

AGREEMENT

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Statement of Work. The Tribe agrees to provide services in accordance with Exhibit A – Statement of Work.
2. Funding. The services to be performed will be funded by payment by the County to the Tribe as described in the attached Statement of Work, in an amount not to exceed \$24,966. This Agreement is expressly contingent throughout its term upon funding availability.
3. State-County Grant Contracts. The State-County Grant Contracts, as they may be amended from time to time, are incorporated by this reference as if set forth fully herein and this Agreement shall be subject to the provisions contained in the State-County Grant Contracts. The Tribe agrees to comply with all provisions contained in the State-County Grant Contracts applicable to subcontractors, except for those provisions, if any, that the State may expressly waive in writing, or is not applicable under federal or state law.
4. Culturally Relevant Services. In providing services, the Tribe may develop and operate programs and deliver goods, services and/or benefits in a manner that is culturally relevant and particularly suited to and/or particularly located for access by members of the Tribe, in accordance with tribal laws and policies.
5. Term. The term of this Agreement is January 1, 2015 – December 31, 2016.
6. Termination for Convenience. Either party may terminate this Agreement for convenience by providing the other party with advance written notice of at least 30 days.
7. Termination for Default. If either defaults in its obligations under this Agreement, the nondefaulting party may terminate this Agreement by written notice to the defaulting party. Before such termination, however, the defaulting party shall be given 10 days to cure its default, if the default is of a type reasonably susceptible to cure.
8. Dispute Panel. The parties may voluntarily submit any contractual dispute to a dispute panel as follows: each party will appoint one member to the panel and those two members in turn will appoint a third member. The dispute panel will review the facts, contract provisions and applicable law, and then decide the matter. This provision does not affect the right of either party to seek legal recourse in a court of competent jurisdiction.
9. Indemnification. Each party agrees to defend and indemnify the other party and its officials, officers, employees and agents for all claims, liabilities, damages, expenses and suits arising from or relating to the performance of this Agreement by the indemnitor or its officials, officers, employees and agents.

10. Commercial General Liability. The Tribe shall have Commercial General Liability Insurance with limits of not less than Combined Bodily Injury/Property Damage Liability of \$1,000,000 each occurrence and \$2,000,000 aggregate. The Tribe will place insurance with insurers licensed to do business in the State of Washington and having A.M. Best Company ratings of no less than A-VII, with the exception that excess and umbrella coverage used to meet the requirements for limits of liability or gaps in coverage need not be placed with insurers or re-insurers licensed in the State of Washington.

Coverage shall contain general requirements and endorsements with Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County named as an additional insured and that in the event of a claim or suit, the insurance carrier agrees to not use sovereign immunity of the assured as defense as respects this agreement. Such insurance as carried by the Tribe is primary over any insurance carried by the Peninsula Regional Support Network and Kitsap County, Jefferson County, Clallam County. The Tribe will include all subcontractors as insureds under its policies or will furnish separate certificates and endorsements for each subcontractor. All coverage for subcontractors will be subject to all the requirements in these provisions.

The Tribe expressly agrees to a limited waiver of sovereign immunity as a defense up to the limits of the insurance policy in connection with the enforcement of the rights of the Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County.

11. Audit Requirements. All payments under this agreement are subject to audit. The Tribe shall provide an independent audit which:

- a. Determines the fiscal integrity of the financial transactions and reports of the Tribe.
- b. Is performed by an independent auditing firm or the Washington State Auditor's Office.
- c. Is performed in accordance with generally accepted auditing standards and with Federal Standards for Audit of Governmental Organizations, Programs, Activities and Functions, and meeting all requirements of OMB Circular A-133, as applicable for agencies receiving federal funding in the amount of \$500,000 or more during their fiscal year.

12. Suspension, Debarment, and Lobbying

The Contractor shall certify, on a separate form (Exhibit D), that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency. Also, the Contractor, on a separate form (Exhibit E), will certify that it does not use Federal funds for lobbying purposes. Both forms are attached to this Contract.

13. Notices. Any notice required or permitted under this Agreement shall be given in writing and addressed as follows:

To the PENINSULA REGIONAL SUPPORT NETWORK

Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366
Attention:
Anders Edgerton, Regional Administrator

To the TRIBE

Port Gamble S'Klallam Tribe
31912 Little Boston Road N.E.
Kingston, WA 98346
Attention:
Jeromy Sullivan, Tribal Council Chair

Either party may change its address for notices by providing written notice to the other party.

14. Independent Capacity. The officials, officers, employees and agents of each party shall continue to be officials, officers, employees and agents of that party and shall not be considered for any purpose to be officials, officers, employees and agents of the other party.

15. Waiver. Waiver of any part of this Agreement may only be made in a writing executed by an authorized representative of the party to be bound.

16. Applicable Law. Each party shall comply with all applicable federal, tribal, state and local law.

17. Amendment. This Agreement may be amended only by a writing executed by authorized representatives of both parties with the same formalities as this Agreement.

18. Survival. Sections 8 (Dispute Panel), and 9 (Indemnification) of this Agreement shall survive the termination or expiration of this Agreement.

19. Authority. Each party warrants that it has taken all steps necessary for this Agreement to have full legal effect and that the signatures hereon are those of its authorized representatives.

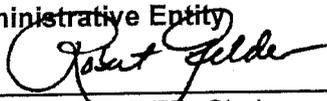
20. Exhibits. The following exhibits are incorporated in this Agreement by reference:

- Exhibit A: Statement of Work
- Exhibit B: Budget Summary
- Exhibit C: Certificate of Liability Insurance and Sovereignty Endorsement
- Exhibit D: Certification Regarding Debarment, Suspension, and Other Responsibility Matters
- Exhibit E: Certification Regarding Lobbying

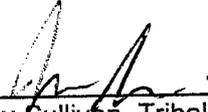
IN WITNESS WHEREOF, THE PARTIES HAVE SUBSCRIBED THEIR NAMES
HERETO ON THE DATES SET FORTH BELOW.

PENINSULA REGIONAL SUPPORT
NETWORK, By the Kitsap County
Board of Commissioners, It
Administrative Entity

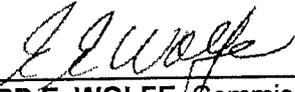
PORT GAMBLE S'KLALLAM TRIBE



ROBERT GELDER, Chair

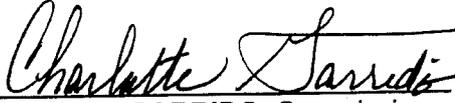


Jeromy Sullivan, Tribal Council Chairman



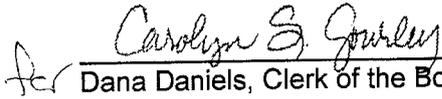
EDWARD E. WOLFE, Commissioner

DATED: 2/20/15



CHARLOTTE GARRIDO, Commissioner

ATTEST:



Dana Daniels, Clerk of the Board



DATED: 3-9-15

EXHIBIT A: STATEMENT OF WORK

Port Gamble S'Klallam Tribe Enhanced Mental Health Services

1. General Statement of Work – Mental Health Services

The Port Gamble S'Klallam's Children and Family Services Department and Wellness Center provide general mental health services to Tribal members and others seeking services through the Tribal Wellness Center. The Wellness Center is in need of providing child and adult psychiatric services to Tribal community members. We estimate we will serve approximately 120 clients.

2. Specific Services Purchased

Funds will be utilized to purchase the services of a licensed professional from Jefferson Mental Health System, with prescriptive authority in the State of Washington. All program funds will be used to pay for the services of this specialized provider. Services that will be made available will include psychiatric evaluations, diagnosis, and medications management services for complex mental health cases. In addition, this position will also work closely with Wellness and other Tribal Operation's staff providing consultation as needed and appropriate.

3. Clients Served

Direct services, case management and consultation services will be provided to Tribal members across the lifespan; including children, youth, adults and elders. The number of clients to be served is approximately 120.

