protection from unauthorized access, including network and internet access.			
(4) Retain an individual's clinical record, including an electronic record, for a minimum of six years after the discharge or transfer of any individual.			
(5) Retain a youth's or child's individual clinical record, including an electronic record, for at least six years after the most recent discharge, or at least three years following the youth's or child's eighteenth birthday.			
(6) Meet the access to clinical records requirements in WAC 388-877-0650.			
CLINICAL RECORD CONTENT WAC 388-877-0640			Applies to all
Each Agency is responsible for the individual's clinical record that must include:			
(1) Documentation the individual received a copy of counselor disclosure requirements established under RCW 18.19.060.			
(2) Demographic information.			
(3) An initial assessment.			
(4) Documentation of the individual's response when asked if:			
(a) The individual is under department of corrections (DOC) supervision.			
(b) The individual is under civil or criminal court ordered mental health or chemical dependency treatment.			
(c) There is a court order exempting the individual participant from reporting requirements. A copy of the court order must be included in the record if the participant claims exemption from reporting requirements.			
(5) Documentation that the agency met all the following requirements when an individual informs the agency that the individual is under supervision by DOC due to a less restrictive alternative or DOC order for treatment:			
(a) The agency notified DOC orally or in writing. The agency must confirm an oral notification with a written notice by electronic mail or fax.			
(b) The agency obtained a copy of the court order from the individual and placed it in the record when the individual has been given relief from disclosure by the committing court.			
(c) When appropriate, the agency requested an evaluation by a designated mental health professional when the provider becomes aware of a violation of the court-ordered treatment and the violation concerns public safety.			
(6) The initial and any subsequent individual service plan that include:			
(a) All revisions to the plan, consistent with the service(s) the individual receives; and			

(b) Documentation of objective progress towards established goals as outlined in the plan.			
(7) Documentation the individual was informed of applicable federal and state confidentiality requirements.			
(8) Documentation of confidential information that has been released without the consent of the individual under RCW 70.02.050, 71.05.390, and 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA).			
(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred.			
(10) If treatment is not court-ordered, documentation of informed consent to treatment by the individual or individual's parent, or other legal representative.			
(11) If treatment is court-ordered, a copy of the detention or involuntary tx order.			
(12) Documentation of coordinator of care, as needed.			
(13) Documentation of all service encounters.			
(14) Medication records, if applicable.			
(15) Laboratory reports, if applicable.			
(16) Properly completed authorizes for release of information, If applicable.			
(17) Copies of applicable correspondence.			
(18) Discharge Information.			
CLINICAL RECORD ACCESS WAC 388-877-0650			
(1) Each Agency must provide access to an individual's clinical record at the request of the individual or, if applicable, the individual's designated representative, and/or legal representative. The agency must:			Applies to All
(a) Review the clinical record before making the record available in order to identify and remove:			
(i) Any material confidential to another person, agency, or provider; and			
(ii) Reports not originated by the agency.			
(b) Make the clinical rec available to the requester w/i 15 days of the request.			
(c) Allow appropriate time and privacy for the review.			
(d) Have a clinical staff member available to answer questions.			
(e) Charge for copying at a rate not higher than defined in RCW 70.02.010(12).			
(f) Meet the individual clinical record system criteria in WAC 388-877-0630.			
(2) Make an individual's clinical record available to department staff as required for department program review.			
(3) If the agency maintains electronic individual clinical records, the agency must:			
(a) Make the clinical record available in paper form; and			

(b) Meet the criteria in (1) and (2) of this section.

Pierce County Personnel File Requirements

Agency Name:

Name of Employee:

Date of Hire:

Title of Position:

Personnel - Agency Policies and Procedures	YES	NO	COMMENTS
Each Agency licensed must maintain a personnel record for each person employed by the agency WAC 388-877-0510			
(1) Each personnel file must contain the following:			
(a) Documentation of annual training, including documentation that the employee successfully completed training on cultural competency (see WAC 388-877-0500(6)(b)).			
(b) A signed and dated commitment to maintain patient confidentiality in accordance with state and federal confidentiality requirements.			
(c) A record of orientation to the agency that includes:			
(i) An overview of the administrative, personnel & clinical policies & procedures.			
(ii) The duty to warn or to take reasonable precautions to provide protection from violent behavior when an individual has communicated an actual imminent threat of physical violence against a reasonably identifiable victim(s). Taking reasonable precautions includes notifying law enforcement as required and allowed by law.			
(iii) Staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities.			
(iv) The process for resolving client complaints and/or grievances.			
(v) The facility evacuation plan.			
(d) A copy of staff member's valid current credential issued by the (DOH) for their scope of practice.			
(e) For non-contract staff, a copy of a current job description, signed and dated by the employee and supervisor which includes:			
(i) Job title;			
(ii) Minimum qualifications for the position;			
(iii) Summary of duties and responsibilities;			
(f) For contract staff, formal agreements or contracts that describe the nature and extent of patient care services may be substituted for job descriptions.			
(g) Performance evaluations conducted by the immediate supervisor or designee.			

(2) Staff members who have received services from the agency must have personnel records that:	YES	NO	COMMENTS
(a) Are separate from clinical records; and			
(b) Have no indication of current or previous recipient status.			
WAC 388-877B-0310			
(5) Each staff member that provides individual care has a copy of an initial TB screen or test and any subsequent screenings or testing in their personnel file.			
(6) All staff members are provided annual training on the prevention and control of communicable disease, blood borne pathogens and TB, and document the training in the personnel file.			
Contract Requirements			
Background checks per County Contract, Exhibit B. Section 2.e.			
LEIE checks per County Contract, Exhibit B. Section 2.g.1.			

Additional Observations/Notations

Pierce County Outpatient Patient File Checklist

Agency Name:
Admit Date:
Program Type:

Client Name:
Assmnt Date:
Assmnt Only:

Client DOB:
Discharge Date:
Discharge Type:

CHEMICAL DEPENDENCY ASSESSMENT REQUIREMENTS WAC 388-877B-0330	YES	NO	COMMENTS
Each agency licensed by the department to provide any behavioral health svc is responsible for an patient(s) initial assessment which must include:			
(1) A face-to-face diagnostic interview w/the patient in order to obtain, review, evaluate, an document a history of the patient's needs. In addition to the assessment requirements in WAC 388-877-0610, the assessment must include:			
(a) The type of substances used; including tobacco;			
(b) The route of administration; and			
(c) Amount, frequency, and duration of use.			
(2) History of alcohol or other drug treatment or education;			
(3) The patient's self-assessment of use of alcohol and other drugs;			
(4) A relapse history;			
(5) A history of self-harm;			
(6) A legal history involvement, and			
(7) A statement regarding the provision of an HIV/AIDS brief risk intervention.			
(8) A diagnostic assessment statement, including sufficient information to determine the patient's diagnosis using the:			
(a) Diagnostic and Statistical Manual (DSM IV TR, 2000), as it existed on the effective date of this section; then			
(b) DSM 5 as it exists when published and released in 2013, consistent with the purposes of this section.			
(9) A placement decision, using PPC dimensions when the assessment indicates the patient is in need of services.			
(10) Evidence the patient was notified of the assessment results and documentation of the treatment options provided and the patient's choice. If the patient was not notified of the results & advised of referral options, the reason must be documented.			

WAC 388-877B-0330 (Continued)	YES	NO	COMMENTS
(11) The additional requirements outlined under WAC 388-877B-0550 for driving under the influence assessment, for an agency providing services to a patient under RCW 46.61.5056.			
(12) Documented attempts to obtain the following information when assessing youth:			
(a) Parental and sibling use alcohol and other drugs;			
(b) History of school assessments for learning disabilities or other problems, which may affect ability to understand written materials;			
(c) Past and present parent/guardian custodial status, including a history of running away and out-of-home placements;			
(d) History of emotional or psychological problems;			
(e) History of child or adolescent developmental problems; and			
(f) Ability of the youth's parents/guardians to participate in treatment.			
INITIAL ASSESSMENT WAC 388-877-0610			
(1) The initial assessment must be:			
(a) Conducted in person; and			
(b) Completed by a professional appropriately credentialed or qualified to provide CD, MH, and/or problem and pathological gambling svcs as determined by state law.			
(2) The initial assessment must include and document the patient's:			
(a) Identifying information;			
(b) Presenting issues;			
(c) Medical provider's name or medical provider's names;			
(d) Medical concerns;			
(e) Medications currently taken;			
(f) Brief mental history;			
(g) Brief substance use history, including tobacco (see above)			
(h) Brief problem and pathological gambling history			
(i) The identification of any risk of harm to self and others, including suicide and/or homicide;			
(j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;			
(k) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and			
(l) treatment recommendations or recommendations for additional program-specific assessment			

PATIENT SERVICE PLAN WAC 388-877-0620	YES	NO	COMMENTS
(1) Patient service plans must be as follows:			
(a) Be completed or approved by a professional appropriately credentialed or qualified to provide MH, CD and/or Problem Gambling services.			
(b) Address age, gender, cultural, strengths and/or disability issues identified by the patient or, the patient's parent(s) or legal representative.			
(c) Be in a terminology that is understandable to the patient and family.			
(d) Document the plan was mutually agreed upon and a copy was provided to patient.			
(e) Demonstrate the patient's participation in the development of the plan.			
(f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.			
(g) Be strength-based.			
(h) Contain measurable goals or objectives, or both.			
(i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.			
(2) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.			
CLINICAL RECORD CONTENT REQUIREMENTS WAC 388-877-0640			
The service provider must ensure patient record content includes:			
(1) Documentation the patient received a copy of counselor disclosure requirements established under RCW 18.19.060.			
(2) Demographic information.			
(3) An initial Assessment.			
(4) Documentation of the patient's response when asked if:			
(a) The patient is under Department of corrections supervision; and			
(b) The patient is under civil or criminal court ordered MH or CD treatment.			
(c) A copy of the court order exempting patient from reporting requirements.			
(5) Documentation that the agency met all the following requirements when a patient informs the agency that he/she is under supervision by DOC due to a less restrictive alternative or DOC order for treatment:			
(a) The agency notified DOC orally or in writing. The agency must confirm an oral notification with a written notice by electronic mail or fax.			
(b) The agency obtained a copy of the court order from the patient and place it in the record when the patient was given relief from disclosure by he committing court.			

WAC 388-877-0640 (Continued)	YES	NO	COMMENTS
(c) When appropriate, the agency requested an evaluation by a designated MH professional when the provider becomes aware of a violation of the court-ordered treatment and the violation concerns public safety.			
(6) The initial and any subsequent patient service plan that include:			
(a) All revisions to the plan, consistent w/the service(s) the patient receives; and			
(b) Documentation of objective progress towards established goals as outlined in the plan			
(7) Documentation the patient was informed of applicable state and federal confidentiality requirements. 388-877B-0320(1)(a)			
(8) Documentation of confidential information that has been released without the consent of the patient under RCW 70.02.050, 71.05.390, and 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA).			
(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with Chapters 26.44 and 74.34 RCW has occurred.			
(10) If treatment is not court-ordered, documentation of informed consent to treatment by the patient or patient's parent, or other legal representative.			
(11) If treatment is court-ordered, a copy of the detention or involuntary treatment order.			
(12) Documentation of coordination of care, as needed.			
(13) Documentation of all service encounters.			
(14) Medication records, if applicable.			
(15) Laboratory reports, if applicable.			
(16) Properly completed authorizations for release of information, if applicable.			
(17) Copies of applicable correspondence.			
(18) Discharge information.			
ADDITIONAL CLINICAL RECORD CONTENT WAC 388-877B-0320			
(1) In addition to the general clinical record content requirements in WAC 388-877-0640, an agency must maintain in the clinical record:			
(a) Documentation the patient was informed of confidential requirements & received a copy of the patient notice required under 42 CFR Part 2. See 388-877-0640(7).			
(b) Documentation that the initial patient service plan was completed before treatment services are received.			

WAC 388-877B-0320 (Continued)	YES	NO	COMMENTS
(c) Documentation of progress in a timely manner & before any scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session & the name of the staff member who provided it.			
(e) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individuals course of treatment were forwarded to the new service provider to include:			
(i) The individual's demographic information; and			
(ii) The diagnostic assessment statement and other assessment information include:			
A. Documentation of HIV/AIDS information			
B. Tuberculosis (TB) screen or test results			
C. A record of the individual's detoxification treatment history			
D. The reason for individual's transfer			
E. Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.			
F. A discharge summary and continuing care plan.			
(f) Justification for the change in the level of care when transferring an individual from one certified treatment service to another within the same agency, at the same location.			
(g) Documentation that staff members met with each individual at the time of discharge, unless the individual left without notice, to:			
(i) Determine the appropriate recommendation for care and finalize a continuing care plan			
(ii) Assist the patient in making contact w/necessary agencies or services.			
(iii) Provide and document the patient was provided with a copy of the plan.			
(h) Documentation that a discharge summary was completed w/i seven days of the patient's discharge, including the date of discharge, a summary of the patient's progress towards each patient service plan goal, legal status, and if applicable, current prescribed medication.			
(2) In addition to the requirements in (1) of this section an agency must ensure the following for each patient service plan. The patient service plan must:			
(a) Be personalized to the patient's unique treatment needs.			

(b) Include individual needs identified in the diagnostic and periodic reviews, addressing:			
(i) All substance use needing treatment, including tobacco, if necessary;			
(ii) The patient's bio-psychosocial problems;			
(iii) Treatment goals;			
(iv) Estimated dates or conditions for completion of each treatment goal; and			
(v) Approaches to resolve the problem.			
(c) Document approval by a CDP if the staff developing the plan is not a CDP.			
(d) Document that the plan was updated to reflect any changes in the patient's treatment needs, or as request by the patient, at least once per month for the first 3 months, and at least quarterly thereafter.			
(e) Document that the plan has been reviewed with the patient.			
LEVEL 2 INTENSIVE OUTPATIENT SERVICES WAC 388-877B-0350			
Level II Intensive Outpatient Services must:			
(1) Develop a patient service plan prior to the individual(s) participation in treatment.			
(2) Provide patient CD counseling sessions with each individual(s) at least once a month or more of clinically needed.			

WAC 388-877B-0350 (Continued)	YES	NO	COMMENTS
(3) Documentation of progress in a timely manner and before any scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
(4) Conduct and document a review of each individuals. Service plan in individual counseling sessions, at least once a month, to assess adequacy and attainment of goals.			
(5) Refer for ongoing treatment or support upon completion of intensive outpatient treatment, as necessary,.			
(6) Ensure that patients admitted under a deferred prosecution order under Chapter 10.05 RCW:			
(a) Receive a minimum of 72 hs of treatment services w/i a maximum of 12 weeks, which consists of the following during the first 4 weeks of treatment.:			
(i) At least 3 sessions each week, with each session occurring on separate days of the week.			
(ii) Group sessions must last at least one hour.			
(b) Attend self-help groups in addition to the 72 hours of treatment. Services.			
(c) Have approval, in writing, by the court having jurisdiction in the case, when there is any exception to the requirements in this subsection.			
LEVEL 1 OUTPATIENT SERVICES WAC 388-877B-0360			
Level 1 Outpatient Services must:			
(1) Develop an patient service plan prior to the individual(s)s participation in treatment.			
(2) Conduct group or patient cd counseling sessions for each individual, each month according to a patient service plan.			
(3) Conduct and document a patient service plan review of each patient once a month for the first 3 mos, and quarterly thereafter or sooner if required by other laws.			
(4) Documentation of progress in a timely manner and before any scheduled appointments. of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.			
MISCELLANEOUS REQUIREMENTS			
WAC 388-877B-0300(4)(d) An agency must provide tuberculosis screenings to patients for the prevention and control of tuberculosis screenings.			

MISCELLANEOUS REQUIREMENTS (Continued)	YES	NO	COMMENTS
WAC 388-877-0600(1)(a-j) An agency must provide client rights.			
WAC 388-877B-0370 An agency must follow the requirements when a patient. is convicted of driving under the influence.			
COUNTY CONTRACT REQUIREMENTS			
(1) Financial Screening, monthly (Exhibit B, Section 3.1 [c]).			
(2) TXIX screening (Exhibit B, Section 3.3 [b]).			
(3) Referral to child care services (Exhibit A, Section 5.6[k]).			
(4) Priority Population (Exhibit B, Section 4.1):			
(a) Pregnant (Assessed w/i 48 hrs of request, Exhibit B, Section 4.1 [a](1);			
(b) IDU (Assessed within 14 days after service requested; Exhibit B, Section 4.1[a](2); and			
(c) Parents with dependent Children (Exhibit B, Section 4.1[a](3).			
Additional priority categories include:			
(a) Post-partum females (Exhibit B,Section 4.1[a](4);			
(b) Parents involved in Children's Administration Division, including CPS (Exhibit B,Section 4.1[a](4);			
(c) Patients transitioning from inpatient/residential care to OP care (Exhibit B, Section 4.1[a](4);			
(d) Offenders as defined in RCW 70.96A.350 (Exhibit B,Section 4.1[a](4); and			
(e) Other Medicaid patients (Exhibit B, Section 4.1[a](4).			
(5) Waiting List Interim Services (Exhibit B, Section 4.4).			
(6) Date of First Contact (Exhibit B, Section 4.5).			
(7) Self Help Grps # of grps attended in the last 30 days for each assessment admission, and discharge submitted to the system.			
(9) GAIN SS (HB 5763) (Exhibit B, Section 5.6(f).			

Additional Observations/Notations:

Pierce County Outpatient Patient File Checklist

Agency Name: **TPCHD**
 Admit Date:
 Program Type: **OST**

Client Name:
 Assmnt Date:
 Assmnt Only:

Client DOB:
 Discharge Date:
 Discharge Type:

CHEMICAL DEPENDENCY ASSESSMENT REQUIREMENTS WAC 388-877B-0430	YES	NO	COMMENTS
Each agency licensed by the department to provide any behavioral health service is responsible for an patient's initial assessment which must include:			
(1) A face-to-face diagnostic interview w/the patient. in order to obtain, review, evaluate, an document a history of the patient.'s needs. In addition to the assessment requirements in WAC 388-877-0610, the assessment must include:			
(i) The type of substances used; including tobacco			
(ii) The route of administration; and			
(iii) Amount, frequency, and duration of use.			
(b) History of alcohol or other drug treatment or education;			
(c) The patient's self-assessment of use of alcohol and other drugs;			
(d) A relapse history;			
(e) A history of self-harm;			
(f) A legal history involvement, and			
(g) A statement regarding the provision of an HIV/AIDS brief risk intervention.			
(2) A diagnostic assessment statement, including sufficient information to determine the patient's diagnosis using the:			
(a) Diagnostic and Statistical Manual (DSM IV TR, 2000), as it existed on the effective date of this section; then			
(b) DSM 5 as it exists when published and released in 2013, consistent with the purposes of this section.			
(3) A placement decision, using PPC dimensions when the assessment indicates the patient is in need of services.			
(4) Evidence the patient was notified of the assessment results and documentation of the treatment options provided and the patient's choice. If the patient was not notified of the results and advised of referral options, the reason must be documented.			

WAC 388-877B-0430 (Continued)	YES	NO	COMMENTS
(11) The additional requirements outlined under WAC 388-877B-0550 for driving under the influence assessment, for an agency providing services to a patient under RCW 46.61.5056.			
(12) Documented attempts to obtain the following information when assessing youth:			
(a) Parental and sibling use alcohol and other drugs;			
(b) History of school assessments for learning disabilities or other problems, which may affect ability to understand written materials;			
(c) Past and present parent/guardian custodial status, including a history of running away and out-of-home placements;			
(d) History of emotional or psychological problems;			
(e) History of child or adolescent developmental problems; and			
(f) Ability of the youth's parents/guardians to participate in treatment			
INITIAL ASSESSMENT WAC 388-877-0610			
(1) The initial assessment must be:			
(a) Conducted in person; and			
(b) Completed by a professional appropriately credentialed or qualified to provide CD, MH, and/or problem and pathological gambling svcs as determined by state law.			
(2) The initial assessment must include and document the patient's:			
(a) Identifying information;			
(b) Presenting issues;			
(c) Medical provider's name or medical provider's names;			
(d) Medical concerns;			
(e) Medications currently taken;			
(f) Brief mental history;			
(g) Brief substance use history, including tobacco (see above)			
(h) Brief problem and pathological gambling history			
(i) The identification of any risk of harm to self and others, including suicide and/or homicide;			
(j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment.			
(k) Information that a person is or is not court-ordered to treatment or under the supervision of the Dept. of Corrections; and			
(l) Treatment recommendations or recommendations for additional program-specific assessment.			

PATIENT SERVICE PLAN WAC 388-877-0620	YES	NO	COMMENTS
(1) Patient service plans must be as follows:			
(a) Be completed or approved by a professional appropriately credentialed or qualified to provide MH, CD and/or Problem Gambling services.			
(b) Address age, gender, cultural, strengths and/or disability issues identified by the patient or, the patient's parent(s) or legal representative.			
(c) Be in a terminology that is understandable to the patient and family.			
(d) Document the plan was mutually agreed upon and a copy was provided to the patient.			
(e) Demonstrate the patient's participation in the development of the plan.			
(f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.			
(g) Be strength-based.			
(h) Contain measurable goals or objectives, or both.			
(i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.			
(2) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.			
CLINICAL RECORD CONTENT REQUIREMENTS WAC 388-877-0640			
The service provider must ensure patient record content includes:			
(1) Documentation the patient received a copy of counselor disclosure requirements established under RCW 18.19.060.			
(2) Demographic information.			
(3) An initial Assessment.			
(4) Documentation of the patient's response when asked if:			
(a) The patient is under Department of corrections supervision; and			
(b) The patient is under civil or criminal court ordered MH or CD treatment			
(c) A copy of the court order exempting patient from reporting requirements.			
(5) Documentation that the agency met all the following requirements when a patient informs the agency that he/she is under supervision by DOC due to a less restrictive alternative or DOC order for treatment:			
(a) The agency notified DOC orally or in writing. The agency must confirm an oral notification with a written notice by electronic mail or fax.			
(b) The agency obtained a copy of the court order from the patient and place it in the record when the patient was given relief from disclosure by he committing court.			

WAC 388-877-0640 (Continued)	YES	NO	COMMENTS
(c) When appropriate, the agency requested an evaluation by a designated MH professional when the provider becomes aware of a violation of the court-ordered treatment and the violation concerns public safety.			
(6) The initial and any subsequent patient service plan that include:			
(a) All revisions to the plan, consistent w/the service(s) the patient receives; and			
(b) Documentation of objective progress towards established goals as outlined in the plan			
(7) Documentation the patient was informed of applicable state and federal confidentiality requirements. 388-877B-0320(1)(a)			
(8) Documentation of confidential information that has been released without the consent of the patient under RCW 70.02.050, 71.05.390, and 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA).			
(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with Chapters 26.44 and 74.34 RCW has occurred.			
(10) If treatment is not court-ordered, documentation of informed consent to treatment by the patient or patient's parent, or other legal representative.			
(11) If treatment is court-ordered, a copy of the detention or involuntary treatment order.			
(12) Documentation of coordination of care, as needed.			
(13) Documentation of all service encounters.			
(14) Medication records, if applicable.			
(15) Laboratory reports, if applicable.			
(16) Properly completed authorizations for release of information, if applicable.			
(17) Copies of applicable correspondence.			
(18) Discharge information.			
ADDITIONAL CLINICAL RECORD CONTENT			
WAC 388-877B-0320			
(1) In addition to the general clinical record content requirements in WAC 388-877-0640, an agency must maintain in the clinical record:			
(a) Documentation the patient was informed of confidential requirements & received a copy of the patient notice required under 42 CFR Part 2. See 388-877-0640(7)			
(b) Documentation that the initial patient service plan was completed before treatment services are received.			
(c) Documentation of progress in a timely manner & before any scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session & the name of the staff member who provided it.			

WAC 388-877B-0320 (Continued)	YES	NO	COMMENTS
(d) Justification for the change in the level of care when transferring an individual(s) from one certified treatment service to another within the same agency, at the same location.			
(e) Documentation that staff members met w/each patient at the time of discharge unless the patient left without to:			
(i) Determine the appropriate recommendation for care and finalize a continuing care plan			
(ii) Assist the patient in making contact w/necessary agencies or services.			
(iii) Provide and document the patient was provided with a copy of the plan.			
(f) Documentation that a discharge summary was completed w/i seven days of the patient.'s discharge, including the date of discharge, a summary of the patient's progress towards each patient service plan goal, legal status, and if applicable, current prescribed medication.			
(2) In addition to the requirements in (1) of this section an agency must ensure the following for each patient service plan. The patient service plan must:			
(a) Be personalized to the patient's unique treatment needs.			
(b) Include individual needs identified in the diagnostic and periodic reviews, addressing:			
(i) All substance use needing treatment, including tobacco, if necessary;			
(ii) The patient's bio-psychosocial problems;			
(iii) Treatment goals;			
(iv) Estimated dates or conditions for completion of each treatment goal; and			
(v) Approaches to resolve the problem.			
(c) Document approval by a CDP if the staff developing the plan is not a CDP.			
(d) Document that the plan was updated to reflect any changes in the patient's treatment needs, or as request by the patient, at least once per month for the first 3 months, and at least quarterly thereafter.			
(e) Document that the plan has been reviewed with the patient.			
OST TREATMENT COUNSELING REQUIREMENTS WAC 388-877B-0420 Clinical Record Content			
(1) In addition to the general clinical record content requirements in WAC 388-877-0640 an agency providing CD opiate substitution treatment svcs must maintain an patient's clinical record which must contain:			
(a) Documentation that the patient was informed of the federal confidentiality requirements and received a copy of the patient notice required under 42 CFR Part 2.			

WAC 388-877B-0420 (Continued)	YES	NO	COMMENTS
(b) Documentation that the agency made a good faith effort to review if the individual is enrolled in any other opiate substitution treatment and take appropriate action.			
(c) Documentation that the agency:			
(i) Referred the patient to self-help group(s);			
(ii) Addressed the patient's vocational, educational, and employment needs; &			
(iii) Encouraged family participation.			
(d) Documentation that the patient received a copy of the rules and responsibilities for treatment participants including the potential use of interventions or sanction.			
(e) Documentation that the patient service plan was completed before the patient received treatment services.			
(f) Documentation that the patient service plan was reviewed:			
(i) Once every month, for the first 90 days in treatment;			
(ii) Once every 3 months, for every 2 years of continued enrollment in treatment;			
(iii) Once every 6 months, after the second year of continued enrollment in treatment; and			
(g) Documentation that individual or group counseling sessions were provided:			
(i) Once a week, for the first 90 days:			
(A) For a new patient in treatment;			
(B) For a patient readmitted more than 90 days since the most recent discharge from opiate substitution treatment.			
(ii) Once every week, for the first month, for an patient readmitted within 90 days since the most recent discharge from OST; and			
(iii) Once every month, for an patient transferring from another OST program when the patient had received treatment for at least 90 days.			
(h) Documentation of progress in a timely manner & before any scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session & the name of the staff member who provided it.			
(i) Documentation when an patient refuses to provide a drug testing specimen sample or refuses to initial the log containing the sample number. The refusal is considered a positive drug screen specimen.			
(j) Documentation of the results and the discussion held with the patient regarding any positive drug screen specimens in the counseling session immediately following the notification of positive results.			
WAC 388-877B-0420 (Continued)	YES	NO	COMMENTS

(k) Justification for the change in the level of care when transferring an individual(s) from one certified treatment service to another within the same agency, at the same location.			
(l) Documentation that staff members met w/each patient at the time of discharge unless the patient left w/o notice to:			
(i) Determine the appropriate recommendation for care and finalize a continuing care plan.			
(ii) Assist the patient in making contact with the necessary agencies or services.			
(iii) Provide and document the patient was provided with a copy of the plan.			
(m) Documentation that a discharge summary was completed w/i seven days of the patient's discharge, including the date of discharge, a summary of the patient's progress towards each patient service plan goal.			
(n) Documentation of all medical services. See WAC 388-877B-0440 and 388-877B-0450, regarding program physician responsibility and medication management.			
(2) In addition to the requirements in (1) of this section an agency must ensure the following for each patient service plan. The patient service plan must:			
(a) Be personalized to the patient's unique treatment needs.			
(b) Include individual(s) needs identified in the diagnostic and periodic reviews, addressing:			
(i) All substance use needing treatment, including tobacco, if necessary;			
(ii) The patient's bio-psychosocial problems;			
(iii) Treatment goals;			
(iv) Estimated dates or conditions for completion of each treatment goal; and			
(v) Approaches to resolve the problem.			
(c) Document approval by a CDP if the staff developing the plan is not a CDP.			
(d) Document that the plan has been reviewed with the patient.			
MISCELLANEOUS REQUIREMENTS			
WAC 388-877B-0300(4)(d) An agency must provide tuberculosis screenings to patients for the prevention and control of tuberculosis screenings.			
WAC 388-877-0600(1)(a-j) An agency must provide client rights.			
WAC 388-877B-0370 An agency must follow the requirements when a patient is convicted of driving under the influence.			

COUNTY CONTRACT REQUIREMENTS	YES	NO	COMMENTS
(1) Financial Screening, monthly (Exhibit B, Section 3.1 [c])			
(2) TXIX screening (Exhibit B, Section 3.3 [b])			
(3) Referral to child care services (Exhibit A, Section 5.6[k])			
(4) Priority Population (Exhibit B, Section 4.1)			
(a) Pregnant (Assessed within 48 hours of request, Exhibit B, Section 4.1 [a](1);			
(b) IDU (Assessed within 14 days after service requested; Exhibit B, Section 4.1[a](2); and			
(c) Parents with dependent Children (Exhibit B, Section 4.1[a](3).			
Additional priority categories include:			
(a) Post-partum females (Exhibit B, Section 4.1[a](4);			
(b) Parents involved in Children's Administration Division, including CPS (Exhibit B, Section 4.1[a](4);			
(c) Patients transitioning from inpatient/residential care to OP care (Exhibit B, Section 4.1[a](4);			
(d) Offenders as defined in RCW 70.96A.350 (Exhibit B, Section 4.1[a](4); and			
(e) Other Medicaid patients (Exhibit B, Section 4.1[a](4).			
(5) Waiting List Interim Services (Exhibit B, Section 4.4).			
(6) Date of First Contact (Exhibit B, Section 4.5).			
(7) Self Help Grps # of grps attended in the last 30 days for each assessment admission, and discharge submitted to the system.			
(9) GAIN SS (HB 5763) (Exhibit B, Section 5.6(f).			

Additional Observations/Notations:

Pierce County Outpatient Patient File Checklist

Agency Name: **MDC - Detox**
 Admit Date:
 Program Type: **Detox**

Client Name:
 Assmnt Date:
 Assmnt Only:

Client DOB:
 Discharge Date:
 Discharge Type:

CLINICAL RECORD CONTENT REQUIREMENTS WAC 388-877-0640	YES	NO	COMMENTS
The service provider must ensure patient record content includes:			
(1) Documentation the pt. received a copy of counselor disclosure requirements established under RCW 18.19.060.			
(2) Demographic information.			
(7) Documentation the patient was informed of applicable state and federal confidentiality requirements. 388-877B-0320(1)(a).			
(8) Documentation of confidential information that has been released without the consent of the patient under RCW 70.02.050, 71.05.390, and 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA).			
(12) Documentation of coordination of care, as needed.			
(13) Documentation of all service encounters.			
(14) Medication records, if applicable.			
(15) Laboratory reports, if applicable.			
(16) Properly completed authorizations for release of information, if applicable.			
(17) Copies of applicable correspondence.			
(18) Discharge information.			
DETOX COUNSELING REQUIREMENTS WAC 388-877B-0120 Clinical Record Requirements			
In addition to the general clinical record content requirements in WAC 388-877-0640, an agency providing CD Detox svcs must maintain an patient's clinical record that contains:			
(1) Documentation of a CD screening before admission.			
(2) A voluntary consent to tx form, or any release forms, signed and dated by the patient or the patient's parent or legal guardian, except as authorized by law for protective custody and involuntary treatment.			
(3) Documentation that the pt. was informed of federal confidentiality requirements and received a copy of the pt. notice required under 42 CFR, Part 2			
(4) Documentation that the pt. received the HIV/AIDS brief risk intervention.			

WAC 388-877B-0120 (Continued)	YES	NO	COMMENTS
(5) Documentation of progress in a timely manner from each shift and as events occur, or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session & the name of the staff member who provided it.			
(6) Documentation that a discharge summary, including a continuing care recommendation and a description of the patient's physical condition, was completed within 7 days of discharge.			
MISCELLANEOUS REQUIREMENTS			
WAC 388-877B-0300(4)(d) An agency must provide tuberculosis screenings to patient's for the prevention and control of tuberculosis screenings.			
WAC 388-877-0600(1)(a-j) An agency must provide client rights.			
COUNTY CONTRACT REQUIREMENTS			
(1) Financial Screening, monthly (Exhibit A, Section 4.1 [c])			

Additional Observations/Notations:

Pierce County Outpatient Patient File Checklist

Agency Name: **Bi-Corp**
 Admit Date:
 Program Type: **Long Term**

Client Name:
 Assmnt Date:
 Assmnt Only:

Client DOB:
 Discharge Date:
 Discharge Type:

CHEMICAL DEPENDENCY ASSESSMENT REQUIREMENTS WAC 388-877B-0330	YES	NO	COMMENTS
Each agency licensed by the department to provide any behavioral health service is responsible for an patient's initial assessment which must include:			
(1) A face-to-face diagnostic interview w/the patient in order to obtain, review, evaluate, an document a history of the patient's needs. In addition to the assessment requirements in WAC 388-877-0610, the assessment must include:			
(a) The type of substances used; including tobacco			
(b) The route of administration; and			
(c) Amount, frequency, and duration of use.			
(2) History of alcohol or other drug treatment or education;			
(3) The patient's self-assessment of use of alcohol and other drugs;			
(4) A relapse history;			
(5) A history of self-harm;			
(6) A legal history involvement; and			
(7) A statement regarding the provision of an HIV/AIDS brief risk intervention.			
(8) A diagnostic assessment statement, including sufficient information to determine the patient's diagnosis using the:			
(a) Diagnostic and Statistical Manual (DSM IV TR, 2000), as it existed on the effective date of this section; then			
(b) DSM 5 as it exists when published and released in 2013, consistent with the purposes of this section.			
(9) A placement decision, using PPC dimensions when the assessment indicates the patient is in need of services.			
(10) Evidence the patient was notified of the assessment results and documentation of the treatment options provided and the patient's choice. If the patient was not notified of the results & advised of referral options, the reason must be documented.			

WAC 388-877B-0330 Continued	YES	NO	COMMENTS
(11) The additional requirements outlined under WAC 388-877B-0550 for driving under the influence assessment, for an agency providing services to a patient under RCW 46.61.5056.			
(12) Documented attempts to obtain the following information when assessing youth:			
(a) Parental and sibling use alcohol and other drugs;			
(b) History of school assessments for learning disabilities or other problems, which may affect ability to understand written materials;			
(c) Past and present parent/guardian custodial status, including a history of running away and out-of-home placements;			
(d) History of emotional or psychological problems;			
(e) History of child or adolescent developmental problems; and			
(f) Ability of the youth's parents/guardians to participate in treatment.			
INITIAL ASSESSMENT WAC 388-877-0610			
(1) The initial assessment must be:			
(a) Conducted in person; and			
(b) Completed by a professional appropriately credentialed or qualified to provide CD, MH, and/or problem and pathological gambling svcs as determined by state law.			
(2) The initial assessment must include and document the patient's:			
(a) Identifying information;			
(b) Presenting issues;			
(c) Medical provider's name or medical provider's names;			
(d) Medical concerns;			
(e) Medications currently taken;			
(f) Brief mental history;			
(g) Brief substance use history, including tobacco (see above);			
(h) Brief problem and pathological gambling history;			
(i) The identification of any risk of harm to self and others, including suicide and/or homicide;			
(j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;			
(k) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and			
(l) Treatment recommendations or recommendations for additional program-specific assessment.			

PATIENT SERVICE PLAN WAC 388-877-0620	YES	NO	COMMENTS
(1) Patient service plans must be as follows:			
(a) Be completed or approved by a professional appropriately credentialed or qualified to provide MH, CD and/or Problem Gambling services.			
(b) Address age, gender, cultural, strengths and/or disability issues identified by the patient or, the patient's parent(s) or legal representative.			
(c) Be in a terminology that is understandable to the patient and family.			
(d) Document the plan was mutually agreed upon and a copy was provided to patient.			
(e) Demonstrate the patient's participation in the development of the plan.			
(f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.			
(g) Be strength-based.			
(h) Contain measurable goals or objectives, or both.			
(i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.			
(2) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.			
CLINICAL RECORD CONTENT REQUIREMENTS WAC 388-877-0640			
The service provider must ensure patient record content includes:			
(1) Documentation the patient received a copy of counselor disclosure requirements established under RCW 18.19.060.			
(2) Demographic information.			
(3) An initial Assessment.			
(4) Documentation of the patient's response when asked if:			
(a) The patient is under Department of Corrections supervision; and			
(b) The patient is under civil or criminal court ordered MH or CD treatment.			
(c) A copy of the court order exempting patient from reporting requirements.			
(5) Documentation that the agency met all the following requirements when a patient informs the agency that he/she is under supervision by DOC due to a less restrictive alternative or DOC order for treatment:			
(a) The agency notified DOC orally or in writing. The agency must confirm an oral notification with a written notice by electronic mail or fax.			
(b) The agency obtained a copy of the court order from the patient and place it in the record when the patient was given relief from disclosure by he committing court.			