EXHIBIT B: BUDGET SUMMARY

Port Gamble S'Klallam Tribe Enhanced Mental Health Services

Expenditure Cost Category	Budget Period	Previous Budget	Changes this Contract	Current Budget
Year 1 State Funded Match Mental Health Services – Contract Services	1/1/15 – 12/31/15	0		\$12,483
Year 2 State Funded Match Mental Health Services – Contract Services	1/1/16 – 12/31/16	0		\$12,483
Total				\$24,966

Exhibit C: Certificate of Liability Insurance



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
12/12/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Brown & Brown of Washington, Inc. 1501 4th Ave Suite 2400 Seattle WA 98101		CONTACT NAME: Denise Swazey PHONE (A/C No. Ext): 206-956-1652 FAX (A/C No.): 206-956-9652 E-MAIL ADDRESS: dswazey@bnbseattle.com	
INSURED Port Gamble S'Klallam Tribe 31912 Little Boston Rd NE Kingston WA 98346		INSURER(S) AFFORDING COVERAGE INSURER A: HUDSON INSURANCE COMPANY INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	NAIC # 25054

COVERAGES **CERTIFICATE NUMBER:** 2064949759 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDITIONAL INSURER	POLICY NUMBER	POLICY EFF DATE	POLICY EXP DATE	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC	Y	NACL00267-09	12/15/2014	12/15/2015	EACH OCCURRENCE \$5,000,000 DAMAGE TO RENTED PREMISES (Per occurrence) \$100,000 MED EXP (Any one person) \$Excluded PERSONAL & ADV INJURY \$Included GENERAL AGGREGATE \$10,000,000 PRODUCTS - COMPI/OP AGG \$7,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS		NACL00267-09	12/15/2014	12/15/2015	COMBINED SINGLE LIMIT (Per occurrence) \$5,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ UMBRELLA LIAB OCCUR \$ EXCESS LIAB CLAIMS-MADE \$ DED RETENTION \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in WA) If yes, describe under DESCRIPTION OF OPERATIONS below		N/A			WC STATUTORY LIMITS OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

RE: Mental Health Services
 Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County are named as an Additional Insured in regards to the above project as required by written contract and or agreement with the named insured.

CERTIFICATE HOLDER Peninsula Regional Support Network 614 Division St., MS-23 Port Orchard WA 98366	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE
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ACORD 25 (2010/05)

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**Exhibit D: CERTIFICATION REGARDING DEBARMENT, SUSPENSION,
AND OTHER RESPONSIBILITY MATTERS**

Primary Covered Transactions 45 CFR 76

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principles:
 - a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
 - b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connections with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;
 - c. Are not presently indicted for or otherwise criminally or civilly charges by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph 1.b. of this certification; and
 - d. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the prospective primary participants are unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

This Certification is executed by the person(s) signing below who warrant they have authority to execute this Certification.

**CONTRACTOR: Port Gamble
S'Klallam Tribe**

Name: _____

Title: _____

DATE: _____

Exhibit E: CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and believe, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Port Gamble S'Klallam Tribe

Contractor Organization



Signature of Certifying Official

2/20/15

Date

**INTERLOCAL AGREEMENT BETWEEN
KITSAP COUNTY as the Administrative entity for the PENINSULA
REGIONAL SUPPORT NETWORK
AND
JAMESTOWN S'KLALLAM TRIBE
FOR
MENTAL HEALTH SERVICES
KC-316-14**

This Interlocal Agreement between Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK and the Jamestown S'Klallam Tribe (this "Agreement") is entered into by Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK (the "PRSN"), a political subdivision of the State of Washington, and the Jamestown S'Klallam Tribe (the "Tribe"), a federally recognized Indian tribe, effective January 1, 2015.

RECITALS

WHEREAS, Kitsap County is the administrative entity for the Peninsula Regional Support Network;

WHEREAS, Kitsap County, on behalf of the Peninsula Regional Support Network, has entered into an "RSN Agreement" with the State of Washington Department of Social and Health Services (the "State"), Division of Behavioral Health and Recovery, under which the State provides funds to the County for the provision of services to mentally ill residents of Kitsap, Jefferson and Clallam Counties;

WHEREAS, the County wishes to subcontract with the Tribe to enable the Tribe to provide enhanced mental health services to Jamestown S'Klallam tribal members and other non tribal members seeking services from the Tribal clinic;

WHEREAS, the Tribe is willing to comply with all applicable contractual and program requirements contained in the State-County Grant Contracts;

WHEREAS, the Tribe, being a sovereign government, has requested that the subcontract be in the form of an interlocal agreement and the State has encouraged the County to subcontract in that form, and

WHEREAS, the State has reviewed the form of this Agreement and found that it satisfies the County's subcontracting obligations under the State-County Grant Contracts.

AGREEMENT

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Statement of Work. The Tribe agrees to provide services in accordance with Exhibit A – Statement of Work.
2. Funding. The services to be performed will be funded by payment by the County to the Tribe as described in the attached Statement of Work, in an amount not to exceed \$24,966. This Agreement is expressly contingent throughout its term upon funding availability.
3. State-County Grant Contracts. The State-County Grant Contracts, as they may be amended from time to time, are incorporated by this reference as if set forth fully herein and this Agreement shall be subject to the provisions contained in the State-County Grant Contracts. The Tribe agrees to comply with all provisions contained in the State-County Grant Contracts applicable to subcontractors, except for those provisions, if any, that the State may expressly waive in writing, or is not applicable under federal or state law.
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5. Term. The term of this Agreement is January 1, 2015 – December 31, 2016.
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10. Commercial General Liability. The Tribe shall have Commercial General Liability Insurance with limits of not less than Combined Bodily Injury/Property Damage Liability of \$1,000,000 each occurrence and \$2,000,000 aggregate. The Tribe will place insurance with insurers licensed to do business in the State of Washington and having A.M. Best Company ratings of no less than A-VII, with the exception that excess and umbrella coverage used to meet the requirements for limits of liability or gaps in coverage need not be placed with insurers or re-insurers licensed in the State of Washington.

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To the PENINSULA REGIONAL SUPPORT NETWORK

Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366
Attention:
Anders Edgerton, Regional Administrator

To the TRIBE

Jamestown S'Klallam Tribe
1033 Old Blyn Highway
Sequim, WA 98382
Attention:
Jessica Payne, Director, Social & Community Services

Either party may change its address for notices by providing written notice to the other party.

14. Independent Capacity. The officials, officers, employees and agents of each party shall continue to be officials, officers, employees and agents of that party and shall not be considered for any purpose to be officials, officers, employees and agents of the other party.

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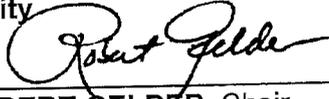
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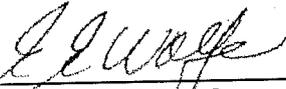
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- Exhibit B: Budget Summary
- Exhibit C: Certificate of Liability Insurance and Sovereignty Endorsement
- Exhibit D: Certification Regarding Debarment, suspension, and Other Responsibility Matters
- Exhibit E: Certification Regarding Lobbying

IN WITNESS WHEREOF, THE PARTIES HAVE SUBSCRIBED THEIR NAMES
HERETO ON THE DATES SET FORTH BELOW.