WAC 388-877-0640 (Continued)	YES	NO	COMMENTS
(c) When appropriate, the agency requested an evaluation by a designated MH professional when the provider becomes aware of a violation of the court-ordered treatment and the violation concerns public safety.			
(6) The initial and any subsequent patient service plan that include:			
(a) All revisions to the plan, consistent w/the service(s) the patient receives; and			
(b) Documentation of objective progress towards established goals as outlined in the plan.			
(7) Documentation the patient was informed of applicable state and federal confidentiality requirements. 388-877B-0320(1)(a).			
(8) Documentation of confidential information that has been released without the consent of the patient under RCW 70.02.050, 71.05.390, and 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA).			
(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with Chapters 26.44 and 74.34 RCW has occurred.			
(10) If treatment is not court-ordered, documentation of informed consent to treatment by the patient or patient's parent, or other legal representative.			
(11) If treatment is court-ordered, a copy of the detention or involuntary treatment order.			
(12) Documentation of coordination of care, as needed.			
(13) Documentation of all service encounters.			
(14) Medication records, if applicable.			
(15) Laboratory reports, if applicable.			
(16) Properly completed authorizations for release of information, if applicable.			
(17) Copies of applicable correspondence.			
(18) Discharge information.			
ADDITIONAL CLINICAL RECORD CONTENT WAC 388-877B-0320			
(1) In addition to the general clinical record content requirements in WAC 388-877-0640, an agency must maintain in the clinical record:			
(a) Documentation the patient was informed of confidential requirements & received a copy of the patient notice required under 42 CFR Part 2. See 388-877-0640(7)			
(b) Documentation that the initial patient service plan was completed before treatment services are received.			
(c) Documentation of progress in a timely manner & before any scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session & the name of the staff member who provided it.			
WAC 388-877B-0320 (Continued)	YES	NO	COMMENTS

(d) Justification for the change in the level of care when transferring an ind from one certified treatment service to another within the same agency, at the same location.			
(e) Documentation that staff members met w/each patient at the time of discharge unless the patient left without to:			
(i) Determine the appropriate recommendation for care and finalize a continuing care plan.			
(ii) Assist the patient in making contact w/necessary agencies or services.			
(iii) Provide and document the patient was provided with a copy of the plan.			
(f) Documentation that a discharge summary was completed w/i seven days of the patient.'s discharge, including the date of discharge, a summary of the patient's progress towards each patient service plan goal, legal status, and if applicable, current prescribed medication.			
(2) In addition to the requirements in (1) of this section an agency must ensure the following for each patient service plan. The patient service plan must:			
(a) Be personalized to the patient's unique treatment needs.			
(b) Include individual needs identified in the diagnostic and periodic reviews, addressing:			
(i) All substance use needing treatment, including tobacco, if necessary;			
(ii) The patient's bio-psychosocial problems;			
(iii) Treatment goals;			
(iv) Estimated dates or conditions for completion of each treatment goal; and			
(v) Approaches to resolve the problem.			
(c) Document approval by a CDP if the staff developing the plan is not a CDP.			
(d) Document that the plan was updated to reflect any changes in the patient's treatment needs, or as request by the patient, at least once per month for the first 3 months, and at least quarterly thereafter.			
(e) Document that the plan has been reviewed with the patient			
NOTE TO REVIEWER: All the above 388-877B-0320 matches 388-877B-0220 for Long Term Residential with the exception of the following:			
RESIDENTIAL TREATMENT REQUIREMENTS FOR LONG TERM WAC 388-877B-0220			
(1) In addition to the general clinical record content requirements in WAC 388-877-0640, an agency providing CD residential treatment services must maintain a patient's clinical record which must contain:			
(b) Documentation that the patient received a copy of the rules and responsibilities for treatment participants including the potential use of interventions or sanction.			
(e) When a pt is transferring to another svc provider, documentation that copies of documents pertinent to the pt's course of treatment were forwarded to the new service provider to include:	YES	NO	COMMENTS
(i) The patient's demographic information; and			
(ii) The diagnostic assessment statement & other assessment information included in the File Chklist			

(A) Documentation of the HIV/AIDS intervention.			
(B) Tuberculosis (TB) screen or test result.			
(C) A record of the patient's detoxification and treatment history.			
(D) The reason for the patient's transfer.			
(E) Court mandated, Department of Correction supervision status or the agency's recommended follow-up treatment.			
(F) A discharge summary and continuing care plan.			
(2) In addition to the requirements in (1) of this section an agency must ensure the following for each patient service plan. The patient service plan must:			
(b) Be initiated with at least one goal identified by the patient during the initial assessment or at the first service session following the assessment.			
RESIDENTIAL TREATMENT REQUIREMENTS FOR LONG TERM WAC 388-877B-0270			
An agency providing CD Long-Term Inpatient Residential Treatment Services must:			
(1) Provide an individual a minimum of 2 hrs each week of individual or group counseling.			
(2) Provide an individual a minimum of 2 hours each week of education regarding alcohol, other drugs, and other addictions.			
(3) Documentation of progress in a timely manner & before any scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session & the name of the staff member who provided it.			
(4) Provide a patient, during the course of services, with:			
(a) Education on social and coping skills;			
(b) Social and recreational skills;			
(c) Assistance in seeking employment; when appropriate; and			
(d) Assistance with re-entry of living skills to include seeking & obtaining safe housing.			
(e) Conduct and document a patient service plan at least monthly.			
MISCELLANEOUS REQUIREMENTS			
WAC 388-877B-0300(4)(d) An agency must provide tuberculosis screenings to patients for the prevention and control of tuberculosis screenings.			
WAC 388-877-0600(1)(a-j) An agency must provide client rights.			
WAC 388-877B-0370 An agency must follow the requirements when a patient is convicted of driving under the influence.			
COUNTY CONTRACT REQUIREMENTS	YES	NO	COMMENTS
(1) Financial Screening, monthly (Exhibit B, Section 3.1 [c]).			
(2) TXIX screening (Exhibit B, Section 3.3 [b]).			
(3) Referral to child care services (Exhibit A, Section 5.6[k]).			
(4) Priority Population (Exhibit B, Section 4.1).			

(a) Pregnant (Assessed w/i 48 hrs of request, Exhibit B, Section 4.1 [a](1).			
(b) IDU (Assessed w/i 14 days after service requested; Exhibit B, Section 4.1[a](2).			
(c) Parents with dependent Children (Exhibit B, Section 4.1[a](3).			
Additional priority categories include:			
(a) Post-partum females (Exhibit B,Section 4.1[a](4).			
(b) Parents involved in CA Division, including CPS (Exhibit B,Section 4.1[a](4).			
(c) Patients transitioning from inpatient/residential care to OP care (Exhibit B, Section 4.1[a](4).			
(d) Offenders as defined in RCW 70.96A.350 (Exhibit B,Section 4.1[a](4).			
(e) Other Medicaid patients (Exhibit B, Section 4.1[a](4).			
(5) Waiting List Interim Services (Exhibit B, Section 4.4).			
(6) Date of First Contact (Exhibit B, Section 4.5).			
(7) Self Help Grps # of grps attended in the last 30 days for each assessment admission, and discharge submitted to the system.			
(9) GAIN SS (HB 5763) (Exhibit B, Section 5.6(f).			

Additional Observations/Notations:

Pierce County Provider Contract Checklist

	YES	NO	Comments
(1) Quarterly Reports (Exhibit A, Section 3[f][g]; Section 4.9[e]) (timely and meeting outcome goals)			
(2) Data Quality, files closed with 60 days of no services (Exhibit A, Section 4.9[d])			
(3) Management Information System (Exhibit A, Section 4.9)			
(4) Monthly Providers Meeting, attendance (Section A, Section 4.7[e])			
(5) TXIX maximized (Exhibit A, Section 4.8[e])			
(6) Treatment Expansion maximized (Exhibit A, Section 4.8[f])			
(7) Client Grievance Procedure Posted (Basic Agreement, Section 8.1)			
(8) Unusual Occurrences (Basic Agreement, Section 9)			
(9) Non-Discrimination in Employment and Services (Basic Agreement, Section 12)			
(10) Drug-Free Workplace Policy Posted (Basic Agreement, Section 14)			
(11) Public materials reveal PCCC/CDD as a funding source (Exhibit A, Sec 4.8[d])			
(12) UAs (Adult/8 monthly & Youth/4 w/i 31 days (Exhibit A, Section 3.2[j])			
(13) Background Checks (Exhibit A, Section 4.7[b]) (WAC 388-805-200(2))			
(14) Check Group Rosters with TARGET information			
(15) Evacuation Posters			
(16) Manual reviewed yearly (388-805-145(3)(b))			
(17) CDP Authentication (388-805-210)(6)			
(18) Evacuation prominently posted WAC 388-805-150(17)(f)			
(19) TARGET - Provider at least one trained primary and a backup data operator (County Contract, Exhibit A, section 2 [2.2])			
(20) ADATSA Clients must have in ITP (job seeking motivation and establish vocational goals) (Exhibit A., Section 3.7d)			
(21) ADATSA Tx Eligibility forms (DSHS 04-433B & 14-299 Assmnt Referral)			



3315 S. 23rd Street, Suite 310 | Tacoma, WA 98405 | phone: (253)292-4200 | fax: (253)292-4219 | www.optumhealthpierceRegional.Support.Network.com

Annual Contractor Review Report

November 1-2, 2014

Submitted To Greater Lakes Recovery Center
April 10, 2015

Compiled by the Optum Pierce Regional Support Network QA/PI Unit

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3315 S. 23rd Street, Suite 310 | Tacoma, WA 98405 | phone: (253)292-4200 | fax: (253)292-4219 | www.optumhealthpierceRegional.Support.Network.com

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Intentions of the Annual Review Report

The Optum Pierce Regional Support Network's Annual Review Team initiated the Annual Review at Greater Lakes Recovery Center Evaluation and Treatment Center (E & T) on November 1-2, 2014. A total of five (5) randomly selected clinical records were reviewed for clinical standards and 28 records for encounter data validation standards. Agency licenses & certifications, all personnel records, policies and procedures, performance measures, and other documents were additionally reviewed.

The purpose of the Annual Reviews by Regional Support Networks is to determine whether the agency fulfilled the requirements of Washington Administrative Code 388-865-0284(3) to monitor contracts with providers and notify the Division of Behavioral Health and Recovery of observations and information that might indicate that providers are not in compliance with licensing and certification requirements. The Annual Review is extensive and generally includes an administrative, personnel record, medical record, data integrity, fiscal, and billing/encounter data review.

This year, Optum Pierce Regional Support Network used the Division of Behavioral Health and Recovery Licensing and Certification Review Tool (2014 Revision), the Optum Pierce Regional Support Network Encounter Data Validation Tool, Division of Behavioral Health and Recovery Personnel Record Review Tool coupled with questions focusing on Washington State regulations, Optum Pierce Regional Support Network policy standards, contract requirements, EQRO review topics, Washington Administrative Code, Revised Code of Washington, Code of Federal Regulations, and Practice Guideline elements not covered in reviews by the Division of Behavioral Health and Recovery.

As detailed in GLMHC's Annual Review report, the Greater Lakes organization has completed multiple reviews over the last year with DBHR. The QA/PI staff from the Optum Pierce RSN sat in on each of these thorough reviews, obtained copies of the scoring sheets, and was included in follow up on corrective actions, thus it was decided that with GLRC and GLMHC's high level of performance and the amount of time reviewers spent on site, the RSN could complete a brief review with a smaller number of charts. The brief review incorporated all required elements and used the full DBHR review tool for E & T's, but reviewed a small number of charts. This approach gives GLRC the advantage of having less work interrupted, having the RSN spend less time at the site, and having fewer opportunities for the review team to spot problem areas. This approach on the other hand disadvantages GLRC by having the review score and report based on a very small number of charts, limited conversations, and a short tour of the facility....thus magnifying the few errors that are found. In the spirit of cooperation with DBHR, a desire to not duplicate paperwork or interfere more than necessary with the running of the business, the Optum Pierce RSN conducted an abbreviated review in 2014.

Reviewers for this audit included: Raetta Daws, QA/PI Manager; Rebecca Panzer, QA Analyst; Allie Franklin, Manager, Clinical Services; Sandy Gregoire, Recovery Specialist; and Nicole Bishop, Data Specialist.

Strengths

- Greater Lakes Recovery Center requests that guests complete satisfaction surveys at the end of their stay. These proactive efforts to gauge and improve satisfaction with services are to be commended.



- The GLRC's Calming Room is a "state of the art" design meant to decrease anxiety, stress and physical acting out, and should be a model for similar programs.
- Of 267 E & T discharges between February 2014 and January 2015, 118 persons changed their legal status from involuntary to voluntary. This represents a 44.19% rate of change towards a more independent status. All individuals who "flipped" to a voluntary status have remained "voluntary."

On-Site Review

Facility Review

A thorough tour was taken during the October review. All licenses and certificates were posted as required inside the attractive facility. A consumer rights statement was posted in the entry hall, but three items were missing or unclear on the posting. The Recovery Center director worked with Optum to quickly rectify this situation and post the updated version of the Rights. A receptionist or staff office was positioned immediately inside the front door. No personal health information was visible on computers or desks in the receptionist's office. Confidential office spaces were available down a hall to the left of the receptionist office. The facility structure is accessible to individuals with disabilities, special needs, sensory deficiencies, and non-English languages. The site at the end of a street in a quiet residential neighborhood can be easily found with directions. The presence of mature trees, shrubs and flowers on the property add a sense of calm to the site. A drop-off room for law enforcement and emergency professionals was located at the far end of the front hall near the receptionist's office. A door along the outside wall provides immediate access to law enforcement or other emergency personnel who drive up to the building. The drop-off room was tastefully decorated, and very clean. A nurse's office was located in the same hall, and appropriately had medications stored in a secure manner as is expected by contract and legal standards. All requirements (WAC 388-877A-180) for psychiatric medications were met.

A locked door separated the hall and a staff work room from the area of the building primarily used by individuals in services. At the time of the facility tour, five or six staff persons sat at desks and tables in the staff work area, recording information in clinical charts, laughing and visiting with one another. While the behavior and conversation was considered appropriate, the review team questioned the E & T managers about why such a number of staff would be interacting with one another rather than being engaged with the individuals in the program. Concern was also expressed that the staff work room has a "fish bowl" appearance with a large glass window looking into the locked community area. The review team voiced concern that individuals in the program could easily misinterpret the staff's choice to work in an area away from them, and perceive the laughter and animated conversation as being about them. The review team suggested that the E & T managers might consider alternative documentation options to increase staff time in the community area with the individuals in services such as concurrent documentation with input by individuals, use of an electronic tablet on a portable stand, or the placement of a computer on a desk in the community area so that all have access.

The review team looked at the bedrooms located down two open hallways from the community area. All rooms were clean and designed with safety in mind. Blinds were built into a small glass panel on the doors with a small knob that allows individuals to twist them open or closed. Bathrooms, restraint and seclusion



areas all met Washington State standards. No deficiencies were identified using the DBHR Facility Check-List tool.

The E & T managers leading the review unlocked the Calming Room in the primary hall where bedrooms are also located. The room was beautifully decorated with deep warm colors, soft oversized leather couches, a stately wooden armoire with a large flat screen television/DVD player and a variety of relaxation discs. A huge wall-sized bubble machine provided a gentle, colorful display of lights and bubbles as they cascaded through an unbreakable glass panel. The management team reported that the Calming Room is used as a preventive measure to help individuals calm themselves when feeling anxious or agitated. A clipboard was demonstrated on which individuals may sign up in advance to request use of the room. The managers reported individuals rotate and use the room all day long. The review team commented that the layout and furnishings were state of the art. It may be obvious to say, but the RSN review team was highly impressed with the Calming Room! A few questions were raised about why the E & T staff thought it necessary to keep the room locked, why the room wasn't being used that afternoon, and how the staff determines who gets to use the room when multiple persons "need" it at the same.

Personnel

The personnel files are clear and extremely well organized, with the information neatly divided and details easy to locate. The files are stored at the primary community mental health agency site in Lakewood. See the GLMHC Annual Review Report for additional details. Personnel records from all sites were reviewed at the same time.

Supervision

Formal supervision takes place monthly for nursing staff as well as on an "as-needed" basis. A good deal of informal coaching takes place during and following shifts, with a focus on challenging situations. Debriefings are held post seclusion or restraint events. Due to the E & T being staffed around the clock by shifts of workers, the management team reported that it is challenging for them to keep individual supervision notes about meetings with each staff person.

Key Documents

Washington State Patrol background checks were complete, and LEIE/OIG exclusion checks were completed on a regular basis. The Human Resources staff compare disciplinary and licensure revocation reports against their staff roster on an ongoing basis. No employees or board members were found to be excluded from working with federal funds. This information is kept at the main building site in Lakewood. See the GLMHC Annual Review report.

Training Report

Safety training was complete for all staff. Cultural competency training was overdue for two persons. Performance evaluations were up to date with one exception. HR staff demonstrated that they are following up with these employees to correct the overdue issues.



Quality Management Interview

The Quality Management Plan and process review was conducted both at GLMHC and at the GLRC. At the E & T interview Glenn Czerwinski, Heather Marsh, and Paul Nutting represented the E & T. Raetta Daws, QA/PI Manager at Optum; Sandy Gregoire, Optum Recovery Specialist; Rebecca Panzer, Optum Quality Analyst, and Allie Franklin, Clinical Manager asked questions about the quality and clinical processes at GLRC. Glenn, Heather and Paul fully responded to each question and shared a thorough, robust quality management plan that is in compliance with Washington Administrative Codes and all state and federal licensing and certification requirements.

Desk Top Review

Policies and Procedures

GLRC provided electronic copies of its Policies and Procedures for this review. They were found to be thorough and met their intended purpose.

Critical Incident Reporting

The Recovery center reported six critical incidents during this review period. Two incidents had to do with involuntarily-detained individuals climbing the exterior fence and going absent. Appropriate agencies were contacted to ensure the safety of these individuals; neither returned to the facility. Another incident involved the escape of an individual while he was being returned from mental health court to the facility; the back door of the van was unlocked and the person was able to run away before staff could stop him. Following this incident the child locks were engaged on the rear doors of the van to prevent similar incidents in future.

A fourth incident involved an assault on another resident by an individual in care; he was appropriately arrested and incarcerated. In a fifth incident, a staff person was punched by an individual while attempting an injection on medical override. The staff person required medical intervention.

The most significant incident reported had to do with a staff person's use of excessive force on an individual in care. The management team took the appropriate action and the staff's employment was terminated immediately.

Critical incident reporting to the RSN from GLRC is generally done in a timely fashion. However, a Category Two incident which occurred on 9/11/14, a Thursday, was not reported until the following Monday, 9/15/14. Another Category Two incident which occurred on 6/19/14 was reported to the agency on 6/23 and an investigation transpired prior to RSN notification on 6/27/14. In both of these instances, an initial report should have been made with a call or email to the RSN within 24 hours. In a third case a report was made to the on-call Care Manager over the weekend (9/20/14); we have clarified with the agency that Category One Critical Incident reports after hours or on the weekend should be made immediately and to the Quality Assurance unit directly. In addition, even if all information is not complete, the initial call to the RSN must be made within 24 hours for Category Two events. Additional information may be added during the subsequent five days.



Grievance Reporting

GLRC reported no grievances during this review period. It is concerning to the Pierce RSN that no grievances were reported at the E & T over the last year, especially given the definition of a grievance as “any expression of dissatisfaction.” Looking at the numbers of critical incidents, restraints and seclusions, and numbers of individuals detained, it is logical to assume that a variety of grievances would have been voiced by individuals in care. Grievance reporting will be watched closely over the next year. If there is not an increase in grievances at the E & T over the next year, additional steps may be put in place to ensure that the voices of individuals in care are heard.

Restraints and Seclusions

GLRC prioritized training and management of a “no force first” facility from the date of their opening to the present. Key staff at the E & T have been through Trauma Informed Care training by SAMSHA, Sanctuary Model training (with Telecare), along with staff safety training in verbal de-escalation and restraint. The team was able to maintain a safe environment throughout the months of March and October in 2014 without the use of seclusion or restraint. Additionally, the E & T went from February through April 2014 without restraints.

Seclusions at GLRC Jan 2014 - Nov 2014

Date	Total Incidents of Seclusion	Average Time per Incident	Total # of Unique Individuals
Jan-2014	3	133.33	3
Feb-2014	1	15	1
Mar-2014	0	0	0
Apr-2014	2	35	2
May-2014	3	65	2
Jun-2014	1	30	1
Jul-2014	3	101.67	3
Aug-2014	3	38.33	2
Sept-2014	2	320	2
Oct-2014	8	91.50	4
Nov-2014	0	0	0
Total	26	31.92	19

Restraints at GLRC Jan 2014-Nov 2014

Date	Total Incidents of Restraint	Average Time per Incident	Total # of Unique Individuals
Jan-2014	1	75	1
Feb-2014	0	0	0
Mar-2014	0	0	0
Apr-2014	0	0	0
May-2014	1	60	1
Jun-2014	1	50	1
Jul-2014	2	111	2
Aug-2014	1	50	1
Sept-2014	0	0	0
Oct-2014	1	240	1
Nov-2014	0	0	0
Totals	7	83.71	7

Changes in Legal Status

Of 267 discharges between February 2014 and January 2015, 118 persons changed their legal status from involuntary to voluntary. This represents a 44.19% rate of change towards a more independent status. All individuals who “flipped” to a voluntary status have remained “voluntary.”

Clinical Record Review

Because this was the first year for reviewing agencies with the new Division of Behavioral Health and Recovery Clinical Review Tool, it is not possible to compare this year’s results with the previous year.

In 2014, there were 71 items on the complete review tool, of which seven (7) were immediately eliminated due to being non-applicable to an adult population in an evaluation and treatment center. Out of the total of 54 remaining items, GLRC’s records were scored at the 100% level on 31 questions. One item received two “no” responses, and 14 items were scored as having one “no” response in the review of the clinical record.

GLRC staff gave essential assistance to the review team in locating information within the hard copy clinical records. Items filed in the charts were well-organized, with information consistently filed in the same location across charts, although it was somewhat challenging to follow the paper trails when an individual had multiple admissions in close proximity to one another. For example, if an individual was discharged to a hospital for treatment, then returned, a new file might be opened, but the current treatment episode might refer back to labs in a previous chart.

Scoring by Question



The following table presents the item, the number of and percentage of “NO” scores. (Please note that **0.0% in the final column is equivalent to a score of 100% positive.**) All items marked with a “no” score will need further attention from the GLRC team.

<u>Number</u>	<u>Question</u>	<u>NO</u>	<u>% NO</u>
<u>E&T ADULTS</u>			
WAC 388-865-0536: STANDARDS FOR ADMINISTRATION			
	Procedures for maintaining and protecting resident medical/clinical records consistent with chapter 70.02 RCW, “Medical Records Health Care Information Access and Disclosure Act” and HIPAA.		
1	The clinical record contains patient authorization of disclosure in accordance with 70.02.030 RCW.	1	2%
2	The clinical record documents that the resident has been advised of HIPAA regulations and adopted rules, policies and procedures establishing agency record acquisition, retention, and security policy consistent with Chapter 70.02 RCW.	0	0.0%
	Procedures to inventory and safeguard the personal property of the consumer being detained, including a process to limit inspection of the inventory list by responsible relatives or other persons designated by the detained consumer.		
3	The clinical record contains an inventory of the resident’s personal property with signature of staff making the inventory.	1- Listed initials only	2%
4	The inventory documents names approved by the consumer to inspect the inventory.	0	0.0%
	Procedures to provide warning to an identified person and law enforcement when a resident has made a threat against an identified victim.		
5	The clinical record documents disclosing information to an identified person and law enforcement when a resident has made a threat against an identified victim.	0	0.0%
WAC 388-865-0541: ADMISSION AND INTAKE EVALUATION			
	For consumers who have been involuntarily detained, the facility must obtain a copy of the petition for initial detention stating the evidence under which the consumer was detained. The facility must demonstrate that each resident has received evaluations to determine the nature of the disorder and the treatment necessary, including:		
6	If the consumer was involuntarily detained, the clinical record contains a copy of the petition for initial detention.	0	0.0%
	A health assessment of the consumer’s physical condition to determine if the consumer needs to be transferred to an appropriate hospital for treatment.		
7	The clinical record contains a health assessment, which includes recommendations and referrals for medical treatment.	0	0.0%
	Examination and medical evaluation within twenty-four hours by a licensed physician, advanced registered nurse practitioner, or physician assistant-certified.		
8	The clinical record contains a medical examination and evaluation.	0	0.0%



Number	Question	NO	% NO
9	The clinical record documents that the medical examination and evaluation were completed within 24 hours of arrival.	0	0.0%
	Development of an initial treatment plan.		
10	The clinical record contains an initial treatment plan developed within 24 hours of arrival.	0	0.0%
	Psychosocial evaluation by a mental health professional.		
11	The clinical record contains a psychosocial evaluation.	0	0.0%
12	The clinical record documents that the psychosocial evaluation was completed by a mental health professional.	0	0.0%
	Consideration of less restrictive alternative treatment at the time of admission.		
13	The clinical record documents consideration of less restrictive alternatives at the time of admission.	0	0.0%
	The admission diagnosis and what information the determination was based upon.		
14	The clinical record contains an admission diagnosis.	0	0.0%
	The admission diagnosis and what information the determination was based upon.		
15	The clinical record contains documentation that supports the admission diagnosis.	0	0.0%
	If the licensed physician and mental health professional determine that the needs of an adult consumer would be better served by placement in a chemical dependency treatment facility, then the consumer must be referred to an approved treatment program defined under chapter 70.96A RCW.		
16	The clinical record documents that if there is a determination by a mental health professional and licensed physician that the needs of the adult consumer would be better served by placement in a chemical dependency treatment facility, the consumer was referred to an approved treatment program defined under chapter 70.96A RCW.	0	0.0%
	WAC 388-865-0545: USE OF SECLUSION AND RESTRAINT PROCEDURES - ADULTS		
	Staff must notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion.		
17	The clinical record documents that if seclusion or restraint was used, physician authorization was obtained within one hour of initiation.	0	0.0%
	The consumer must be informed of the reasons for use of seclusion or restraint, and the specific behaviors which must be exhibited in order to gain release from these procedures.		
18	The consumer was informed of the specific behavioral criteria for their use.	1	2%
19	The clinical record documents the consumer was informed of the specific behavioral criteria for the discontinuation of seclusion and restraint.	0	0.0%



Number	Question	NO	% NO
	The clinical record must document staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record.		
20	The clinical record documents that if seclusion or restraint was used, staff observed the consumer at least every fifteen minutes.	0	0.0%
	If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician must assess the consumer and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used.		
21	The clinical record documents that if seclusion or restraint exceeded twenty-four hours a licensed physician assessed the consumer and wrote a new order if the intervention was continued.	0	0.0%
22	The clinical record documents that this procedure was repeated for each twenty-four hour period that restraint or seclusion was used.	0	0.0%
	All assessments and justification for the use of seclusion or restraint must be documented in the consumer's medical record.		
23	The clinical record documents assessments and justification for each episode of seclusion and restraint.	0	0.0%
	WAC 388-865-0547: PLAN OF CARE/TREATMENT		
	The medical record must contain documentation of:		
	Diagnostic and therapeutic services prescribed by the attending clinical staff.		
24	The clinical record contains documentation of diagnostic and therapeutic services prescribed by the attending clinical staff.	0	0.0%
	A plan for treatment developed collaboratively with the consumer. This may include participation of a multi-disciplinary team or mental health specialists as defined in WAC 388-865-0150, or collaboration with members of the consumer's support system as identified by the consumer.		
25	The clinical record documents evidence of collaboration with the consumer and/or the consumer's identified support system in the development of the plan for treatment.	0	0.0%
26	Plan of treatment targets issues identified in the intake and assessment, needs raised by the consumer, identified members of the consumer's support system, multi-disciplinary team and mental health specialists.	0	0.0%
27	Plan of treatment uses language and terminology that is understandable to the consumer, and members of his/her support system.	2	4%
28	The clinical record contains copies of any advance directives, or that a copy of the advance directive was requested and not provided, or that this does not apply.	1	2%
29	The clinical record contains copies of any powers of attorney, or that a copy of any powers of attorney were requested and not provided, or that this does not apply.	1	2%
30	The clinical record contains copies of any letters of guardianship, or that a copy of the letters of guardianship were requested and not provided, or that this does not apply.	1	2%



Number	Question	NO	% NO
	A plan for discharge, including a plan for follow-up where appropriate.		
31	The clinical record documents a discharge plan, which includes a plan for follow up services, and:	1	2%
32	Informing the consumer of the purpose and reason for follow-up services;	1	2%
33	Informing the consumer of follow-up service name, address, phone number, appointment date and contact person if known.	1	2%
	Documentation of the course of treatment.		
34	The documentation of treatment is individualized to describe the individual's unique circumstances.	0	0.0%
35	The documentation includes interventions in response to specific needs.	1	2%
36	The documentation includes coordination of community care for discharge.	1	2%
	That a mental health professional has contact with each involuntary consumer at least daily for the purpose of: (a) Observation; (b) Evaluation; (c) Release from involuntary commitment to accept treatment on a voluntary basis; (d) Discharge from the facility to accept voluntary treatment upon referral.		
37	The clinical record documents at least daily contact with a mental health professional.	0	0.0
38	The documentation includes observation of functional behavior.	0	0.0%
39	The documentation includes evaluation of response to treatment.	1	2%
40	The documentation includes evaluation for release from involuntary commitment to accept treatment on a voluntary basis.	0	0.0
41	The documentation includes evaluation for discharge from the facility to accept voluntary treatment upon referral.	0	0.0
	WAC 388-865-0561: POSTING OF CONSUMER RIGHTS		
	Consumer rights assured by RCW 71.05.370 and 71.34.160 must be prominently posted within the department or ward of the community or inpatient evaluation and treatment facility and provided to the consumer. Note: RCW 71.05.370 has been re-codified as RCW 71.05.217; RCW 71.34.160 has been re-codified as RCW 71.34.355.		
42	The clinical record documents that the consumer was provided a written copy of the rights assured by RCW 71.05.360, RCW. 71.05.217 and 71.34.355.	0	0.0
	WAC 388-865-0570: RIGHTS RELATED TO ANTIPSYCHOTIC MEDICATIONS		
	Clinical record must document: (a) The physician's attempt to obtain informed consent. (b) The consumer was asked if he or she wishes to decline treatment during the twenty-four hour period prior to any court proceeding wherein the consumer has the right to attend and is related to his or her continued treatment. The answer must be in writing and signed when possible. In the case of a child under the age of eighteen, the physician must be able to explain to the court the probable effects of the medication. (c) The reason why any antipsychotic medication is administered over the consumer's objection or lack of consent.		
43	The clinical record documents the physician's attempt to obtain informed consent.	0	0.0%



<u>Number</u>	<u>Question</u>	<u>NO</u>	<u>% NO</u>
44	The clinical record documents that the consumer was asked if he or she wishes to decline treatment during the twenty-four hour period prior to any court proceeding wherein the consumer has the right to attend and is related to his or her continued treatment. The answer is in writing and signed when possible by the consumer.	0	0.0%
45	If antipsychotic medication was administered over the consumer's objection or lack of consent, the reasons are documented in the clinical record.	0	0.0
	The physician may administer antipsychotic medication over a consumer's objection or lack of consent only when: a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists when: i. The consumer presents an imminent likelihood of serious harm to self or others; ii. Medically acceptable alternatives to administration of antipsychotic medication are not available or unlikely to be successful; and iii. In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician; b) There is an additional concurring opinion by a second physician for treatment up to thirty days; c) For continued treatment beyond thirty days through the hearing on any one hundred eighty day petition filed under RCW 71.05.370(7), provided the facility medical director or medical director's designee reviews the decision to medicate the consumer. Thereafter, antipsychotic medications may be administered involuntarily only upon order of the court. The review must occur at least every sixty days. Note: RCW 71.05.370 has been re-codified as RCW 71.05.217.		
46	If antipsychotic medication was administered over a consumer's objection or without consent, the clinical record documents that an emergency existed.	0	0.0%
47	The clinical record documents a review by a second physician within twenty-four hours.	0	0.0%
48	The clinical record documents that the consumer presented an imminent likelihood of serious harm to self or others, that medically acceptable alternatives to administration of antipsychotic medication were not available or unlikely to be successful, and that, in the opinion of the physician, the consumer's condition constituted an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician.	1	2.0%
49	The clinical record documents an additional concurring opinion by a second physician for continued involuntary administration of antipsychotic medication up to thirty days.	0	0.0%
50	The clinical record documents the review by the facility medical director or the medical director's designee of the decision to medicate the consumer, if the involuntary administration of antipsychotic medication continued beyond thirty days.	0	0.0%



Number	Question	NO	% NO
51	The clinical record contains an order by the court for the continued involuntary administration of involuntary medication for thirty days through the hearing on any one hundred eighty-day petition filed under RCW 71.05.217(7).	0	0.0%
	The examining physician must sign all one hundred eighty-day petitions for antipsychotic medications files under the authority of RCW 71.05.370(7). Note: RCW 71.05.370 has been recodified as RCW 71.05.217.		
52	The clinical record documents that the examining physician has signed all one hundred eighty-day petitions for antipsychotic medications filed under the authority of RCW 71.05.217.	0	0.0%
	Consumers committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW 71.05.370(7) prior to the administration of involuntary medications. Note: RCW 71.05.370 has been recodified as RCW 71.05.217.		
53	The clinical record documents that if the consumer is committed for one hundred eighty days, and if the consumer has refused or lacks the capacity to consent to antipsychotic medications, s/he has been advised, in writing, of the right to a court hearing under RCW 71.05.217 (7) prior to the administration of involuntary medications.	0	0.0%
	In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician files a petition for an antipsychotic medication order the next judicial day.		
54	If antipsychotic medications have been administered to the consumer involuntarily, the clinical record documents that a petition was filed by an examining physician the next judicial day.	0	0.0%

Out of the total of 54 items, GLRC’s five (5) randomly selected records were scored at the 100% level on 31 questions. One item received two “no” responses (*a specific deficiency was identified in two (2) charts*), and 14 items were scored as having one “no” response (*a specific deficiency was identified in 1 chart*), in the review of the clinical records.

In studying the list of missed standards above, one quickly notes that some of the areas listed are either new to the WAC or are being interpreted and scored in a manner that is new within the Pierce RSN. The following chart details the “new emphasis” applied in the interpretation of the WACs that went into effect in July, 2013.

Application Example of the 2013 WACs	
Intake assessment contains sufficient clinical information, including a review of any documentation of a mental health condition provided by the individual, to justify the diagnosis using criteria in the current DSM	<i>This isn’t new, but there is a new emphasis on ensuring there is a clear, logical, professional justification for the selection of the diagnoses.</i>



Clinical Summary and Recommendations:

Many of the ‘NO’ responses are either related to systemic problems and are easily remedied through form modification, improved staff training and supervision, and improved documentation practices.

The clinical record contains a consent for treatment form, notification of rights, mental health assessment, treatment plan, crisis plan, progress notes, correspondence including documentation if any information is given, received or shared with anyone besides the consumer, his or her legal guardian, provider agency, or entity legally entitled by Washington Administrative Code or the Revised Code of Washington, release of information forms, and copies of any letters of guardianship, or that a copy of the letters of guardianship were requested and not provided, or that this does not apply. The record also contains an authorization to release information that is signed by the consumer or his or her legal guardian if any.

Fiscal Audit/Financial Review

A fiscal review needs to be scheduled for a date in 2015. It was not completed during the October or November site visits.

Encounter Data Validation

The Data Validity portions of the review were completed on June 30, 2014 by Nicole Bishop.

Audit Period: October 1, 2013 – April 30, 2014

FINAL SCORES

AUDIT TYPE	2014 SCORE	2013 SCORE	% CHANGE
ENCOUNTERS	100%	100%	-
CHART	99.06%	96.88%	-2.2%

ENCOUNTER REVIEW

After review of 28 encounters the final score is 100%.

1. We reviewed at least one random encounter for each client selected for the audit. This review identified matches for Date of Service, Service Code, Duration of Service, Location, Provider Type, and Provider of the service.
2. We also reviewed the clinical notes to ensure the reported service code was appropriate for the service provided.
3. Each category met the 95% RSN and Washington state requirement.

Date	Episode	Service	Duration	Descrip	Location	Provider	Provider
------	---------	---------	----------	---------	----------	----------	----------



	#	Code	tion	Type
2013	100%	-	100%	100%
2014	100%	100%	100%	100%
% Change	-	-	-	-

NON-ENCOUNTER DATA REVIEW

28 charts were reviewed for the non-encounter data audit. Overall score for this portion was 99.06%, an increase of 2.2% from the 2013 audit.

ACCURACY

To verify accuracy of certain fields: Date of Birth, Gender, Social Security Number, Guarantor ID, and ProviderOne ID. The data was confirmed against ProviderOne.