PENINSULA REGIONAL SUPPORT
NETWORK, By the Kitsap County Board
of Commissioners, Its Administrative
Entity



ROBERT GELDER, Chair



EDWARD E. WOLFE, Commissioner



CHARLOTTE GARRIDO, Commissioner

ATTEST:



Dana Daniels, Clerk of the Board

DATED: 4-13-15

JAMESTOWN S'KLALLAM TRIBE



Digitally signed by W. Ron Allen
DN: cn=W. Ron Allen, o=Jamestown
S'Klallam Tribe, ou=Office of CEO,
email=rallen@jamestowntribe.org,
c=US
Date: 2015.03.13 00:16:30 -07'00'

Ron Allen, Tribal Council Chairman

DATED: 3-12-2015



**EXHIBIT A: STATEMENT OF WORK Jamestown S'Klallam Tribe,
Project Plan 2015 -2016**

Activity YEAR 1	Need / Purpose / Outcome	Timeline and Budget
GOAL 1: Strengthen positive cultural identity which acts as a preventative tool to decrease mental health problems in the Tribal community.		
<p>This project will bring together 20 - 30 Tribal teens and parents in a 3-4 day retreat to focus on the topic of suicide prevention and education. Support year round activities supporting the annual canoe journey (gift making, intertribal singing/ drumming/dancing, canoe & protocol practices). These topics will be integrated within a series of activities to work with established Tribal artists to practice traditional arts such as Salish design, cedar weaving, button blankets/vests and Salish regalia design. This event will also include singing, drumming, canoe journey planning and food and storytelling. These activities are designed to learn the art and skills, and continue to rejuvenate tradition within the Tribe. This project supports strengthening positive cultural identity, which acts as a preventative tool to decrease mental health problems in the Tribal community. There are only a handful of Tribal Citizens who retain knowledge concerning these unique forms of traditional art. These projects traditions and values encompass the importance of a holistic approach to mental health services in a Tribal Community.</p>	<p>In our experience, implementing projects such as these creates a tremendous opportunity to support the wellness and stability of individuals, youth/teens, families and the community. The project will strengthen cultural identity and self-reliance. The project will reaffirm cultural traditions, the value of working together and build community and sense of belonging among Tribal Citizens, specifically youth/teens having a broad range of cultural identity and understanding.</p>	<p>1/1/15 – 12/31/15 \$7,483.00</p>
<p>4 cultural classes including food, instructor and materials. We will be providing 2 bentwood box classes and 2 paddle-rattle classes. This will increase the number of participants to 60 (anticipated 10 per class).</p>		
GOAL 2: Provide Additional Mental Health Services for Tribal Citizens		
<p>Assist Tribal Citizens to use mental health services available in the local community by assisting with payment for services.</p>	<p>Tribal resources for mental health services are limited and individual Tribal Citizen's insurance coverage limits their access to counseling services. Tribal Citizens will receive additional mental health services based on assessment by Jamestown S'Klallam Tribe staff and mental health professionals.</p>	<p>1/1/15 – 12/31/15 \$5,000.00</p>

Activity YEAR 2	Need / Purpose / Outcome	Timeline and Budget
GOAL 1: Strengthen positive cultural identity which acts as a preventative tool to decrease mental health problems in the Tribal community.		
<p>This project will bring together 20 - 30 Tribal teens and parents in a 3-4 day retreat to focus on the topic of suicide prevention and education. Support year round activities supporting the annual canoe journey (gift making, intertribal singing/ drumming/dancing, canoe & protocol practices). These topics will be integrated within a series of activities to work with established Tribal artists to practice traditional arts such as Salish design, cedar weaving, button blankets/vests and Salish regalia design. This event will also include singing, drumming, canoe journey planning and food and storytelling. These activities are designed to learn the art and skills, and continue to rejuvenate tradition within the Tribe. This project supports strengthening positive cultural identity, which acts as a preventative tool to decrease mental health problems in the Tribal community. There are only a handful of Tribal Citizens who retain knowledge concerning these unique forms of traditional art. These projects traditions and values encompass the importance of a holistic approach to mental health services in a Tribal Community.</p>	<p>In our experience, implementing projects such as these creates a tremendous opportunity to support the wellness and stability of individuals, youth/teens, families and the community. The project will strengthen cultural identity and self-reliance. The project will reaffirm cultural traditions, the value of working together and build community and sense of belonging among Tribal Citizens, specifically youth/teens having a broad range of cultural identity and understanding.</p>	<p>1/1/16 – 12/31/16 \$6,000.00</p>
<p>4 cultural classes including food, instructor and materials. We will be providing 2 bentwood box classes and 2 paddle-rattle classes. This will increase the number of participants to 60 (anticipated 10 per class).</p>		

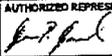
GOAL 2: Provide Additional Mental Health Services for Tribal Citizens		
<p>Assist Tribal Citizens to use mental health services available in the local community by assisting with payment for services.</p>	<p>Tribal resources for mental health services are limited and individual Tribal Citizen's insurance coverage limits their access to counseling services. Tribal Citizens will receive additional mental health services based on assessment by Jamestown S'Klallam Tribe staff and mental health professionals.</p>	<p>1/1/16 – 12/31/16 \$6,483.00</p>

EXHIBIT B: BUDGET SUMMARY

Jamestown S'Klallam Tribe Enhanced Mental Health Services

Expenditure Cost Category	Budget Period	Previous Budget	Changes this Contract	Current Budget
Year 1 State Funded Match Mental Health Services – Contract Services	1/1/15 – 12/31/15	0		\$12,483
Year 2 State Funded Match Mental Health Services – Contract Services	1/1/16 – 12/31/16	0		\$12,483
Total				\$24,966

EXHIBIT C: CERTIFICATE OF LIABILITY INSURANCE

 CERTIFICATE OF LIABILITY INSURANCE		DATE (MM/DD/YYYY)																																			
		6/30/2014																																			
<p>THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.</p> <p>IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).</p>																																					
PRODUCER Brown & Brown of Washington, Inc. 1501 Fourth Ave., Suite 2400 Seattle WA 98101	CONTACT NAME: Danisa Swazey PHONE (Lic. No.): 206-958-1852 FAX (Lic. No.): 206-958-9652 E-MAIL: Address: dswazey@hnbseattle.com	INSURER(S) AFFORDING COVERAGE INSURER A: HUDSON INSURANCE COMPANY NAIC # 26054 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:																																			
INSURED Jamestown S' Klallam Tribe 1033 Old Blyn Highway Sequim WA 98382	CERTIFICATE NUMBER: 1757208191 REVISION NUMBER:																																				
<p>THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.</p>																																					
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CERTIFICATE HOLDER Peninsula Regional Support Network Kitsap County 614 Division St. MS-23 Port Orchard WA 98366	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE 																																				

ACORD 25 (2010/05)

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**EXHIBIT D: CERTIFICATION REGARDING DEBARMENT,
SUSPENSION, AND OTHER RESPONSIBILITY MATTERS**

Primary Covered Transactions 45 CFR 76

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principles:
 - a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
 - b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connections with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;
 - c. Are not presently indicted for or otherwise criminally or civilly charges by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph 1.b. of this certification; and
 - d. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.
2. Where the prospective primary participants are unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

This Certification is executed by the person(s) signing below who warrant they have authority to execute this Certification.

**CONTRACTOR: Jamestown
S'Klallam Tribe**

Name: W. Ron Allen
Ron Allen

Digitally signed by W. Ron Allen
DN: cn=W. Ron Allen, o=Jamestown
S'Klallam Tribe, ou=Office of CEO,
email=allen@jamestowntribe.org, c=US
Date: 2015.03.16 14:52:53 -0700

Title: Tribal Council Chairman

DATE: _____

EXHIBIT E: CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and believe, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Jamestown S'Klallam Tribe

Contractor Organization



Digitally signed by W. Ron Allen
DN: cn=W, Ron Allen, o=Jamestown
S'Klallam Tribe, ou=Office of CEO,
email=rallen@jamestowntribe.org, c=US
Date: 2015.03.16 14:56:28 -07'00'

3-16-2015

Signature of Certifying Official

Date

**INTERLOCAL AGREEMENT BETWEEN
KITSAP COUNTY as the Administrative entity for the PENINSULA
REGIONAL SUPPORT NETWORK
AND
MAKAH TRIBE
FOR
MENTAL HEALTH SERVICES
KC-317-14**

This Interlocal Agreement between Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK and the Makah Tribe (this "Agreement") is entered into by Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK (the "PRSN"), a political subdivision of the State of Washington, and the Makah Tribe (the "Tribe"), a federally recognized Indian tribe, effective January 1, 2015.