Social Security Number did not meet the 95% RSN & Washington State requirement.

Field	2014 Score	2013 Score	% Change
Date of Birth	100%	100%	-
Gender	100%	100%	-
Social Security Number	92%	100%	-8.7%
Guarantor ID	100%	100%	-
ProviderOne ID	100%	100%	-
Overall Score	98.41%	100%	-1.62%

ADMISSION OUTPATIENT

Each field met the 95% RSN & Washington State requirement.

Field	2014 Score	2013 Score	% Change
Admission Date	100%	100%	-
Attending Practitioner	100%	100%	-
Date of Birth	100%	100%	-
Gender	100%	100%	-
Client's Name	100%	100%	-
Social Security Number	96.3%	100%	-3.84%
Overall Score	99.4%	100%	-0.60%

DEMOGRAPHIC SECTION

Phone Number fell below the 95% RSN & Washington State requirement.

Field	2014 Score	2013 Score	% Change
Phone Number	89.29%	60%	32.8%
Primary Language	100%	96%	4.0%
Overall Score	94.64%	78%	17.55%

ADDITIONAL CLIENT DEMOGRAPHICS

Impairment Kind fell below the 95% RSN & Washington State requirement.



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Field	2014 Score	2013 Score	% Change
Address 1	100%	96%	4.0%
Address 2	100%	-	-
City, State, Zip	100%	96%	4.0%
County	100%	100%	-
Education	96.43%	88%	8.74%
Employment Status	100%	88%	12.0%
Ethnicity	100%	92%	8.0%
Grade Level	100%	96%	4.0%
Hispanic Origin	100%	96%	4.0%
Impairment Kind	92.86%	88%	5.23%
Impairment Kind 2	100%	50%	50.0%
Impairment Kind 3	100%	-	-
Living Situation	96.43%	92%	4.59%
Sexual Orientation	100%	92%	8.0%
Overall Score	98.74%	92.78%	6.04%

DISCHARGE

Both fields met the 95% RSN & Washington State requirement.

Field	2014 Score	2013 Score	% Change
Discharge Date	96.43%	100%	-3.7%
Discharge Type	96.43%	100%	-3.7%
Overall Score	96.43%	100%	-3.7%

DIAGNOSIS

Each field met the 95% RSN & Washington State requirement.

Field	2014 Score	2013 Score	% Change
Date of Diagnosis	100%	100%	-
Time of Diagnosis	-	-	-
Axis I	100%	100%	-
Axis I-2	100%	100%	-
Axis I-3	-	-	-
Axis II	100%	100%	-
Axis II-2	-	-	-
Axis II-3	-	-	-
Axis IV: Primary Sppt	100%	100%	-
Axis IV: Social Envir	100%	100%	-
Axis IV: Education	100%	100%	-
Axis IV: Occupational	100%	100%	-
Axis IV: Housing	100%	100%	-
Axis IV: Economic	100%	100%	-
Axis IV: Health Care	100%	100%	-
Axis IV: Legal/Crime	100%	100%	-
Axis IV: Other	100%	100%	-



Principal Diagnosis	100%	100%	-
Axis V: CGAS	-	-	-
Axis V: GAF	100%	100%	-
Overall Score	100%	100%	-

CONSUMER INCOME

All fields met the 95% RSN & Washington State standard.

Field	2014 Score	2013 Score	% Change
Income Date	100%	96%	4.0%
Gross Monthly Income	100%	92%	8.0%
Number of Dependents	100%	92%	8.0%
Overall Score	100%	93.33%	6.67%

FINANCIAL ELIGIBILITY

All fields met the 95% RSN & Washington State standard.

Field	2014 Score	2013 Score	% Change
Guarantor ID	100%	100%	-
Level Start Date	100%	100%	-
Level End Date	-	-	-
ProviderOne ID	100%	100%	-
Overall Score	100%	100%	-

CORRECTIVE ACTION

The following data elements require review of data collection and reporting (all rates are percent correct of total reviewed for that element):

Accuracy

- Social Security Number – 92%

Demographics

- Clients Home Phone – 89.29%

Additional Client Demographics

- Impairment Kind – 92.86%

Upon receipt of the final report, please be prepared to submit a corrective action plan to address meeting the 95% threshold for acceptable data match. Optum is available to help Greater Lakes Recovery Center achieve this goal.

RECOMMENDATIONS

Although you may have met the 95% target for the fields listed below it is imperative you continue to strive for 100% as these data sets are critical to our operation.

→ SOCIAL SECURITY NUMBER

The SSN is critical in identifying and preventing duplicate clients.



→ ADDRESS

The address, which includes the city, state, and zip code, is critical data for assignment of the consumer to the RSN of residence.

→ ETHNICITY & HISPANIC ORIGIN

These data fields are essential for geo-mapping and analysis of equity in served populations.

→ EDUCATION, GRADE LEVEL, LIVING SITUATION, & EMPLOYMENT

These data fields are outcome indicators that will receive more attention as we move forward.

Overall Annual Review Summary and Recommendations

Deficient Area	Page Number	Follow-up Expectation	Due Date
Data Collection and Reporting	18	Submission of a Corrective Action Plan within 30 days of receipt of this report* <i>Plan already submitted to Optum by GLRC and approved.</i>	CAP received and approved



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Annual Contractor Review Report

July 28-30, 2015

Submitted To Recovery Innovations

Compiled by the Optum Pierce Regional Support Network QA/PI Unit



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CLINICAL REVIEW for Recovery Life Pathways E&T

The Recovery Life Pathways evaluation and treatment unit was reviewed using the Optum Pierce RSN E&T review tool developed specifically for this year’s review and based on the WACs and Optum policies which inform the Recovery Innovations contract. The tool consists of 19 items each of which was scored “yes,” “no,” or “not applicable.” Items scored “not applicable” were not included in scoring.

A total of 18 Evaluation and Treatment center charts were reviewed. The scoring standard was 95%, a standard reached on eight (8) out of 19 items. The overall score is 84%. Results for each item are tabulated below.

Yes	#	Questions
100%	1	Are Access to Care standards met? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
82%	2	Was the individual evaluated by a physician and another mental health professional within the first 24 hours?
100%	3	If the facility determines that further care is necessary, did the physician and mental health professional file a petition requesting up to 14 days further treatment?
100%	4	Once the acute symptoms subsided and the individual stabilized, was the individual discharged prior to the end of the order?
100%	5	If care was needed beyond the initial 14 days, was another petition filed requesting up to 90 days treatment?
89%	6	If the individual is on a Less Restrictive Alternative outpatient order at discharge, was s/he referred to a case manager?
82%	7	Does the individual service plan reflect the identified needs? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
89%	8	Was the individual service plan developed collaboratively with the individual and other people identified by the individual if he or she desires their inclusion? <i>CM-01 Development of Service Plans, p. 2.</i>
82%	9	Is there a direct connection between the progress notes and the Individual Service Plan? <i>CM-01 Development of Service Plans, p. 4.</i>
100%	10	Are services provided in an age-, culturally and linguistically appropriate manner to foster recovery? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 4. E & T SOW.</i>
75%	11	If the individual refused to sign a Release of Information form, was the refusal documented in the clinical record? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care</i>

		<i>Providers, p. 5</i>
28%	12	<p>Are the following items documented in the Clinical Chart? (Y= yes. N = no)</p> <p>* Number of "no" answers on review</p> <p><input type="checkbox"/> Consent for services</p> <p><input type="checkbox"/> Legal status</p> <p><input type="checkbox"/> Intake assessment</p> <p><u>2</u> Individual service plan</p> <p><u>2</u> Participation of the individual and, when appropriate, their family in treatment planning and goal setting</p> <p><u>12</u> Diagnostic education</p> <p><input type="checkbox"/> Special health care needs</p> <p><input type="checkbox"/> Referrals</p> <p><u>3</u> Timely progress notes</p> <p><input type="checkbox"/> Psychiatric treatment</p> <p><input type="checkbox"/> Complete medication lists</p> <p><u>2</u> Need for labs and frequency</p> <p><u>2</u> Coordination with medical providers</p> <p><input type="checkbox"/> Discharge summaries (on closed charts)</p>
100%	13	Are services reasonable and necessary?
100%	14	<p>Are the authorized services appropriate for the diagnosis?</p> <p><i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i></p>
78%	15	Are services provided and documented in a strengths-based, person-centered manner? <i>Optum contract term.</i>
100%	16	If restraint, seclusion, pharmacological restraint, and/or forced medication was used, did the staff first apply a "no-force first" approach? <i>Optum contract term.</i>
88%	17	Did the individual participate in treatment and discharge planning meetings? <i>Optum contract term.</i>
20%	18	Was Peer Bridgers given an opportunity to meet with the individual?
83%	19	Did discharge planning begin at intake?
YES		Totals
84%		Overall Percentage for RI E&T

CLINICAL REVIEW for Recovery Response Center

The Recovery Response Center was reviewed using the **Crisis Stabilization Unit Clinical Record Review Tool** from DBHR. It is based on the WACs as listed. A total of eight (8) charts were reviewed. The standard of success is 95 %. This standard was reached on 21 out of 27 items. (5 items were marked NA on all charts reviewed, and another item will not be counted because the responsibility for accessing Crisis Plans does not lie with the RRC.) The overall score for the RRC was 90%.

STANDARD	INTERPRETIVE GUIDELINE	SCORE
1. WAC 388-865-0755(5)(a): Procedures for maintaining and protecting resident medical/clinical records consistent with chapter 70.02 RCW, "Medical Records Health Care Information Access and Disclosure Act" and HIPAA.	<ul style="list-style-type: none"> The clinical record contains patient authorization of disclosure in accordance with 70.02.030 RCW. The clinical record documents that the resident has been advised of HIPAA regulations and adopted rules, policies and procedures establishing agency record acquisition, retention, and security policy consistent with Chapter 70.02 RCW. 	<p>a. 86 %</p> <p>b. 100 %</p>
2. WAC 388-865-0755(5)(e): Procedures to ensure that for persons who have been brought to the unit involuntarily by police, the stay is limited to twelve hours unless the individual has signed voluntarily into treatment.	<ul style="list-style-type: none"> The clinical record contains documentation that if the person had been brought to the unit involuntarily by police, the stay was limited to twelve hours unless the individual had signed voluntarily into treatment. 	100 %
3. WAC 388-865-0755(5)(f): Procedures to ensure that within twelve hours of the time of arrival to the crisis stabilization unit, individuals who have been detained by a designated mental health professional or designated crisis responder under RCW 71.05 or RCW 70.96B are transferred to a certified evaluation and treatment facility.	<ul style="list-style-type: none"> The clinical record contains documentation that if the person was detained by a designated mental health professional or designated crisis responder under RCW 71.05 or RCW 70.96B, the person was transferred to a certified evaluation and treatment facility within twelve hours of the time of arrival to the crisis stabilization unit. 	<p>0* %</p> <p>*Only 1 chart was reviewed in this category and it did not include this documentation</p>
4. WAC 388-865-0755(5)(k): Procedures to inventory and safeguard the personal property of the persons being detained.	<ul style="list-style-type: none"> The clinical record contains an inventory of personal property and its disposition upon discharge. 	100 %
5. WAC 388-865-0755(5)(n): Procedures to provide warning to an identified individual and law enforcement when an individual has made a threat against an identified victim, in accordance with RCW 71.05.390(10).	<ul style="list-style-type: none"> The clinical record contains documentation of warning to an identified individual and law enforcement when the individual has made a threat against an identified victim, in accordance with RCW 71.05.390(10). 	100 %
6. WAC 388-865-0755(5)(p): Procedures to establish unit protocols for responding to the provisions of the advanced	<ul style="list-style-type: none"> The clinical record contains documentation of response to the provisions of the advanced directives 	100 %



directives consistent with RCW <u>71.32.150</u> .	consistent with RCW <u>71.32.150</u> .	
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WAC 388-865-0760: ADMISSION AND INTAKE EVALUATION

STANDARD	INTERPRETIVE GUIDELINE	SCORE
1. WAC 388-865-0760(1)(a): For persons who have been brought to the unit involuntarily by police the clinical record must contain: (i) A statement of the circumstances under which the person was brought to the unit; (ii) The admission date and time; and (iii) The date and time when the twelve hour involuntary detention period ends.	<ul style="list-style-type: none"> If the consumer was brought to the unit involuntarily by police, the clinical record contains documentation of (i) through (iii). 	100 %
2. WAC 388-865-0760(1)(b): The evaluation required in subsection (2)(c) of this section must be performed within three hours of arrival at the facility.	<ul style="list-style-type: none"> The clinical record contains documentation that the evaluation required in subsection (2)(c) of this section was performed within three hours of arrival at the facility. 	100 %
WAC 388-865-0760(2): The facility must demonstrate that each resident has received evaluations to determine the nature of the disorder and the services necessary, including at a minimum:		
3. WAC 388-865-0760(2)(a): A health screening by an authorized healthcare provider as defined in WAC 246-337-005(22) to determine the healthcare needs of a person.	<ul style="list-style-type: none"> The clinical record contains documentation of a health screening to determine the healthcare needs of the person. The health screening was performed by a an authorized healthcare provider as defined in WAC 246-337-005(22). 	100 %
4. WAC 388-865-0760(2)(b): An assessment for chemical dependency and/or a co-occurring mental health and substance abuse disorder, utilizing the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) or its successor.	<ul style="list-style-type: none"> The clinical record contains an assessment for chemical dependency and/or a co-occurring mental health and substance abuse disorder, utilizing the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) or its successor. 	100 %
5. WAC 388-865-0760(2)(c): An evaluation by a mental health professional to include at a minimum: (i) Mental status examination; (ii) Assessment of risk of harm to self, others, or property; (iii) Determination of whether to refer to a designated mental health professional (DMHP) or designated crisis responder (DCR) to initiate civil commitment	<ul style="list-style-type: none"> The clinical record contains an evaluation by a mental health professional. The evaluation includes (i) through (iii). 	100 %

proceedings.		
6. WAC 388-865-0760(2)(d): Documentation that an evaluation by a DMHP/DCR was performed within the required time period, the results of the evaluation, and the disposition of the person.	<ul style="list-style-type: none"> The clinical record contains documentation that an evaluation by a DMHP/DCR was performed within the required time period, the results of the evaluation, and the disposition of the person. 	<p>0%*</p> <p>*Only 1 chart was reviewed in this category and it did not include this documentation</p>
7. WAC 388-865-0760(2)(e): Review of the person's current crisis plan, if applicable and available.	<ul style="list-style-type: none"> The clinical record documents review of the person's current crisis plan, if applicable and available. 	<p>75 %*</p> <p>*This score will not be a corrective action; RRC is not responsible for accessing crisis plans</p>
8. WAC 388-865-0760(2)(f): The admission diagnosis and what information the determination was based upon.	<ul style="list-style-type: none"> The clinical record contains an admission diagnosis. The clinical record contains documentation that supports the admission diagnosis. 	<p>a. 100 %</p> <p>b. 86 %</p>
9. WAC 388-865-0760(3): If the mental health professional determines that the needs of a person would be better served by placement in a chemical dependency treatment facility, then the person must be referred to an approved treatment program defined under chapter 70.96A RCW.	<ul style="list-style-type: none"> The clinical record documents that if there is a determination by a mental health professional that the needs of the person would be better served by placement in a chemical dependency treatment facility, the person was referred to an approved treatment program defined under chapter 70.96A RCW. 	<p>100 %</p>

WAC 388-865-0765: USE OF SECLUSION AND RESTRAINT PROCEDURES WITHIN THE CRISIS STABILIZATION UNIT

STANDARD	INTERPRETIVE GUIDELINE	SCORE
1. WAC 388-865-0765(2): The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the person or others from harm. The reasons for the determination must be clearly documented in the clinical record.	<ul style="list-style-type: none"> The clinical record contains clear documentation of the reasons for use of seclusion or restraint. The clinical record documents evidence of imminent danger if seclusion or restraint is used. The clinical record documents determination that less restrictive measures have been ineffective to protect the person or others from harm if seclusion or restraint is used. 	<p>a. N/A</p> <p>b. N/A</p> <p>c. N/A</p>



WAC 388-865-0770: ASSESSMENT AND STABILIZATION SERVICES – DOCUMENTATION REQUIREMENTS

STANDARD	INTERPRETIVE GUIDELINE	SCORE
WAC 388-865-0770(1): For all persons admitted to the crisis stabilization unit, the clinical record must contain documentation of:		
1. WAC 388-865-0770(1)(a): Assessment and stabilization services provided by the appropriate staff.	<ul style="list-style-type: none"> The clinical record contains documentation of assessment and stabilization services provided by the appropriate staff. 	100 %
2. WAC 388-865-0770(1)(b): Coordination with the person’s current treatment provider, if applicable.	<ul style="list-style-type: none"> The clinical record documents coordination with the person’s current treatment provider, if applicable. If there is no coordination with the person’s current treatment provider, the reasons are documented in the clinical record. 	a. 43 % b. 17 %
3. WAC 388-865-0770(1)(c): A plan for discharge, including a plan for follow up that includes: (i) The name, address, and telephone number of the provider of follow-up services; and (ii) The follow-up appointment date and time, if known.	<ul style="list-style-type: none"> The clinical record contains documentation of a plan for discharge. The plan for discharge includes (i) and (ii). 	a. 100 % b. 100 %
4. WAC 388-865-0770(2): For persons admitted to the crisis stabilization unit on a voluntary basis, a crisis stabilization plan developed collaboratively with the person within twenty-four hours of admission that includes: (a) Strategies and interventions to resolve the crisis in the least restrictive manner possible; (b) Language that is understandable to the person and/or members of the person’s support system; and (c) Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning.	<ul style="list-style-type: none"> For persons admitted to the crisis stabilization unit on a voluntary basis, the clinical record contains a crisis stabilization plan developed collaboratively with the person within twenty-four hours of admission. The crisis stabilization plan includes (a) through (c). 	a. 100 % b. 100 %

WAC 388-865-780: POSTING OF RIGHTS

STANDARD	INTERPRETIVE GUIDELINE	SCORE
1. WAC 388-865-0780: The rights outlined in WAC 388-865-0561 must be prominently posted within the crisis stabilization unit and provided in writing to the person.	<ul style="list-style-type: none"> The clinical record documents that the rights outlined in WAC 388-865-0561 had been provided in writing to the person. 	100 %

WAC 388-865-0785: RIGHTS RELATED TO ANTIPSYCHOTIC MEDICATIONS

STANDARD	INTERPRETIVE GUIDELINE	SCORE
1. WAC 388-865-0785(1): The clinical record must document: <ul style="list-style-type: none"> (a) The physician's attempt to obtain informed consent for antipsychotic medication; (b) The reasons why any antipsychotic medication is administered over the person's objection or lack of consent. 	<ul style="list-style-type: none"> The clinical record documents the physician's attempt to obtain informed consent for antipsychotic medication. If antipsychotic medication was administered over the consumer's objection or lack of consent, the reasons are documented in the clinical record. 	<p>a. 100 %</p> <p>b. 0 %*</p> <p>*Only 1 chart was reviewed in this category and it did not include this documentation</p>
2. WAC 388-865-0785(2): The physician may administer antipsychotic medication over a consumer's objection or lack of consent only when: <ul style="list-style-type: none"> (a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists when: <ul style="list-style-type: none"> (i) The consumer presents an imminent likelihood of serious harm to self or others; (ii) Medically acceptable alternatives to administration of antipsychotic medication are not available or unlikely to be successful; and (iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician; (b) There is an additional concurring opinion by a second physician for treatment up to thirty days. 	<ul style="list-style-type: none"> If antipsychotic medication was administered over a consumer's objection or without consent, the clinical record documents that an emergency existed as defined in (a)(i) through (iii). The clinical record documents a review and concurring opinion by a second physician for treatment up to thirty days. 	<p>a. 0 %*</p> <p>b. N/A</p> <p>*Only 1 chart was reviewed in this category and it did not include this documentation</p>

Overall Score for the Recovery Response Center

90 %



CLINICAL REVIEW for the Community Building Program

The **Community Building** program was scored using the Optum Pierce RSN outpatient review tool for 2015. Two charts were reviewed for this program. The standard of 95% “Yes” scores was met 24 out of 29 times. (Note: 23 of the 52 items were marked “NA” and not considered in the scoring). Overall score for the Community Building program was 89%.

Score		Questions
Referral and Intake		
N/A	1.	If mental health services were requested through an EPSDT referral, was a written notice sent as a reply to the Primary Care Provider who made the EPSDT referral? This notice includes at least the scheduled date of intake and diagnosis. The level of care assignment, when applicable, is included. <i>CM-06 EPSDT Policy, p. 2</i>
N/A	2.	If mental health services were requested by a primary care provider referral, was the referral acknowledged in writing, with at least the sharing of the intake date and diagnosis (if known at that point)? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 3.</i>
N/A	3.	If mental health services were requested for a child without an EPSDT referral, was a formal written recommendation for a Healthy Kids screening sent to the individual’s PCP and a copy of the letter offered to the individual and/or family? If the individual does not identify a PCP, was a copy of the EPSDT rights contained in the DSHS Mental Health Benefits booklet given to the individual to assist with the selection of a PCP? <i>CM-06 EPSDT Policy, p. 2</i>
100 %	4.	Was an attempt to obtain a signed Authorization for Release of Information documented to have occurred as soon as it was clinically appropriate during the intake evaluation process or as early as possible in the treatment episode so that communication could occur with PCPs and other health care providers? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2-3.</i>
N/A	5.	Was documentation found in the clinical record if the individual refused to sign Release of Information forms? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 5.</i>
100 %	6.	Is documentation for Advance Directives (for physical and mental health) present to reflect that the individual received and understood the information provided, and that the individual either did or did not chose to execute an Advance Directive? <i>CR-7 Advance Directives, p. 3.</i>
100 %	7.	If an individual did not have a physical exam by a PCP in the year prior to intake, was a recommendation documented for the individual to make an appointment with a PCP? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 4.</i>
50 %	8.	Is medical necessity established and documented? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 1</i>
100 %	9.	Are Access to Care standards met?

Score		Questions
		<i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
Specialist Assessments		
N/A	10	Was a <i>Special Population Evaluation</i> provided by a child, geriatric or disabled specialist? <i>AD-18 Cultural Competency, page</i>
N/A	11	Did the specialist assessment include information about age, disability, cultural factors and sensory impairments? (Intake, psychosocial, psychiatric, nursing, specialist or other assessment) <i>AD-18 Cultural Competency, page 2</i>
N/A	12	If the mental health care provider developing the individual service plan was not a mental health specialist for that population, per <i>WAC 388-865-0405(5)</i> , did the community mental health agency seek consultation from a respected staff or community member with training and experience in that area? <i>CM-01 Development of Service Plans, p. 3.</i>
Individual Service Plan		
100 %	13	Does the individual service plan reflect the identified needs? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
100 %	14	Was the initial individual service plan completed within 30 days from the date of the first session following the initial assessment? <i>CM-01 Development of Service Plans, page 2.</i>
100 %	15	Does the individual service plan reflect the individual's voice and is it in the language and terminology that is understandable to the individual and his/her family; is it driven by the individual, person-centered, strength-based, and does it meet the individual's unique mental health needs? <i>CM-01 Development of Service Plans, p. 2.</i>
100 %	16	Does the individual service plan include goals/objectives that are measurable? <i>CM-01 Development of Service Plans, p. 2.</i>
100 %	17	Does the individual service plan take into account the age, self-disclosed culture and sexual orientation of individuals (where appropriate)? <i>CM-03 Timely Access to Care, p. 2</i>
100 %	18	Was there evidence of documentation related to coordination with any systems or organizations the individual identified as being relevant to treatment with the individual's consent or if applicable, the consent of the individual's parents or legal representative? <i>CM-01 Development of Service Plans, p. 3.</i>
100 %	19	If an individual disagreed with their individual service plan, is there documentation in the clinical record of notification to the Pierce RSN so that a Notice of Action letter could be sent to the individual? <i>CM-01 Development of Service Plans, p. 3.</i>
100 %	20	Was a review of the individual service plan documented and updated at least every one hundred eighty (180) days, or more often at the request of the individual, or when the individual's condition changes? <i>CM-01 Development of Service Plans, p. 3; QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
100 %	21	Did the 180-day review update the diagnostic information and provide justification for the



		<p>level of continued treatment? QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</p>
		Progress Notes
100 %	22	<p>Is there a direct connection between the progress notes and the Individual Service Plan? <i>CM-01 Development of Service Plans, p. 4.</i></p>
100 %	23	<p>Do the progress notes support the use of each state-plan service? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i></p>
100 %	24	<p>Are services provided by staff with the appropriate credentials? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 4.</i></p>
100 %	25	<p>Are services provided in an age, cultural and linguistically appropriate manner? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 4.</i></p>
100 %	26	<p>Was a referral made to a PCP when the individual was in need of physical health care? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i></p>
N/A	27	<p>Was the individual referred to an emergency room when they had a medical condition that needed immediate attention or was potentially life-threatening? Staff should have contacted the emergency room as soon as possible, described the situation, and ensured that the individual reached the emergency room safely. Information should have been provided if a request was made from the hospital. <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i></p>
100 %	28	<p>Did communication with the PCP occur at intake and on an ongoing basis (with a signed release of information)? Communication is expected at the initial prescribing of psychotropic medication, when changes in psychotropic medications are made, if there are changes in condition that might adversely impact a medical condition, and at hospital admissions and discharges. <i>Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i></p>
100 %	29	<p>Was a release of information in place or criteria met for emergency communication (as stipulated by HIPAA or RCW 71.05.390 and RCW 71.05.630) when coordinating with Primary Care Physicians, Emergency Rooms and other Health Care Providers? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i></p>
		General Requirements
100 %	30	<p>Is the documentation written in a recovery-oriented, strengths-based manner? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 4.</i></p>
0	31	<p>Are the following items documented in the Clinical Chart? (Y = yes. N = no)</p> <p>* Number of "No" answers on review:</p> <ul style="list-style-type: none"> ___ Consent for services ___ Legal status ___ Intake assessment ___ Participation of the individual and, when appropriate their family, in treatment planning and goal setting <u> 2 </u> Diagnostic education <u> 1 </u> Crisis Planning (when appropriate) ___ Timely progress notes

		<input type="checkbox"/> Psychiatric treatment (when appropriate) <input type="checkbox"/> Complete medication lists <input checked="" type="checkbox"/> Need for labs and frequency <input type="checkbox"/> Discharge summaries (on closed charts)
0	32	<p>Were the following timelines met? (Y=Yes, N=No)</p> <p>* Number of "No" answers on review</p> <input type="checkbox"/> Emergent services within 2 hours of the request <input type="checkbox"/> Urgent services within 24 hours of the request <input type="checkbox"/> Initial inpatient certification within 12 hours of the request <input type="checkbox"/> Crisis and phone services by a live person 24/7/365 days a year <input type="checkbox"/> Post-stabilization services within 7 days of discharge from a psychiatric hospital <input checked="" type="checkbox"/> Intake Evaluation within 14 days of the request <input type="checkbox"/> 1 st routine outpatient service within 28 days of the request <p><i>AD-01 Compliance, Fraud and Abuse, page 9</i></p>
100 %	33	<p>Are services reasonable and necessary?</p> <p><i>AD-01 Compliance, Fraud and Abuse Policy, page 6</i></p>
100 %	34	<p>Are authorized services appropriate for the diagnosis?</p> <p><i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i></p>
		Children's Services
N/A	35	<p>If this chart is for a child or youth authorized at the Universal level, is there a minimum of one contact per month? <i>Care Standards</i></p>
N/A	36	<p>If this chart is for a child or youth authorized at the Targeted level, is there documentation of family therapy once a month at a minimum and based on family choice, either case management, medication management, or a modified wraparound model of care? <i>Care Standards</i></p>
N/A	37	<p>If this chart is for a child or youth authorized for Wraparound services, are intensive home- and community-based services provided for the child/youth and family with the goal of maintaining the child/youth in a home environment using the Wraparound model of care?</p>
N/A	38	<p>If this chart is for a child or youth authorized for Wraparound services, are youth mentors and family support services involved and available 24 hours a day/ 7 days a week in any location the child, youth or family desires?</p>
N/A	39	<p>If this chart is for a child or youth authorized for Wraparound services, is there documentation in the chart that respite services are available by the provider? <i>Care Standards</i></p>
		Crisis Plans and Care Coordination
100 %	40	<p>If the individual has a history of any of the following behaviors, was a crisis plan developed?</p> <ul style="list-style-type: none"> • A child/youth individual who was in a psychiatric hospital in the past six (6) months, including a Children's Long-term Inpatient Program (CLIP). • A child/youth who was enrolled in Family Assessment and Stabilization Treatment or Wraparound; • A child/youth who was exhibiting danger to self or others or has history of exhibiting danger to self or others within the past six months. • An adult who had a psychiatric hospitalization or stay at an evaluation & treatment center in the past six (6) months • An adult who has a history of exhibiting danger to self or others within the past six months.

		<i>CM-02 Crisis Plans, p. 4.</i>
100 %	41	<p>If a crisis plan is required, does it include the following elements? (Y = yes. N = no)</p> <p><input type="checkbox"/> What constitutes a crisis</p> <p><input type="checkbox"/> Natural supports, including whom to contact as a crisis develops, a backup contact, and phone numbers for each</p> <p><input type="checkbox"/> Prevention plan</p> <p><input type="checkbox"/> Red flags/ Triggers</p> <p><input type="checkbox"/> Recommended steps the individual and family members can take when a crisis occurs</p> <p><input type="checkbox"/> A safe place to go in a crisis, and a backup location if the first place is unavailable</p> <p><input type="checkbox"/> Significant historical information such as: gravely disabled;</p> <p>threatens harm to others; has harmed others; threatens injury to self; injures or has injured self; has weapons; hallucinations; delusions; substance abuse; and advance directive</p> <p><input type="checkbox"/> Direction to individuals to seek immediate crisis services if they are feeling urgent distress, or if they are a risk to themselves or others, or are at risk for grave disability?</p> <p><i>CM-01 Development of Service Plans, p. 4.</i></p>
N/A	42	<p>If an individual is high risk, was assistance arranged and provided, if necessary, for a follow-up appointment within five (5) calendar days of discharge from an inpatient psychiatric facility? Or was follow-up provided within twenty-four (24) hours for any individual who received emergency room or other crisis services related to his/her mental illness?</p> <p><i>CM-07 Assessment, Engagement, and Utilization of Services for Individuals with High Risk, p. 3-4.</i></p>
N/A	43	<p>If a high risk individual missed three (3) or more outpatient appointments within a month's period of time, did the agency initiate a home-based visit to check on well-being and discuss current treatment needs?</p> <p><i>CM-07 Assessment, Engagement, and Utilization of Services for Individuals with High Risk, p. 3-4.</i></p>
0	44	<p>Was a high risk individual referred to PACT if he/she met the eligibility criteria? Or were other referrals made to natural supports in the community such as "Clubhouse", "A Common Voice", or Tacoma Area Coalition for Individuals with Disabilities (TACID) or other supports as applicable?</p> <p><i>CM-07 Assessment, Engagement, and Utilization of Services for Individuals with High Risk, p. 3-4.</i></p>
Conditional Release or Less Restrictive Alternative		
N/A	45	<p>If the individual is on a Less Restrictive Alternative, is there documentation in the chart that the individual was provided with a copy of their individual rights and responsibilities as specified in RCW 71.05 or 71.34 and WAC 388-877A-0195(a), or its successor ?</p> <p><i>CM-11 Involuntary Evaluation and Treatment, p. 1.</i></p>
N/A	46	<p>If the individual is on a Less Restrictive Alternative, is there documentation to show that the individual's progress is monitored in accordance with the conditions of the court order?</p> <p><i>CM-11 Involuntary Evaluation and Treatment, p. 1.</i></p>
N/A	47	<p>If the individual is on a Less Restrictive Alternative or CR, were the conditions of the LRA or CR incorporated into the individualized service plan?</p>
Second Opinions		



N/A	49	Did an appointment for a second opinion occur within 30 days of the request? (Unless the individual requests a later date.) <i>CM-03 Timely Access to Care, p. 4.</i>
N/A	50	If a second opinion was given, was it rendered by an MHP whose degree is equal to or higher than the MHP who yielded the original opinion? <i>CM-20 Second Opinions, p. 2.</i>
N/A	51	If a second opinion was given, did the treating MHP document provision of information about the individual's right to file a grievance and/or to request a change of MHP or network provider when they explained the outcome of the second opinion? <i>CM-20 Second Opinions, p. 3.</i>
N/A	52	If a second opinion was given, was the opinion and authorized follow-up care documented? <i>CM-20 Second Opinions, p. 3</i>
89 %		Overall Score for Community Building

CLINICAL REVIEW for the Peer Bridgers Program

The **Peer Bridger** program was scored using the Optum Pierce RSN outpatient review tool for 2015. A total of four (4) charts were reviewed for this program. One chart scored N/A for every item. The 95% standard was met on 24 out of 27 items. The overall score for Peer Bridgers is 94%.

Score		Questions
		Referral and Intake
N/A	1.	If mental health services were requested through an EPSDT referral, was a written notice sent as a reply to the Primary Care Provider who made the EPSDT referral? This notice includes at least the scheduled date of intake and diagnosis. The level of care assignment, when applicable, is included. <i>CM-06 EPSDT Policy, p. 2</i>
N/A	2.	If mental health services were requested by a primary care provider referral, was the referral acknowledged in writing, with at least the sharing of the intake date and diagnosis (if known at that point)? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 3.</i>
N/A	3.	If mental health services were requested for a child without an EPSDT referral, was a formal written recommendation for a Healthy Kids screening sent to the individual's PCP and a copy of the letter offered to the individual and/or family? If the individual does not identify a PCP, was a copy of the EPSDT rights contained in the DSHS Mental Health Benefits booklet given to the individual to assist with the selection of a PCP? <i>CM-06 EPSDT Policy, p. 2</i>
100 %	4.	Was an attempt to obtain a signed Authorization for Release of Information documented to have occurred as soon as it was clinically appropriate during the intake evaluation process or as early as possible in the treatment episode so that communication could



Score		Questions
		occur with PCPs and other health care providers? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2-3.</i>
N/A	5.	Was documentation found in the clinical record if the individual refused to sign Release of Information forms? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 5.</i>
0	6.	Is documentation for Advance Directives (for physical and mental health) present to reflect that the individual received and understood the information provided, and that the individual either did or did not chose to execute an Advance Directive? <i>CR-7 Advance Directives, p. 3.</i>
100 %	7.	If an individual did not have a physical exam by a PCP in the year prior to intake, was a recommendation documented for the individual to make an appointment with a PCP? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 4.</i>
N/A	8.	Is medical necessity established and documented? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 1</i>
100 %	9.	Are Access to Care standards met? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>

		Specialist Assessments
N/A	10	Was a <i>Special Population Evaluation</i> provided by a child, geriatric or disabled specialist? <i>AD-18 Cultural Competency, page</i>
N/A	11	Did the specialist assessment include information about age, disability, cultural factors and sensory impairments? (Intake, psychosocial, psychiatric, nursing, specialist or other assessment) <i>AD-18 Cultural Competency, page 2</i>
N/A	12	If the mental health care provider developing the individual service plan was not a mental health specialist for that population, per <i>WAC 388-865-0405(5)</i> , did the community mental health agency seek consultation from a respected staff or community member with training and experience in that area? <i>CM-01 Development of Service Plans, p. 3.</i>
Individual Service Plan		
100 %	13	Does the individual service plan reflect the identified needs? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
100 %	14	Was the initial individual service plan completed within 30 days from the date of the first session following the initial assessment? <i>CM-01 Development of Service Plans, page 2.</i>
100 %	15	Does the individual service plan reflect the individual's voice and is it in the language and terminology that is understandable to the individual and his/her family; is it driven by the individual, person-centered, strength-based, and does it meet the individual's unique mental health needs? <i>CM-01 Development of Service Plans, p. 2.</i>
100 %	16	Does the individual service plan include goals/objectives that are measurable? <i>CM-01 Development of Service Plans, p. 2.</i>
100 %	17	Does the individual service plan take into account the age, self-disclosed culture and sexual orientation of individuals (where appropriate)? <i>CM-03 Timely Access to Care, p. 2</i>

100 %	18	Was there evidence of documentation related to coordination with any systems or organizations the individual identified as being relevant to treatment with the individual's consent or if applicable, the consent of the individual's parents or legal representative? <i>CM-01 Development of Service Plans, p. 3.</i>
N/A	19	If an individual disagreed with their individual service plan, is there documentation in the clinical record of notification to the Pierce RSN so that a Notice of Action letter could be sent to the individual? <i>CM-01 Development of Service Plans, p. 3.</i>
N/A	20	Was a review of the individual service plan documented and updated at least every one hundred eighty (180) days, or more often at the request of the individual, or when the individual's condition changes? <i>CM-01 Development of Service Plans, p. 3; QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
N/A	21	Did the 180-day review update the diagnostic information and provide justification for the level of continued treatment? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
		Progress Notes
100 %	22	Is there a direct connection between the progress notes and the Individual Service Plan? <i>CM-01 Development of Service Plans, p. 4.</i>
100 %	23	Do the progress notes support the use of each state-plan service? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
100 %	24	Are services provided by staff with the appropriate credentials? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 4.</i>
100 %	25	Are services provided in an age, cultural and linguistically appropriate manner? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 4.</i>
100 %	26	Was a referral made to a PCP when the individual was in need of physical health care? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i>
N/A	27	Was the individual referred to an emergency room when they had a medical condition that needed immediate attention or was potentially life-threatening? Staff should have contacted the emergency room as soon as possible, described the situation, and ensured that the individual reached the emergency room safely. Information should have been provided if a request was made from the hospital. <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i>
100 %	28	Did communication with the PCP occur at intake and on an ongoing basis (with a signed release of information)? Communication is expected at the initial prescribing of psychotropic medication, when changes in psychotropic medications are made, if there are changes in condition that might adversely impact a medical condition, and at hospital admissions and discharges. <i>Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i>
100 %	29	Was a release of information in place or criteria met for emergency communication (as stipulated by HIPAA or RCW 71.05.390 and RCW 71.05.630) when coordinating with Primary Care Physicians, Emergency Rooms and other Health Care Providers? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 2.</i>