RECITALS

WHEREAS, Kitsap County is the administrative entity for the Peninsula Regional Support Network;

WHEREAS, Kitsap County, on behalf of the Peninsula Regional Support Network, has entered into an "RSN Agreement" with the State of Washington Department of Social and Health Services (the "State"), Division of Behavioral Health and Recovery, under which the State provides funds to the County for the provision of services to mentally ill residents of Kitsap, Jefferson and Clallam Counties;

WHEREAS, the County wishes to subcontract with the Tribe to enable the Tribe to provide enhanced mental health services to Makah tribal members and other non tribal members seeking services from the Tribal clinic;

WHEREAS, the Tribe is willing to comply with all applicable contractual and program requirements contained in the State-County Grant Contracts;

WHEREAS, the Tribe, being a sovereign government, has requested that the subcontract be in the form of an interlocal agreement and the State has encouraged the County to subcontract in that form, and

WHEREAS, the State has reviewed the form of this Agreement and found that it satisfies the County's subcontracting obligations under the State-County Grant Contracts.

AGREEMENT

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Statement of Work. The Tribe agrees to provide services in accordance with Exhibit A – Statement of Work.
2. Funding. The services to be performed will be funded by payment by the County to the Tribe as described in the attached Statement of Work, in an amount not to exceed \$24,966. This Agreement is expressly contingent throughout its term upon funding availability.
3. State-County Grant Contracts. The State-County Grant Contracts, as they may be amended from time to time, are incorporated by this reference as if set forth fully herein and this Agreement shall be subject to the provisions contained in the State-County Grant Contracts. The Tribe agrees to comply with all provisions contained in the State-County Grant Contracts applicable to subcontractors, except for those provisions, if any, that the State may expressly waive in writing, or is not applicable under federal or state law.
4. Culturally Relevant Services. In providing services, the Tribe may develop and operate programs and deliver goods, services and/or benefits in a manner that is culturally relevant and particularly suited to and/or particularly located for access by members of the Tribe, in accordance with tribal laws and policies.
5. Term. The term of this Agreement is January 1, 2015 – December 31, 2016.
6. Termination for Convenience. Either party may terminate this Agreement for convenience by providing the other party with advance written notice of at least 30 days.
7. Termination for Default. If either defaults in its obligations under this Agreement, the nondefaulting party may terminate this Agreement by written notice to the defaulting party. Before such termination, however, the defaulting party shall be given 10 days to cure its default, if the default is of a type reasonably susceptible to cure.
8. Dispute Panel. The parties may voluntarily submit any contractual dispute to a dispute panel as follows: each party will appoint one member to the panel and those two members in turn will appoint a third member. The dispute panel will review the facts, contract provisions and applicable law, and then decide the matter. This provision does not affect the right of either party to seek legal recourse in a court of competent jurisdiction.
9. Indemnification. Each party agrees to defend and indemnify the other party and its officials, officers, employees and agents for all claims, liabilities, damages, expenses and suits arising from or relating to the performance of this Agreement by the indemnitor or its officials, officers, employees and agents.

10. Commercial General Liability. The Tribe shall have Commercial General Liability Insurance with limits of not less than Combined Bodily Injury/Property Damage Liability of \$1,000,000 each occurrence and \$2,000,000 aggregate. The Tribe will place insurance with insurers licensed to do business in the State of Washington and having A.M. Best Company ratings of no less than A-VII, with the exception that excess and umbrella coverage used to meet the requirements for limits of liability or gaps in coverage need not be placed with insurers or re-insurers licensed in the State of Washington.

Coverage shall contain general requirements and endorsements with Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County named as an additional insured and that in the event of a claim or suit, the insurance carrier agrees to not use sovereign immunity of the assured as defense as respects this agreement. Such insurance as carried by the Tribe is primary over any insurance carried by the Peninsula Regional Support Network and Kitsap County, Jefferson County, Clallam County. The Tribe will include all subcontractors as insureds under its policies or will furnish separate certificates and endorsements for each subcontractor. All coverage for subcontractors will be subject to all the requirements in these provisions.

The Tribe expressly agrees to a limited waiver of sovereign immunity as a defense up to the limits of the insurance policy in connection with the enforcement of the rights of the Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County.

11. Audit Requirements. All payments under this agreement are subject to audit. The Tribe shall provide an independent audit which:

- a. Determines the fiscal integrity of the financial transactions and reports of the Tribe.
- b. Is performed by an independent auditing firm or the Washington State Auditor's Office.
- c. Is performed in accordance with generally accepted auditing standards and with Federal Standards for Audit of Governmental Organizations, Programs, Activities and Functions, and meeting all requirements of OMB Circular A-133, as applicable for agencies receiving federal funding in the amount of \$500,000 or more during their fiscal year.

12. Suspension, Debarment, and Lobbying

The Contractor shall certify, on a separate form (Exhibit D), that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency. Also, the Contractor, on a separate form (Exhibit E), will certify that it does not use Federal funds for lobbying purposes. Both forms are attached to this Contract.

13. Notices. Any notice required or permitted under this Agreement shall be given in writing and addressed as follows:

To the PENINSULA REGIONAL SUPPORT NETWORK

Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366
Attention:
Anders Edgerton, Regional Administrator

To the TRIBE

Makah Tribe
P.O. Box 115
Neah Bay, WA 98357
Attention:
Monica McGee, Contract Specialist

Either party may change its address for notices by providing written notice to the other party.

14. Independent Capacity. The officials, officers, employees and agents of each party shall continue to be officials, officers, employees and agents of that party and shall not be considered for any purpose to be officials, officers, employees and agents of the other party.

15. Waiver. Waiver of any part of this Agreement may only be made in a writing executed by an authorized representative of the party to be bound.

16. Applicable Law. Each party shall comply with all applicable federal, tribal, state and local law.

17. Amendment. This Agreement may be amended only by a writing executed by authorized representatives of both parties with the same formalities as this Agreement.

18. Survival. Sections 8 (Dispute Panel), and 9 (Indemnification) of this Agreement shall survive the termination or expiration of this Agreement.

19. Authority. Each party warrants that it has taken all steps necessary for this Agreement to have full legal effect and that the signatures hereon are those of its authorized representatives.

20. Exhibits. The following exhibits are incorporated in this Agreement by reference:

- Exhibit A: Statement of Work
- Exhibit B: Budget Summary
- Exhibit C: Certificate of Liability Insurance and Sovereignty Endorsement
- Exhibit D: Certification Regarding Debarment, Suspension, and Other Responsibility Matters
- Exhibit E: Certification Regarding Lobbying

IN WITNESS WHEREOF, THE PARTIES HAVE SUBSCRIBED THEIR NAMES
HERETO ON THE DATES SET FORTH BELOW.

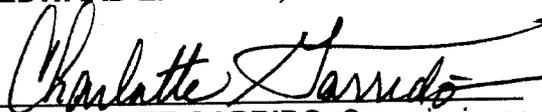
PENINSULA REGIONAL SUPPORT
NETWORK, By the Kitsap County Board
of Commissioners, Its Administrative
Entity



ROBERT GELDER, Chair



EDWARD E. WOLFE, Commissioner



CHARLOTTE GARRIDO, Commissioner

ATTEST:


Dana Daniels, Clerk of the Board

DATED: 4-27-15

MAKAH TRIBE



TIMOTHY J. GREENE, SR.
Tribal Council Chairman

DATED: 4/06/15

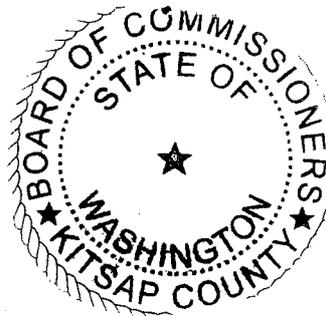


EXHIBIT A: STATEMENT OF WORK

Makah Tribe Enhanced Mental Health Services

1. General Statement of Work – Mental Health Services

The Makah Tribe provides general mental health services to tribal members and others seeking services. The Tribe is in need of providing additional child and family counseling services to Tribal community members.