General Requirements		
100 %	30	Is the documentation written in a recovery-oriented, strengths-based manner? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 4.</i>
67 %	31	Are the following items documented in the Clinical Chart? (Y = yes. N = no) * Number of "No" answers on review <input type="checkbox"/> Consent for services <input type="checkbox"/> Legal status <input type="checkbox"/> Intake assessment <input type="checkbox"/> Participation of the individual and, when appropriate their family, in treatment planning and goal setting <input checked="" type="checkbox"/> Diagnostic education <input type="checkbox"/> Crisis Planning (when appropriate) <input type="checkbox"/> Timely progress notes <input type="checkbox"/> Psychiatric treatment (when appropriate) <input type="checkbox"/> Complete medication lists <input type="checkbox"/> Need for labs and frequency <input type="checkbox"/> Discharge summaries (on closed charts)
100 %	32	Were the following timelines met? (Y=Yes, N=No) <input type="checkbox"/> Emergent services within 2 hours of the request <input type="checkbox"/> Urgent services within 24 hours of the request <input type="checkbox"/> Initial inpatient certification within 12 hours of the request <input type="checkbox"/> Crisis and phone services by a live person 24/7/365 days a year <input type="checkbox"/> Post-stabilization services within 7 days of discharge from a psychiatric hospital <input type="checkbox"/> Intake Evaluation within 14 days of the request <input type="checkbox"/> 1 st routine outpatient service within 28 days of the request <i>AD-01 COMPLIANCE, FRAUD AND ABUSE POLICY, PAGE 9</i>
100 %	33	Are services reasonable and necessary? <i>AD-01 Compliance, Fraud and Abuse Policy, page 6</i>
100 %	34	Are authorized services appropriate for the diagnosis? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
Children's Services		
N/A	35	If this chart is for a child or youth authorized at the Universal level, is there a minimum of one contact per month? <i>Care Standards</i>
N/A	36	If this chart is for a child or youth authorized at the Targeted level, is there documentation of family therapy once a month at a minimum and based on family choice, either case management, medication management, or a modified wraparound model of care? <i>Care Standards</i>
N/A	37	If this chart is for a child or youth authorized for Wraparound services, are intensive home- and community-based services provided for the child/youth and family with the goal of maintaining the child/youth in a home environment using the Wraparound model of care?
N/A	38	If this chart is for a child or youth authorized for Wraparound services, are youth mentors and family support services involved and available 24 hours a day/ 7 days a week in any location the child, youth or family desires?

N/A	39	If this chart is for a child or youth authorized for Wraparound services, is there documentation in the chart that respite services are available by the provider? <i>Care Standards</i>
Crisis Plans and Care Coordination		
N/A	40	<p>If the individual has a history of any of the following behaviors, was a crisis plan developed?</p> <ul style="list-style-type: none"> • A child/youth individual who was in a psychiatric hospital in the past six (6) months, including a Children’s Long-term Inpatient Program (CLIP). • A child/youth who was enrolled in Family Assessment and Stabilization Treatment or Wraparound; • A child/youth who was exhibiting danger to self or others or has history of exhibiting danger to self or others within the past six months. • An adult who had a psychiatric hospitalization or stay at an evaluation & treatment center in the past six (6) months • An adult who has a history of exhibiting danger to self or others within the past six months. <p><i>CM-02 Crisis Plans, p. 4.</i></p>
N/A	41	<p>If a crisis plan is required, does it include the following elements? (X = yes. Blank = no</p> <p><input type="checkbox"/> What constitutes a crisis</p> <p><input type="checkbox"/> Natural supports, including whom to contact as a crisis develops, a backup contact, and phone numbers for each</p> <p><input type="checkbox"/> Prevention plan</p> <p><input type="checkbox"/> Red flags/ Triggers</p> <p><input type="checkbox"/> Recommended steps the individual and family members can take when a crisis occurs</p> <p><input type="checkbox"/> A safe place to go in a crisis, and a backup location if the first place is unavailable</p> <p><input type="checkbox"/> Significant historical information such as: gravely disabled;</p> <p>threatens harm to others; has harmed others; threatens injury to self; injures or has injured self; has weapons; hallucinations; delusions; substance abuse; and advance directive</p> <p><input type="checkbox"/> Direction to individuals to seek immediate crisis services if they are feeling urgent distress, or if they are a risk to themselves or others, or are at risk for grave disability?</p> <p><i>CM-01 Development of Service Plans, p. 4.</i></p>
N/A	42	<p>If an individual is high risk, was assistance arranged and provided, if necessary, for a follow-up appointment within five (5) calendar days of discharge from an inpatient psychiatric facility? Or was follow-up provided within twenty-four (24) hours for any individual who received emergency room or other crisis services related to his/her mental illness?</p> <p><i>CM-07 Assessment, Engagement, and Utilization of Services for Individuals with High Risk, p. 3-4.</i></p>
N/A	43	<p>If a high risk individual missed three (3) or more outpatient appointments within a month’s period of time, did the agency initiate a home-based visit to check on well-being and discuss current treatment needs?</p> <p><i>CM-07 Assessment, Engagement, and Utilization of Services for Individuals with High Risk, p. 3-4.</i></p>
N/A	44	<p>Was a high risk individual referred to PACT if he/she met the eligibility criteria? Or were other referrals made to natural supports in the community such as “Clubhouse”, “A Common Voice”, or</p>

		Tacoma Area Coalition for Individuals with Disabilities (TACID) or other supports as applicable? <i>CM-07 Assessment, Engagement, and Utilization of Services for Individuals with High Risk, p. 3-4.</i>
		Conditional Release or Less Restrictive Alternative
N/A	45	If the individual is on a Less Restrictive Alternative, is there documentation in the chart that the individual was provided with a copy of their individual rights and responsibilities as specified in RCW 71.05 or 71.34 and WAC 388-877A-0195(a), or its successor ? <i>CM-11 Involuntary Evaluation and Treatment, p. 1.</i>
N/A	46	If the individual is on a Less Restrictive Alternative, is there documentation to show that the individual's progress is monitored in accordance with the conditions of the court order? <i>CM-11 Involuntary Evaluation and Treatment, p. 1.</i>
100 %	47	If the individual is on a Less Restrictive Alternative or CR, were the conditions of the LRA or CR incorporated into the individualized service plan?
100 %	48	If the individual is on a Less Restrictive Alternative or CR, was a plan for transition to voluntary treatment included? <i>CM-11 Involuntary Evaluation and Treatment, p. 2.</i>
		Second Opinions
N/A	49	Did an appointment for a second opinion occur within 30 days of the request? (Unless the individual requests a later date.) <i>CM-03 Timely Access to Care, p. 4.</i>
N/A	50	If a second opinion was given, was it rendered by an MHP whose degree is equal to or higher than the MHP who yielded the original opinion? <i>CM-20 Second Opinions, p. 2.</i>
N/A	51	If a second opinion was given, did the treating MHP document provision of information about the individual's right to file a grievance and/or to request a change of MHP or network provider when they explained the outcome of the second opinion? <i>CM-20 Second Opinions, p. 3.</i>
N/A	52	If a second opinion was given, was the opinion and authorized follow-up care documented? <i>CM-20 Second Opinions, p. 3</i>
94 %		Overall Score for Peer Bridgers Program

Desk Top and Non-Clinical Review

Facility Reviews

- Consumer Rights Postings
- Medication Management
- Licenses and Certificates
- ADA Standards met

All three facilities were reviewed. No deficits were noted.

Document Review

- Governing and Advisory Board Minutes
- Disaster Recovery Plan
- Policies and Procedures

List of Evidence-based Practices
Second Opinions – None requested
Alternative formats for written materials—Available
Out of Network referrals – None requested
Brochures, Ads, Public Communication examples
Outcome Data or reports on satisfaction surveys
Second Opinions—none requested
Written information in alternative formats—none requested
Client rights statements for each program

All requested documents were received. No corrective actions.

Improvements based on data and reviews:

Each Recovery Services Administrator (RSA) receives reports on record reviews. Discussion and training take place as a result.
External and Internal Corrective Action Plans used for improvement
Revision of the Quality Management plan is underway. The new plan will have 3- 6- 9- and 12-month reviews built in
“Golden Thread” documentation training underway based on previous reviews
Ongoing training regarding the blending of medical/clinical and recovery language for documentation, especially in the area of medical necessity
Incidents are reviewed and tracked, and trends are identified
The safety committee reviews workman’s compensation claims and other incidents for risk assessment and improvements in safety

Personnel Records :

Completion of Required Medicaid Exclusion Checks
Documentation of Cultural Competency Training—Two persons overdue
Documentation of Workplace Violence Prevention Training (Marty Smith Bill) – Two persons overdue

Personnel Information Still Needed:

Documentation of training for supervision

Corrective Actions, Personnel:

Overdue trainings in Cultural Competency and Workplace Violence Prevention must be brought up to date.

Training in supervision must be documented.



Performance Measure Outcomes:

Access to Care:

- Request to Intake within 14 Days:
 - Report for year indicates 33.3% rate;
 - Report for June 2015 demonstrates no data.
 - **Corrective Action** - Work with IT department to ensure proper data flow.
- Request to first service within 28 days:
 - Report for year indicates 100% performance. No corrective action needed.
 - Report for June 2015 indicates no data
 - **Corrective Action** - Work with IT department to ensure proper data flow.
- Use of Certified Peer Support Counselors
- Restraint and Seclusion Report
- Use of Interpreters

Recommendations

1. Identify the *role* of staff in each chart note, i.e., Peer, MHP, nurse. (Notation of credentials is also necessary and falls under corrective action.)
2. More specificity is needed in notes. For example, the term “coping skills” could be replaced with the type of skill needed such as anger management, money management, relaxation, etc.
3. Must provide education about the individual’s illness as well as education about medications being prescribed.
4. Comments are sometimes vague, such as “not very happy today”; we suggest the use of terms such as “observed,” “reported,” “as evidenced by,” or “stated” to reduce subjectivity.
5. Document the inclusion and education of family members.
6. Increase documentation of family involvement and opportunities for psychoeducation.
7. Increase the emphasis on the individual’s strengths and add cultural identity and awareness.

Corrective Actions



1. In all programs the credentials (degree or license) of the person documenting in the individual's chart must be listed in each note.

2. Any item which scored under 95% in the tabulations above is considered to be a corrective action. The following are the items which require corrective action:

Recovery Life Pathways E&T

11 items:

82%	2	Was the individual evaluated by a physician and another mental health professional within the first 24 hours?
89%	6	If the individual is on a Less Restrictive Alternative outpatient order at discharge, was s/he referred to a case manager?
82%	7	Does the individual service plan reflect the identified needs? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 2.</i>
89%	8	Was the individual service plan developed collaboratively with the individual and other people identified by the individual if he or she desires their inclusion? <i>CM-01 Development of Service Plans, p. 2.</i>
82%	9	Is there a direct connection between the progress notes and the Individual Service Plan? <i>CM-01 Development of Service Plans, p. 4.</i>
75%	11	If the individual refused to sign a Release of Information form, was the refusal documented in the clinical record ? <i>CM-08 Coordination Among Primary Care Physicians, Emergency Rooms and other Health Care Providers, p. 5</i>
28%	12	Are the following items documented in the Clinical Chart? (Y= yes. N = no <input type="checkbox"/> Consent for services <input type="checkbox"/> Legal status <input type="checkbox"/> Intake assessment <input checked="" type="checkbox"/> Individual service plan <input checked="" type="checkbox"/> Participation of the individual and, when appropriate, their family in treatment planning and goal setting <input checked="" type="checkbox"/> Diagnostic education <input type="checkbox"/> Special health care needs <input type="checkbox"/> Referrals <input checked="" type="checkbox"/> Timely progress notes <input type="checkbox"/> Psychiatric treatment <input type="checkbox"/> Complete medication lists <input checked="" type="checkbox"/> Need for labs and frequency <input checked="" type="checkbox"/> Coordination with medical providers



___ Discharge summaries (on closed charts)		
78%	15	Are services provided and documented in a strengths-based, person-centered manner? <i>Optum contract term.</i>
88%	17	Did the individual participate in treatment and discharge planning meetings? <i>Optum contract term.</i>
20%	18	Was Peer Bridgers given an opportunity to meet with the individual?
83%	19	Did discharge planning begin at intake?

RECOVERY RESPONSE CENTER

8 ITEMS:

Admission and Intake Evaluation

1. WAC 388-865-0755(5)(a): Procedures for maintaining and protecting resident medical/clinical records consistent with chapter 70.02 RCW, "Medical Records Health Care Information Access and Disclosure Act" and HIPAA.	<ul style="list-style-type: none"> The clinical record contains patient authorization of disclosure in accordance with 70.02.030 RCW. (86%)
3. WAC 388-865-0755(5)(f): Procedures to ensure that within twelve hours of the time of arrival to the crisis stabilization unit, individuals who have been detained by a designated mental health professional or designated crisis responder under RCW 71.05 or RCW 70.96B are transferred to a certified evaluation and treatment facility.	<ul style="list-style-type: none"> The clinical record contains documentation that if the person was detained by a designated mental health professional or designated crisis responder under RCW 71.05 or RCW 70.96B, the person was transferred to a certified evaluation and treatment facility within twelve hours of the time of arrival to the crisis stabilization unit. (0% yes)
6. WAC 388-865-0760(2)(d): Documentation that an evaluation by a DMHP/DCR was performed within the required time period, the results of the evaluation, and the disposition of the person.	<ul style="list-style-type: none"> The clinical record contains documentation that an evaluation by a DMHP/DCR was performed within the required time period, the results of the evaluation, and the disposition of the person. (0%)
7. WAC 388-865-0760(2)(e): Review of the person's current crisis plan, if applicable and available.	<ul style="list-style-type: none"> The clinical record documents review of the person's current crisis plan, if applicable and available. (75%)
8. WAC 388-865-0760(2)(f): The admission diagnosis and what information the determination was based upon.	<ul style="list-style-type: none"> The clinical record contains documentation that supports the admission diagnosis. (86%)

Admission and Stabilization Services—Documentation Requirements

2. WAC 388-865-0770(1)(b): Coordination with the person's current treatment provider, if applicable.	<ul style="list-style-type: none"> The clinical record documents coordination with the person's current treatment provider, if
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	applicable. (43%) <ul style="list-style-type: none"> If there is no coordination with the person's current treatment provider, the reasons are documented in the clinical record. (17%)
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Rights Related to Antipsychotic Medications

WAC 388-865-0785(1): The clinical record must document: (a) The physician's attempt to obtain informed consent for antipsychotic medication; (b) The reasons why any antipsychotic medication is administered over the person's objection or lack of consent.	<ul style="list-style-type: none"> If antipsychotic medication was administered over the consumer's objection or lack of consent, the reasons are documented in the clinical record. (0%) *Only 1 chart was reviewed in this category and it did not include this documentation
2. WAC 388-865-0785(2): The physician may administer antipsychotic medication over a consumer's objection or lack of consent only when: (a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists when: (i) The consumer presents an imminent likelihood of serious harm to self or others; (ii) Medically acceptable alternatives to administration of antipsychotic medication are not available or unlikely to be successful; and (iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician; (b) There is an additional concurring opinion by a second physician for treatment up to thirty days.	<ul style="list-style-type: none"> If antipsychotic medication was administered over a consumer's objection or without consent, the clinical record documents that an emergency existed as defined in (a)(i) through (iii). (0%) The clinical record documents a review and concurring opinion by a second physician for treatment up to thirty days.

COMMUNITY BUILDING

4 ITEMS

50 %	8.	Is medical necessity established and documented? <i>QA-08 Clinical and Administrative Review Including Annual Review of Community Mental Health Agencies, p. 1</i>
0	31	Are the following items documented in the Clinical Chart? (Y = yes. N = no ___ Consent for services ___ Legal status ___ Intake assessment ___ Participation of the individual and, when appropriate their family,

		<p>in treatment planning and goal setting</p> <p><u> </u> 2_ Diagnostic education</p> <p><u> </u> 1_ Crisis Planning (when appropriate)</p> <p><u> </u> Timely progress notes</p> <p><u> </u> Psychiatric treatment (when appropriate)</p> <p><u> </u> 1_ Complete medication lists</p> <p><u> </u> Need for labs and frequency</p> <p><u> </u> Discharge summaries (on closed charts)</p>
0	32	<p>Were the following timelines met? (Y=Yes, N=No)</p> <p><u> </u> Emergent services within 2 hours of the request</p> <p><u> </u> Urgent services within 24 hours of the request</p> <p><u> </u> Initial inpatient certification within 12 hours of the request</p> <p><u> </u> Crisis and phone services by a live person 24/7/365 days a year</p> <p><u> </u> Post-stabilization services within 7 days of discharge from a psychiatric hospital</p> <p><u> </u> 1_ Intake Evaluation within 14 days of the request</p> <p><u> </u> 1st routine outpatient service within 28 days of the request</p> <p><i>AD-01 Compliance, Fraud and Abuse, page 9</i></p>
0	44	<p>Was a high risk individual referred to PACT if he/she met the eligibility criteria? Or were other referrals made to natural supports in the community such as "Clubhouse", "A Common Voice", or Tacoma Area Coalition for Individuals with Disabilities (TACID) or other supports as applicable?</p> <p><i>CM-07 Assessment, Engagement, and Utilization of Services for Individuals with High Risk, p. 3-4.</i></p>

PEER BRIDGERS

2 ITEMS:

0	6.	<p>Is documentation for Advance Directives (for physical and mental health) present to reflect that the individual received and understood the information provided, and that the individual either did or did not chose to execute an Advance Directive?</p> <p><i>CR-7 Advance Directives, p. 3.</i></p>
67 %	31	<p>Are the following items documented in the Clinical Chart? (Y = yes. N = no)</p> <p><u> </u> Consent for services</p> <p><u> </u> Legal status</p> <p><u> </u> Intake assessment</p> <p><u> </u> Participation of the individual and, when appropriate their family, in treatment planning and goal setting</p> <p><u> </u> 1_ Diagnostic education</p> <p><u> </u> Crisis Planning (when appropriate)</p> <p><u> </u> Timely progress notes</p> <p><u> </u> Psychiatric treatment (when appropriate)</p> <p><u> </u> Complete medication lists</p>

		<input type="checkbox"/> Need for labs and frequency <input type="checkbox"/> Discharge summaries (on closed charts)
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Access to Care:

- Request to Intake within 14 Days:
 - Report for year indicates 33.3% rate;
 - Report for June 2015 demonstrates no data.
 - **Corrective Action** - Work with IT department to ensure proper data flow.
- Request to first service within 28 days:
 - Report for year indicates 100% performance. No corrective action needed.
 - Report for June 2015 indicates no data
 - **Corrective Action** - Work with IT department to ensure proper data flow.

Personnel:

Overdue trainings in Cultural Competency and Workplace Violence Prevention must be brought up to date.

Training in supervision must be documented.

Corrective Action Plans must be submitted to Rebecca Panzer within 30 days of receipt of this report. (Additional time may be negotiated if necessary.)

Attachment Xa - Grievance System Analysis Appendix

CFR Reference	Optum Example	Compliance Status
<p>§ 431.201 Definitions. For purposes of this subpart: <i>Action</i> means a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act. <i>Adverse determination</i> means a determination made in accordance with sections 1919(b)(3)(F) or 1919(e)(7)(B) of the Act that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services. <i>Date of action</i> means the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the determination made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act. <i>De novo hearing</i> means a hearing that starts over from the beginning. <i>Evidentiary hearing</i> means a hearing conducted so that evidence may be presented. <i>Notice</i> means a written statement that meets</p>	<p>Optum Pierce BHO Notice of Action Policy in in sync with the 42 CFR with the below definitions. Prior to Jan. 1, 2016, the Optum Pierce BHO Notice of Action Policy will remain in sync with the 42 CFR, and will adopt the definitions in the next column released in a Due Process Document by DBHR on 9/1/2015. Action: A decision by the Optum Pierce BHO regarding:</p> <ul style="list-style-type: none"> • The denial or limited authorization of a requested service, including the type or level of service; • The reduction, suspension, or termination of a previously authorized service; • The denial in whole or in part, of payment for a service; • The failure to provide services in a timely manner, as defined by the Department of Social & Health Services (DSHS); or • The failure of Optum Pierce BHO to act within the timeframes outlined in 42 CFR 438.52(b) (2) (ii). • Denial: The decision to not authorize Title XIX-covered behavioral health services that meet the DSHS Access to Care Standards or 	<p>DBHR definitions as of 9/1/15 in the Draft Due Process Document distributed by David Reed. The Optum Pierce BHO will incorporate these specifications into policy prior to Jan. 1, 2016.</p> <p>Action: May only be taken by a BHO. An Action, for a Medicaid covered individual, consists of any of the following:</p> <ul style="list-style-type: none"> -The denial or limited authorization of a requested service, including the type or level of service; -The reduction, suspension, or termination of a previously authorized service; -The denial in whole, or in part, of payment for a service. -The failure to provide services in a timely manner as defined by the state. -The failure of an BHO or its contracted behavioral health agency to act within the grievance timeframes as provided in WAC. <p>Administrative Hearing: Is a proceeding before an administrative law judge that gives an individual an opportunity to be heard in disputes about DSHS programs and services.</p> <p>Appeal: Is an oral or written request made by an individual or their authorized representative for the BHO or BHO to review an <i>action</i>.</p>

CFR Reference	Optum Example	Compliance Status
<p>the requirements of § 431.210.</p> <p><i>Request for a hearing</i> means a clear expression by the applicant or recipient, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.</p> <p><i>Service authorization request</i> means a managed care enrollee’s request for the provision of a service.</p>	<p>the decision not to authorize Title XIX-covered behavioral health services due to lack of medical necessity.</p> <ul style="list-style-type: none"> • Prior Authorization: A determination made that an applicable Title XIX-covered service is medically necessary. • Reduction: A decision to decrease the frequency and/or duration of an on-going service. A reduction does not include a planned change in service frequency or duration that is initially identified in the person’s individual service plan and agreed to in writing by the person receiving services or his/her legal guardian. <p><i>The below CFR definition for service authorization request will be added to the Optum Pierce BHO Policy on Notices of Action prior to Jan. 1, 2015.</i></p> <p>Service authorization request means a managed care enrollee’s request for the provision of a service</p> <ul style="list-style-type: none"> • Suspension: A decision to temporarily stop providing a previously authorized Title XIX-covered behavioral health service. • Termination: A decision to stop providing a previously authorized Title XIX-covered behavioral health service. Termination does not include the end of a specific treatment program with an established end date initially 	<p>Appeal Process: Is one of the processes included in the grievance system that allows an individual to appeal an <i>action</i> made by the BHO/BHO and communicated through a <i>notice of action</i>.</p> <p>Authorized Representative: A person authorized by an individual to assist with the grievance, appeal, or Fair Hearing. Authorization must be in writing, but may be as simple as: “_____ has my permission to help me with my grievance.”</p> <p>Expedited Appeal Process: Is the process which allows an individual, in certain instances, to file an appeal that will be reviewed by the BHO/BHO more quickly than a standard appeal.</p> <p>Exhaustion: An Administrative Hearing may not be requested by the individual until the grievance and appeal process have been completed.</p> <p>Grievance: Any expression of dissatisfaction by an individual with BHO related services. Grievances are reported without regard to the ease of resolution.</p> <p>Grievance Process: Is the process used to resolve grievances. The grievance process requires letters of acknowledgement and resolution, as well as procedures for expediting grievances. The BHO is responsible for meeting grievance process requirements, but may delegate responsibilities to CMHAs by contract.</p>

CFR Reference	Optum Example	Compliance Status
	<p>identified in the person’s individual service plan and agreed to in writing by the person receiving services or their legal guardian.</p> <p>Grievance Policy:</p> <p>For Title XIX consumers, grievance means a formal expression of dissatisfaction about any matter other than an “Action” as defined in the Pierce BHO policy entitled, “CR-02C: Grievance System - Notice of Action”.</p> <p>For State-funded consumers, grievance means a formal expression of dissatisfaction about any matter.</p> <p>The term grievance also refers to the overall system that includes grievances and appeals handled through Optum Pierce BHO and the state administrative Fair Hearing process. Grievances may include, but are not limited to, problems with quality of care or services provided, and aspects of interpersonal relationships, such as rudeness. A grievance may be pursued at the provider level or at the Optum Pierce BHO level. Grievances may be initiated verbally or in writing.</p> <p>Expedited Grievance: A request for a more immediate response to a grievance than occurs through the standard procedure. Expedited grievances may be pursued at the provider or the Optum Pierce BHO level.</p>	<p>Grievance System: Consists of the processes within an BHO/BHO which allows individuals applying for, eligible for, or receiving services may express dissatisfaction about services. The grievance system must include all of the following components:</p> <ul style="list-style-type: none"> • A grievance process. • An appeal process. • Access to the DSHS administrative hearing process. <p>Individual: A person meeting the criteria for a consumer under WAC 388-865-0150. This definition includes a parent of a child under 13 who is receiving services, or a parent of a child under 18 who is involved with the treatment team. It does not include parents of adult children, other family members, or any other individual unless they are an authorized representative.</p> <p>Notice of Action (NOA): Is the written notice which an BHO/BHO provides to an individual, receiving Medicaid services, to communicate an <i>action</i>. [Note: The BHO/BHO cannot delegate making determinations regarding actions or issuing or NOAs to a provider agency.] The NOA must include all of the elements listed below:</p> <ul style="list-style-type: none"> • The action taken by the BHO/BHO. • The reason for the action and a citation of the rule or rules being implemented. • The individual’s right to file an appeal with

CFR Reference	Optum Example	Compliance Status
		<p>the BHO/BHO and the required timeframes if the individual does not agree with the decision or action.</p> <ul style="list-style-type: none"> • The circumstances under which an expedited resolution is available and how it can be requested. • The individual’s right to receive mental health services while an appeal is pending, how to make the request for continued services, and notification that the individual may be liable for the cost of the services received while the appeal is pending if the appeal decision upholds the action.
<p>(b) Definitions. As used in this subpart, the following terms have the indicated meanings: Action means— In the case of an MCO or PIHP— (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO or PIHP to</p>		<p>Compliant</p>

CFR Reference	Optum Example	Compliance Status
<p>act within the timeframes provided in § 438.408(b); or</p> <p>(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.</p> <p>Appeal means a request for review of an action, as “action” is defined in this section.</p> <p>Grievance means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.)</p>	<p>As recorded above, the definition for Action (Notice of Action) in the Optum Pierce BHO “Notice of Action Policy” matches that of the listed CFRs.</p> <p>The term “Appeal” is defined in the Optum Pierce BHO “Enrollee Right to Appeal Policy” as a request for review of an Action. The definition matches the CFRs.</p> <p>The Grievance Policy definitions listed below are in-line with the CFR definition.</p> <p>For Title XIX consumers, grievance means a formal expression of dissatisfaction about any matter other than an “Action” as defined in the Pierce BHO policy entitled, “CR-02C: Grievance System - Notice of Action”.</p> <p>For State-funded consumers, grievance means a formal expression of dissatisfaction about any matter.</p> <p>The term grievance also refers to the overall system that includes grievances and appeals handled through Optum Pierce BHO and the state administrative Fair Hearing process. Grievances may include, but are not limited to,</p>	

CFR Reference	Optum Example	Compliance Status
	<p>problems with quality of care or services provided, and aspects of interpersonal relationships, such as rudeness. A grievance may be pursued at the provider level or at the Optum Pierce BHO level. Grievances may be initiated verbally or in writing.</p> <p>Expedited Grievance: A request for a more immediate response to a grievance than occurs through the standard procedure. Expedited grievances may be pursued at the provider or the Optum Pierce BHO level.</p>	
<p>42 CFR 438.52(b)(2)(ii) (ii) To obtain services from any other provider under any of the following circumstances: (A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, PAHP, or PCCM network. (B) The provider is not part of the network, but is the main source of a service to the beneficiary, provided that— (1) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network as other network providers of that type. (2) If the provider chooses not to join the network, or does not meet the necessary</p>	<p>Out of Network Policy</p> <p>If an individual who is Medicaid-eligible requires medically necessary behavioral health services that are not available through the Optum Pierce BHO provider network, or are not available within Optum Pierce BHO access timeframes, or there is not a behavioral health care provider with the appropriate training and experience within the Optum Pierce BHO provider network, Optum Pierce BHO shall pay for services outside its network until the network is able to provide them. Providers outside the Optum Pierce BHO must meet all state and federal requirements and enter into a contract for services with Optum Pierce BHO or one of its subcontracted behavioral health agencies.</p> <p>Network Adequacy Policy</p> <p>The Optum Pierce BHO monitors the status of</p>	

CFR Reference	Optum Example	Compliance Status
<p>qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates).</p> <p>(C) The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.</p> <p>(D) The beneficiary’s primary care provider or other provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.</p> <p>(E) The State determines that other circumstances warrant out-of-network treatment.</p> <p>(3) As used in this paragraph, “rural area” is any area other than an “urban area” as defined in § 412.62(f)(1)(ii) of this chapter.</p> <p>(c) Exception for certain health insuring organizations (HIOs). The State may limit beneficiaries to a single HIO if—</p> <p>(1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and</p> <p>(2) The beneficiary who enrolls in the HIO has a choice of at least two primary</p>	<p>the network, projecting future needs and identifying any network deficiencies or gaps.</p> <p>Optum Pierce BHO maintains a network of behavioral health care providers supported by written agreements which provide adequate access to all services covered under the contract.</p> <p>Tools for identifying trends include:</p> <ul style="list-style-type: none"> • Analysis of current and projected enrollee and consumer needs; • Medicaid and state-funded enrollment (current and projected) and penetration rate: • Analysis by age group (0-17, 18-20, 21-59, 60+); • . Analysis by gender; • Analysis by race/ethnicity; • Analysis by primary language. • Review of behavioral health care provider input through monthly meetings as well as month end meetings individually with providers; • Review of individual and family input through the Quality Review Team, Ombuds, and QA/PI Committees; • Review of grievance trends and analysis; • Review of annual consumer satisfaction survey trends and analysis; • Review of critical incidents involving 	

CFR Reference	Optum Example	Compliance Status
<p>care providers within the entity. (d) Limitations on changes between primary care providers. For an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of this section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under § 438.56(c).</p>	<p>access to services concerns;</p> <ul style="list-style-type: none"> • Analysis of current and projected network capacity; • Numbers and types of behavioral health care providers available to deliver contracted Medicaid services (including individual clinician licenses, specialists and cultural/linguistic capacity); • Geographic location of providers and Medicaid consumers; • GeoAccess reports verify the adequacy of the network and map the membership to the contracted providers. • Travel time analysis from Community Behavioral Health Agencies; • Review of other data sources (medical record reviews, grievances) regarding pertinent issues (such as means of transportation, physical access for consumers with disabilities); • Access data analysis and review: timeliness for routine service requests, timeliness for urgent service requests, timeliness for emergent service requests • Other access indicators, from medical record reviews, grievances and other data sources. • Provide access to and support a “behavioral health home” for all 	

CFR Reference	Optum Example	Compliance Status
	<p>Medicaid enrollees/consumers;</p> <ul style="list-style-type: none"> • Ensure that Medicaid enrollees/consumers have access equal to, or better than, community norms; • Ensure that services are accessible to enrollees/consumers in terms of timeliness, amount, duration and scope; • Provide Washington State Plan-covered services within designated time and distance limits according to DSHS standards; • Meet the unique cultural and linguistic needs of all enrollees/consumers; • Maintain the ability to adjust the number, mix and geographic distribution of behavioral health care providers to meet access and distance standards as the population of enrollees/consumers shifts within the service area; • Maintain the ability to shift reimbursement amounts for different specialties to meet access and distance standards; • Adhere to the principles of Recovery & Resiliency. • In accordance with WAC 388-865-0260(3), if more than five hundred (500) persons in the total population in an BHO geographic area report in 	

CFR Reference	Optum Example	Compliance Status
	<p>the U.S. census that they belong to racial/ethnic groups as defined in WAC 388-865-0150, the BHO is to contract or otherwise establish a working relationship with the required specialists to:</p> <ul style="list-style-type: none"> • Provide all or part of the care and services for these populations; or • Supervise or provide consultation to staff members providing care and services to these populations. 	
<p>42 CFR 438.56(f)(2) (2) Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment.</p>		<p>Standard met. The Optum Pierce BHO does not disenroll Medicaid consumers.</p>

**BHO Washington Integrated Avatar Users Group
BHO Information System Project Plan**

Milestone	#	Task	Owner	Dependencies	Status	% Complete	Start Date	Target Complete Date	Revised Target Complete Date	Actual Complete Date	Comments
x		<i>Spec from State</i>				0%		9/1/2015	incomplete	?	Document Not Complete
x		<i>Spec development for Netsmart</i>				0%	8/12/2015	9/11/2015	9/24/2015	C	
		PM/CWS Data Elements and Functionality				0%	8/12/2015	9/11/2015	9/24/2015	C	
		File Imports				0%	8/12/2015	9/11/2015	9/24/2015	C	
		EDI to MSO				0%	8/12/2015	9/11/2015	9/24/2015	C	
		MSO Functionality				0%	8/12/2015	9/11/2015	9/24/2015	C	
		State EDI				0%	8/12/2015	9/11/2015	9/24/2015	C	
X		<i>Spec Review with Netsmart - Face to Face NY</i>				0%	9/14/2015	9/16/2015	9/29/2015	C	
X		<i>Create Agency PM DB</i>				0%	1/0/1900	10/31/2015			
		Netsmart Create PM DB						10/14/2015			
		Finalize Build				0%	10/15/2015	10/31/2015			
X		<i>ICD-10 Go Live</i>				0%	9/30/2015	10/1/2015	10/5/2015	Y	
X		<i>Development and Testing</i>				0%	9/16/2015	11/25/2015			
X		Parallel Testing On-Site in NY				0%	10/19/2015	11/27/2015			
X		<i>Agency Networks and Evaluation Preparedness</i>				0%	10/5/2015	10/30/2015			
		Updated Agency System/hardware/security/P&P in place				0%	11/2/2015	1/15/2016			
X		<i>Documentation</i>				0%	9/21/2015	12/1/2015			
		<i>NETSMART</i>				0%					
		Project Documentation					9/21/2015	12/1/2015			
		<i>OHPRSN</i>				0%					
		MIS P&P					9/21/2015	12/1/2015			
		P&P					9/21/2015	12/1/2015			
		Data Collection Forms					9/21/2015	12/1/2015			
		Data Dictionary					9/21/2015	12/1/2015			
		File Import Layout Specifications					9/21/2015	12/1/2015			
X		<i>Final testing, QC and software signoff</i>				0%	12/7/2015	12/31/2015			
X		<i>Develop site-specific training for agencies</i>				0%	1/4/2016	2/28/2016			
X		<i>Load final version of Avatar into UAT</i>				0%	1/4/2016	2/1/2016			
X		<i>Agency Setup</i>				0%	2/1/2016	2/19/2016			
X		<i>MSO Setup</i>				0%	2/1/2016	2/12/2016			
X		<i>Reports Modified/Created</i>				0%	1/4/2016	2/28/2016			
		PM				0%	1/4/2016	2/28/2016			
		MSO				0%	1/4/2016	2/28/2016			
X		<i>Test MSO Transactions to the State</i>				0%	2/1/2016	2/28/2016			
		Native Transactions				0%	2/1/2016	2/28/2016			
		ProviderOne (837P&837I)				0%	2/1/2016	2/28/2016			
X		<i>Training</i>				0%	3/2/2016	3/25/2016			
		Training for new agencies				0%	3/2/2016	3/25/2016			
		Training existing agencies				0%	3/2/2016	3/25/2016			
		MSO Staff				0%	3/14/2016	3/31/2016			
X		<i>Go-Live</i>				0%	4/1/2016	4/22/2016			
		Hold data input 4/1/16, collect data, no input				0%	4/1/2016	4/22/2016			
		March data in system				0%	4/1/2016	4/5/2016			
		RSN final data submission to the State				0%	4/7/2016	4/7/2016			
		Final data clean-up w/submission				0%	4/8/2016	4/10/2016			
X		<i>Great Rivers BHO MSO Database Live</i>				0%	8/17/2015	12/31/2015			

Completed	Complete
On track to complete on time	Green
Not on track / At risk of missing schedule	Yellow
Behind Schedule	Red

Data Collection Process

OptumHealth Pierce Regional Support Network Information System Design