2. Specific Services Purchased

Funds will be utilized to purchase the professional services of Betty Poffenbarger, a licensed mental health counselor. All program funds will be used to pay for the staff time of Ms. Poffenbarger. She will provide the Tribe with specific child and family direct counseling services to approximately 43 children and their families.

3. Clients Served

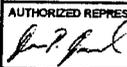
Direct counseling services will be provided to approximately 43 children and their families, the total served is approximately 43.

EXHIBIT B: BUDGET SUMMARY

Makah Tribe Enhanced Mental Health Services

Expenditure Cost Category	Budget Period	Previous Budget	Changes this Contract	Current Budget
Year 1 State Funded Match Mental Health Services – Contract Services	1/1/15 – 12/31/15	0		\$12,483
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		12/31/2014																																			
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PRODUCER Brown & Brown of Washington, Inc. 1501 Fourth Ave Suite 2400 Seattle WA 98101	CONTACT NAME: Melanie Van Gelder PHONE (A/C No., Ext): 206-956-1626 FAX (A/C No.): 206-956-9626 E-MAIL ADDRESS: mvangeld@bnbseattle.com	INSURER(S) AFFORDING COVERAGE INSURER A: HUDSON INSURANCE COMPANY NAIC # 25054 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:																																			
COVERAGES CERTIFICATE NUMBER: 276423040 REVISION NUMBER:																																					
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**Exhibit D: CERTIFICATION REGARDING DEBARMENT, SUSPENSION,
AND OTHER RESPONSIBILITY MATTERS**

Primary Covered Transactions 45 CFR 76

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principles:
 - a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
 - b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connections with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;
 - c. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph 1.b. of this certification; and
 - d. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.
2. Where the prospective primary participants are unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

This Certification is executed by the person(s) signing below who warrant they have authority to execute this Certification.

CONTRACTOR: MakahTribe

Name: Timothy Aremu

Title: Chairman

DATE: 4/6/15

Exhibit E: CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and believe, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Makah Tribe

Contractor Organization



Signature of Certifying Official



Date

**INTERLOCAL AGREEMENT BETWEEN
KITSAP COUNTY as the Administrative entity for the PENINSULA
REGIONAL SUPPORT NETWORK
AND
LOWER ELWHA KLALLAM TRIBE
FOR
MENTAL HEALTH SERVICES
KC-315-14**

This Interlocal Agreement between Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK and the Lower Elwha Klallam Tribe (this "Agreement") is entered into by Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK (the "PRSN"), a political subdivision of the State of Washington, and the Lower Elwha Klallam Tribe (the "Tribe"), a federally recognized Indian tribe, effective January 1, 2015.

RECITALS

WHEREAS, Kitsap County is the administrative entity for the Peninsula Regional Support Network;

WHEREAS, Kitsap County, on behalf of the Peninsula Regional Support Network, has entered into an "RSN Agreement" with the State of Washington Department of Social and Health Services (the "State"), Division of Behavioral Health and Recovery, under which the State provides funds to the County for the provision of services to mentally ill residents of Kitsap, Jefferson and Clallam Counties;

WHEREAS, the County wishes to subcontract with the Tribe to enable the Tribe to provide enhanced mental health services to Lower Elwha Klallam tribal members and other non tribal members seeking services from the Tribal clinic;

WHEREAS, the Tribe is willing to comply with all applicable contractual and program requirements contained in the State-County Grant Contracts;

WHEREAS, the Tribe, being a sovereign government, has requested that the subcontract be in the form of an interlocal agreement and the State has encouraged the County to subcontract in that form; and

WHEREAS, the State has reviewed the form of this Agreement and found that it satisfies the County's subcontracting obligations under the State-County Grant Contracts.

AGREEMENT

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Statement of Work. The Tribe agrees to provide services in accordance with Exhibit A – Statement of Work.
2. Funding. The services to be performed will be funded by payment by the County to the Tribe as described in the attached Statement of Work, in an amount not to exceed \$24,966. This Agreement is expressly contingent throughout its term upon funding availability.
3. State-County Grant Contracts. The State-County Grant Contracts, as they may be amended from time to time, are incorporated by this reference as if set forth fully herein and this Agreement shall be subject to the provisions contained in the State-County Grant Contracts. The Tribe agrees to comply with all provisions contained in the State-County Grant Contracts applicable to subcontractors, except for those provisions, if any, that the State may expressly waive in writing, or is not applicable under federal or state law.
4. Culturally Relevant Services. In providing services, the Tribe may develop and operate programs and deliver goods, services and/or benefits in a manner that is culturally relevant and particularly suited to and/or particularly located for access by members of the Tribe, in accordance with tribal laws and policies.
5. Term. The term of this Agreement is January 1, 2015 - December 31, 2016.
6. Termination for Convenience. Either party may terminate this Agreement for convenience by providing the other party with advance written notice of at least 30 days.
7. Termination for Default. If either defaults in its obligations under this Agreement, the nondefaulting party may terminate this Agreement by written notice to the defaulting party. Before such termination, however, the defaulting party shall be given 10 days to cure its default, if the default is of a type reasonably susceptible to cure.
8. Dispute Panel. The parties may voluntarily submit any contractual dispute to a dispute panel as follows: each party will appoint one member to the panel and those two members in turn will appoint a third member. The dispute panel will review the facts, contract provisions and applicable law, and then decide the matter. This provision does not affect the right of either party to seek legal recourse in a court of competent jurisdiction.
9. Indemnification. Each party agrees to defend and indemnify the other party and its officials, officers, employees and agents for all claims, liabilities, damages, expenses and suits arising from or relating to the performance of this Agreement by the indemnitor or its officials, officers, employees and agents.

10. Commercial General Liability. The Tribe shall have Commercial General Liability Insurance with limits of not less than Combined Bodily Injury/Property Damage Liability of \$1,000,000 each occurrence and \$2,000,000 aggregate. The Tribe will place insurance with insurers licensed to do business in the State of Washington and having A.M. Best Company ratings of no less than A-VII, with the exception that excess and umbrella coverage used to meet the requirements for limits of liability or gaps in coverage need not be placed with insurers or re-insurers licensed in the State of Washington.

Coverage shall contain general requirements and endorsements with Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County named as an additional insured and that in the event of a claim or suit, the insurance carrier agrees to not use sovereign immunity of the assured as defense as respects this agreement. Such insurance as carried by the Tribe is primary over any insurance carried by the Peninsula Regional Support Network and Kitsap County, Jefferson County, Clallam County. The Tribe will include all subcontractors as insureds under its policies or will furnish separate certificates and endorsements for each subcontractor. All coverage for subcontractors will be subject to all the requirements in these provisions.

The Tribe expressly agrees to a limited waiver of sovereign immunity as a defense up to the limits of the insurance policy in connection with the enforcement of the rights of the Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County.

11. Audit Requirements. All payments under this agreement are subject to audit. The Tribe shall provide an independent audit which:

- a. Determines the fiscal integrity of the financial transactions and reports of the Tribe.
- b. Is performed by an independent auditing firm or the Washington State Auditor's Office.
- c. Is performed in accordance with generally accepted auditing standards and with Federal Standards for Audit of Governmental Organizations, Programs, Activities and Functions, and meeting all requirements of OMB Circular A-133, as applicable for agencies receiving federal funding in the amount of \$500,000 or more during their fiscal year.

12. Suspension, Debarment, and Lobbying

The Contractor shall certify, on a separate form (Exhibit D), that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency. Also, the Contractor, on a separate form (Exhibit E), will certify that it does not use Federal funds for lobbying purposes. Both forms are attached to this Contract.

13. Notices. Any notice required or permitted under this Agreement shall be given in writing and addressed as follows:

To the PENINSULA REGIONAL SUPPORT NETWORK

Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366
Attention:
Anders Edgerton, Regional Administrator

To the TRIBE

Lower Elwha Health Clinic
243511 Hwy 101 West
Port Angeles, WA 98363
Attention:
Mervyn A. Chambers, MNPL, Health Services Director

Either party may change its address for notices by providing written notice to the other party.

14. Independent Capacity. The officials, officers, employees and agents of each party shall continue to be officials, officers, employees and agents of that party and shall not be considered for any purpose to be officials, officers, employees and agents of the other party.

15. Waiver. Waiver of any part of this Agreement may only be made in a writing executed by an authorized representative of the party to be bound.

16. Applicable Law. Each party shall comply with all applicable federal, tribal, state and local law.

17. Amendment. This Agreement may be amended only by a writing executed by authorized representatives of both parties with the same formalities as this Agreement.

18. Survival. Sections 8 (Dispute Panel), and 9 (Indemnification) of this Agreement shall survive the termination or expiration of this Agreement.

19. Authority. Each party warrants that it has taken all steps necessary for this Agreement to have full legal effect and that the signatures hereon are those of its authorized representatives.

20. Exhibits. The following exhibits are incorporated in this Agreement by reference:

- Exhibit A: Statement of Work
- Exhibit B: Budget Summary
- Exhibit C: Certificate of Liability Insurance and Sovereignty Endorsement
- Exhibit D: Certification Regarding Debarment, suspension, and Other Responsibility Matters
- Exhibit E: Certification Regarding Lobbying

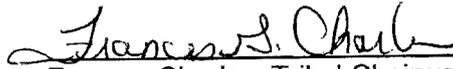
IN WITNESS WHEREOF, THE PARTIES HAVE SUBSCRIBED THEIR NAMES
HERETO ON THE DATES SET FORTH BELOW.

PENINSULA REGIONAL SUPPORT
NETWORK, By the Kitsap County Board
of Commissioners, Its Administrative
Entity

LOWER ELWHA KLALLAM TRIBE



ROBERT GELDER, Chair

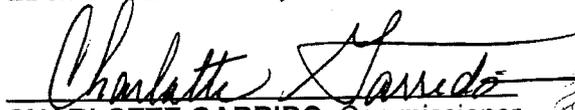


Frances Charles, Tribal Chairwoman

NOT PRESENT

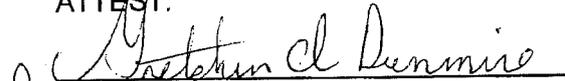
DATED: 1/15/15

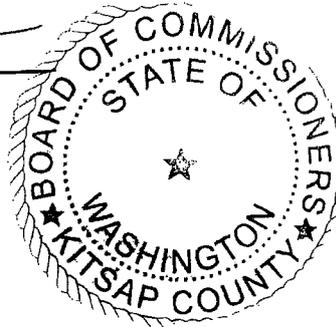
EDWARD E. WOLFE, Commissioner



CHARLOTTE GARRIDO, Commissioner

ATTEST:


Dana Daniels, Clerk of the Board



DATED: Feb 9, 2015

EXHIBIT A: STATEMENT OF WORK



Lower Elwha Health Clinic

PRSN Interlocal Agreement 2015 - 2016 Project Plan

Goal: Improve access and quality of direct mental health services for Native American families in the service area of the Elwha Klallam Reservation. This project will include staff training and consultation to other mental health staff and Head Start personnel.

Objective: Establish service contracts with one or more independent mental providers specializing in child and family mental health and therapy, who will provide services to identified children and family members in need on the Elwha Klallam Reservation. This project calls for a target of 15-20 hours of therapeutic services per week to be delivered directly to approximately 50 total Native children and family members.

Dates: For the purposes of this proposed Project Plan, dates of service will cover services provided January 1, 2015 through December 31, 2016.

The total allowable expenditures reimbursable by the PRSN for this Project Plan is \$24,966.

*Lower Elwha Health Clinic, 243511 Hwy 101 West, Port Angeles, WA 98363
Phone: 360-452-6252*

EXHIBIT B: BUDGET SUMMARY

Lower Elwha Klallam Tribe Enhanced Mental Health Services

Expenditure Cost Category	Budget Period	Previous Budget	Changes this Contract	Current Budget
Year 1 State Funded Match Mental Health Services – Contract Services	1/1/15 – 12/31/15	0		\$12,483
Year 2 State Funded Match Mental Health Services – Contract Services	1/1/16 – 12/31/16	0		\$12,483
Total				\$24,966

Exhibit C: Certificate of Insurance



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
10/3/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Arthur J. Gallagher Risk Management Services, Inc. P.O. Box 2925 Tacoma WA 98401-2925		CONTACT NAME Janette Ladley PHONE (A/C No., Ext.) 253-627-7183 FAX (A/C No.) 253-572-1430 E-MAIL ADDRESS: Janette_Ladley@ajg.com	
INSURED Lower Elwha Klallam Tribe Warren Stevens 2851 Lower Elwha Road Port Angeles WA 98363		INSURER(S) AFFORDING COVERAGE INSURER A: Gemini Insurance Company NAIC # 10833 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES CERTIFICATE NUMBER: 1100712575 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADD'L SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Stop Gap \$1mil GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO JECT <input type="checkbox"/> LOC OTHER:		TGL0000079-01	10/1/2014	10/1/2015	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (EA occurrence) \$1,000,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMPOP AGG \$2,000,000 \$ COMBINED SINGLE LIMIT (EA accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					\$ \$ \$ \$ \$ \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$		TGX0000062-01	10/1/2014	10/1/2015	EACH OCCURRENCE \$4,000,000 AGGREGATE \$4,000,000 \$ PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in WA) If yes, describe under DESCRIPTION OF OPERATIONS below					\$ \$ \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
 Additional insured per SN 75 01 04 13 (item H page 23 of 26)
 Peninsula Regional Support Network, Kitsap County, Jefferson County and Clallam County are named as Re: Interlocal Agreement for Mental Health Services

CERTIFICATE HOLDER Peninsula Regional Support Network 614 Division Street, MS-23 Port Orchard WA 98366 USA	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE
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ACORD 25 (2014/01) The ACORD name and logo are registered marks of ACORD © 1988-2014 ACORD CORPORATION. All rights reserved.

SOVEREIGN NATION COMMERCIAL LIABILITY INSURANCE COVERAGE FORM

SECTION V – CONDITIONS

- A. NOTICE OF "OCCURRENCE":** Whenever the Risk Manager or designated representatives of the Named Insured has information from which the "Insured" may reasonably conclude that an "occurrence" covered under of this policy involves injuries or damages, notice shall be given to the service organization as soon as practicable. "Claims" shall not be prejudiced if the "Insured", through clerical oversight or error, fails to notify the above firm of any "occurrence" provided that such clerical oversight or error is rectified immediately upon discovery of same.
- B. SALVAGE AND RECOVERY CLAUSE:** All salvages, recoveries and payments recovered or received subsequent to a loss settlement under this policy shall be applied as if recovered or received prior to the said settlement and all necessary adjustments shall be made by the parties hereto.
- C. INSPECTIONS, AUDIT AND VERIFICATION OF VALUES:** The Carrier or their duly authorized representatives shall be permitted at all reasonable times during continuance of this policy to inspect the premises used by the Named Insured and to examine the Named Insured's books or records so far as they relate to coverage afforded by this policy.
- D. CANCELLATION / NON-RENEWAL:** The Carrier may not cancel the policy for any reason with the exception of non-payment of premium by the Named Insured. The Carrier will give notice of cancellation in writing, sent via certified mail to the Named Insured and all coverage afforded by this policy will terminate fifteen (15) days after the mailing of such notice. The Named Insured may cancel the policy by mailing notice to the Carrier. Carrier will give notice of Non-renewal of the policy in writing sixty (60) days prior to the expiration of the policy.
- E. CURRENCY:** The premium and losses under this policy are payable in United States currency.
- F. BANKRUPTCY AND INSOLVENCY:** In the event of the bankruptcy or insolvency of the "Insured" or any entity comprising the "Insured", Carrier shall not be relieved of the payment of any "claims" hereunder because of such bankruptcy or insolvency.
- G. OTHER INSURANCE:** This policy is primary unless the "Insured" has other insurance providing coverage against loss that is also covered by this policy. The Carrier shall be liable, under the terms of this policy, only in excess of that coverage provided by such other insurance and no monies payable or collectible from such other insurance shall accrue to the "retained limit" or "deductible".
- H. ADDITIONAL INSURED CLAUSE:** The interest of any additional "Insured" with respect to liability covered hereunder is included as if a separate Insuring Agreement were attached hereto to the extent of their interest as of the date of loss subject to the Limits of Liability set forth in this policy.
- I. CLAIMS:** The Risk Manager or designated representative of the Named Insured shall immediately notify the Carrier through the service organization of any "occurrence" or "claim", which is likely to result in payment by the Carrier under this policy. The Carrier shall have the opportunity to be associated with the Named Insured in defense of any "claims", suits or proceedings relative to any

**Exhibit D: CERTIFICATION REGARDING DEBARMENT, SUSPENSION,
AND OTHER RESPONSIBILITY MATTERS**

Primary Covered Transactions 45 CFR 76

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principles:
 - a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
 - b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connections with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;
 - c. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph 1.b. of this certification; and
 - d. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.
2. Where the prospective primary participants are unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

This Certification is executed by the person(s) signing below who warrant they have authority to execute this Certification.

**CONTRACTOR: Lower Elwha Klallam
Tribe**

Name: Frances G Charles

Title: Chairwoman

DATE: 1/15/15

Exhibit E: CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and believe, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Lower Elwha Klallam Tribe

Contractor Organization

Francis J. Clark

1/15/15

Signature of Certifying Official

Date



PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: PROTECTIONS AGAINST RETALIATION

Policy Number: 2.22

Reference: DSHS contract, WAC 388-865-0208

Effective Date: 6/2000

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Plan: Compliance Plan
- Policy: Corrective Action Plans
- Policy: Fraud and Abuse Compliance Reporting Standards

PURPOSE

The Peninsula Regional Support Network (PRSN) will prevent any incidence of retaliation, intimidation, coercion, or harassment directed against any consumer, Ombuds, PRSN Advisory Board, Quality Review Team (QRT) member, PRSN staff and Board of Directors, and investigate any alleged incidents thereof.

Individuals may perform functions that may put themselves and/or family member consumers at risk or perceived risk of retaliation. The PRSN shall assure these individuals may perform their duties free from retaliation or threat of retaliation.

DEFINITIONS

Retaliation refers to any actions perceived as revengeful or vindictive in nature.

POLICY

Retaliation is completely incompatible with the values and goals of the PRSN and will not be tolerated. Retaliation, whether actual or threatened, destroys a sense of community and trust that is central to a quality mental health care program.

1. There will be no retaliation, intimidation, coercion or harassment directed against any consumer for filing a grievance or for disclosing or alleging official misconduct. The term retaliation shall have the meaning that it does under state whistleblower laws.
2. The PRSN prohibits retaliation of any kind against the Ombuds and QRT, PRSN staff, Board of Directors or Advisory Board members for the completion of their official duties, in accordance with PRSN policies and procedures.
3. The PRSN believes that the improvement of the quality of services through the concern and grievance process is vital to Quality Management and Quality Improvement processes.

PROCEDURE

1. If an individual experiences any action perceived as retaliatory in nature (as defined above) from a PRSN network mental health provider, subcontractor, ancillary community provider, or individual members of the community, or PRSN staff, the individual must report the incident to the PRSN Regional Administrator.
 - The PRSN Regional Administrator will review all substantiated concerns and grievances regarding retaliation. The PRSN Regional Administrator may delegate the issues of concern to the PRSN Compliance Officer.
2. The PRSN will take action in accordance with the provider contract, allied system coordination plan, and/or personnel policies and procedures to prevent and correct behavior that violates this policy.
 - If the incident involves an employee of a network provider agency, the incident will be reported to the agency human resources department and the employee's direct supervisor.
 - A PRSN employee who violates this policy, or acts in a way that is contrary to this policy, is subject to progressive disciplinary action in accordance with the PRSN/Kitsap County personnel policies and procedures.
 - If the concern involves the Regional Administrator, the individual will report the incident to the Kitsap County Personnel and Human Services Department Head or Assistant Department Head.
 - If the concern involves the Kitsap County Department Head or a member of the PRSN Executive Board, their respective county will be informed so that they may follow their own policies and procedures.
3. The PRSN will investigate any acts reported and perceived as retaliatory in nature within thirty (30) days from the date of report.

4. The PRSN will provide a written conclusion of the investigation to the complainant within fifteen (15) days of the completion of the investigation.
5. The PRSN may consult with the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery or their subcontractor, such as the external quality review organization (EQRO) entity or WIMRT, to adopt procedures to prevent retaliation or deal with a noted trend of retaliation.
6. The PRSN will participate, to the fullest extent, with any investigation facilitated by the Department or their formal designee.
7. Remedial action to retaliation allegations determined to be founded may include:
 - Education and training
 - Referral to Employee Assistance Programs (EAP)
 - Employee disciplinary action
 - Employee or member appointment suspended
 - Employee or member appointment terminated
8. Full records of all concerns or grievances regarding retaliation will be maintained in confidential files by the PRSN Regional Administrator or designee.

MONITORING

This policy is a mandated by statute and contract.

1. The PRSN will monitor this policy through the use of:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Biennial Provider Quality Review Team On-site Review
 - Grievance Tracking Reports
 - Quality Management Plan activities and Quality Improvement Committee (QUIC) oversight, such as review targeted issues for trends and recommendations
2. Due to the nature of this policy, policy monitoring activities and Corrective Action Plans may be individualized to address the threat of retaliation concerns.
Reference PRSN Corrective Action Plan Policy



PENINSULA RSN

FISCAL MANAGEMENT POLICIES AND PROCEDURES

Policy Name: ENROLLEE LIABILITY FOR PAYMENT

Policy Number: 8.01

Reference: 42 CFR 438.106

Effective Date: 7/2005

Revision Date(s): 12/2012

Reviewed Date: 1/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan

PURPOSE

Medicaid enrollees shall not be held liable for the costs of covered services.

PROCEDURE

Medicaid enrollees shall not be financially liable for:

- Debts of the Peninsula Regional Support Network (PRSN) in the event of insolvency
- Costs of any covered service

If an enrollee is receiving community based inpatient services at the time an inpatient provider closes, the PRSN, through its provider network, shall arrange for continued services through an alternative provider.

MONITORING

This policy is a mandate by contract and federal regulation.

1. This policy will be monitored through use of PRSN:

- Annual PRSN Provider and Subcontractor Administrative Review
 - Annual PRSN Provider Fiscal Review
 - Annual Provider Chart Review
 - Exhibit N Reports and Grievance Oversight
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan policy.



Peninsula Regional Support Network
Quality Review Team
Biennial Assessment of Kitsap Mental Health Services
2015

The QRT conducted Ancillary Community Provider interviews on April 28th at Worksource facility and then was on site at KMHS throughout April 29th and 30th 2015 meeting with program staff and clients.

BREMERTON POLICE DEPARTMENT

The primary purpose of the Bremerton Police Department is to serve the public, provide community service, and check property.

The police bring people eligible to be declared voluntary and involuntary to Harrison. “ We don’t always interact directly with KMHS—sometimes over phone.” (Just the day this interview the police received four calls from the same troubled individual, another call to Auto Center Way and then one more.) Just last year there were 272 report titles with mental investigation. Just nine were titled jointly suicide and mental. Just a suicide attempt or a threat 134 are in report titles. There could be other issues among the nine or 134. The officer is aware that at end of a month people run short of money and meds so that can stimulate calls.

The officer reported that the working relationship between the police and KMHS is good. No negative things. What we can do isn’t always in line with what KMHS wants done. What is still a problem is one brought up in a previous QRT review. . People are being released without an in person DMHP evaluation and possibly documentation of such a review. The officer cited that the RCW provides for persons to be evaluated by DMHP within 3 hours of arrival and within 12 determine whether a person meets detention criteria. The RCW stipulates that the DMHP must consult with the physician (emergency room consultation must be documented). Social workers have released people because they signed a paper saying they would not hurt themselves. If someone leaves without seeing a DMHP, from hospital, then there can be problems if they hurt themselves or others. According to the law only the DMHP can clear patient for release from Harrison, not solely a physician or social worker—hopefully not just a phone call. A lawyer can argue a telephone call evaluation by a DMHP is inadequate. The PRSN office representative and police officer agreed that there should be a document about each case. We will determine if this is happening.

Better funding and an enlarged facilities room are both needed by KMHS according to the same officer cited above. There need to be a place for people to go, Harrison doesn’t always have enough lock down space. Harrison doesn’t always want people without a physical medical need. There’s not enough space, security and nurses. That gets tense. Where do we bring people? With Harrison going to Silverdale there could be problems. We don’t just need holding places but places where people can live their lives with managed care. We’re talking about the chronic people. Sometimes the same person is

brought in every day or sometimes repeatedly during the week. The facility in Port Orchard will be helpful. The new Bremerton police chief more outspoken on mental health issues than previous chiefs.

During the discussion the officer humorously suggested they be permitted to bring people in on a voluntary/involuntary agreement with the potential detainee. The officer uses mediation. The police, "have to protect ourselves or determine their mode." One woman threatened daily to jump off Warren Ave bridge and one day she did. Trying to gauge is difficult. It is aggravating, for example, that one day seven people were brought to Harrison for mental evaluations and six were released. People are coming out so quickly officers question if the hospital process is complete.

AGING AND LONG TERM CARE

The mission of Aging and Long Term Care is to help older adults and people with disabilities remain in community. This department serves people 60 years and older without a means test.

Among the services provided by KMHS to this department are: A Medicaid long term care unit where clients can receive services on caseloads shared with KMHS. Provide services through KMHS under contract 60 years and older and who wouldn't otherwise meet KMHS or other benefits. We run referrals through intake and then refer to the older adult team at KMHS. Meet in home or neutral locations too. (Access to mental health care—is all under contract. There is also a focus on stress education support for family caregivers. Sometimes services are refused so long term care works with the family to ensure understandings. Senior and family care. The department is able to offer services at no cost, but do have a limited budget. These services are intended to be transitional, not permanent. They provide intake and referral to other providers. Providers are trained in dual diagnosis. Referrals from community for those in crisis—whether emergency room or social work referrals. Most clients non Medicaid.

This department assists with transitions between home and nursing home. There is a Caseload of 900 but only a small percentage are Medicaid. Title 19 case managers are funded by Medicaid. Administration services are funded by Medicaid.

Some KMHS providers are skilled and compassionate. There is some strong advocacy. The interviewed supervisor of this department is in awe of clinicians at KMHS. There has been harm reduction and a reduced consumption of alcohol among shared clients. Harm reduction and safety build empathy. The KMHS employees are compassionate. very skilled, strong advocates and a great team to work with. There is a diversity of team members and flexibility in the work force.

Possibly concerned about HIPPA this department is not always notified about KMHS activities or services received by shared clients. Case managers want to know if mental health services are provided—want releases upfront. People don't always sign releases so that aging and long term services know. Sometimes DMHP notified because Aging and Long Term is not notified. Kitsap Supported Housing—referrals are being made because individual income qualified. Sometimes case managers find services not being met. "What are real needs and appropriate referrals?" Our case management cannot do med management. This department wants to increase support for: 1. Hoarding is an issue. The need is great and referrals keep coming. Eviction notices create a crisis. 2. Dementia or mental health is another issue. Sometimes service are needed for anxiety and depression but those conditions don't meet KMHS criteria but there is a need for intervention. The interviewee said, "We could be doing prevention." The

department is always looking for beds for people in crisis. 3. Persons with disability when these individuals have personal care needs.

HARRISON MEDICAL CENTER

The primary mission of Harrison Medical Center is to provide medical care for all of Kitsap County.

KMHS provides a number of outpatient services to Harrison Medical Center, including: 1) Outpatient care coordination. 2) Older adult services that focuses more on geriatric population. 3) More intensive case management. 4) In patient services at the AIU and YIU which serve outpatient and dual diagnosis patients as well. 5) Oasis day program. 6) General pharmacy. 7) Keller House. 8) DMHP located at KMHS. KMHS provides some support to Kitsap Recovery Center—Triage Program. How we get along with them depends on the program we are talking about.

Every day there are holds for KMHS therapy slots for Harrison clients that might be released for KMHS care.

The most frequent contact between Harrison and KMHS is the frequent contact the DMHP, AIU and equally YIU and outpatient which includes PACT.

There are some strengths with KMHS. Every Friday there is a conference with KMHS leadership. The conferees share difficult cases and how it is going. This started years ago. There is a “Good relationship with leadership there.”

Care conferences are held about high utilizers in ED (about 1 persons a month with Harrison and KMHS staff. What’s the plan to help support them in the community?

EDIE—is a computer network care plan that enables emergency care plan. It’s great because as soon as a patient is registered he/she gets into system which flags 5 emergency visits in a year. (This includes treatment date and what the problem is prescribing information and any efforts to reduce opiate use. Within 3 minutes all prescriptions that have been filled are on the screen. This is an effort to reduce emergency room visits—encourage use of private physicians and urgent care instead. DMHP might have access to EDIE .EDIE will tell you what care plan is already in place. EDIE is an acronym for Medicaid Emergency Department Information Exchange. Some people who come to the emergency department visit twice a day. EDIE reveals prescription filling ability in addition to what the doctors already had. CAT scans and xrays relevant to the patient are noted so they can be captured. 85% of frequent users are Medicaid. The motivation is to standardize care of patients such as doctors being able to use how their prescriptions compare with peer (other physicians).

There has been improved collaboration with the KMHS care teams. This minimizes overnight stays which the emergency department is not designed to use.

One interviewee remarked, “Since Dec 26th there has not been any improvement in our constant inability of physicians to resolve cases while same doctor is attending.” Some patients stay in the ED 2 or 3 nights and yet only the initial physician is familiar with the detained individuals. There are no psych nurses. There has been no improvement in staffing for beds available in AIU and YIU. You can increase beds but if you don’t increase staffing then the staff suffers from boarding patients in the ED. Some patients are violent in the emergency room. Harrison has a controlled environment with enough staff to maintain order.

Sometimes Harrison staff is told by KMHS staff that an AIU bed is available but within hours KMHS will cancel that availability after Harrison has made plans for the transfer. This Delays de facto cancellation pattern and assessments and medications. "A debacle."

One 8 year old was housed in the ED for eight days until being admitted to Seattle Children's. He was a Developmentally Delayed individual so the YIU refused admission.

The interviewees from Harrison said Keller House finds every reason possible to avoid taking patients from Harrison. One ED mentally challenged patient was in the ED for 18 days although medically eligible for Keller House. The ED was assured a bed was being held. Keller House didn't want the patient without more discussion with the Outpatient Team. There is an "attitude from residential services."

Compared to other agencies in other counties this is the best mental health agency.

The Harrison interviewee claim that the staff does not preempt DMHP about discharge decisions regarding whether or not to ITA a patient.

The purpose of the Department of Children and Family Services is to keep children safe, hopefully, with their parents.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The purpose of the Department of Children and Family Services is to investigate allegations of physical or sexual abuse. Within DCFS there are these categories or efforts:

- 1) Family Assessment Response—neglect or low level abuse allegations work with families to keep kids safe at home and provide services. 70% of the referrals don't need a investigation. Parents not findings keep kids safe." A finding can impact employment—parents pay and pay for their mistake or finding again again.
- 2) Child Welfare Services—foster and relative care. Parents sometimes have time to ameliorate. Sometimes there is a termination of parental rights.
- 3) Child & Family Services.
- 4) Family Reconciliation Services—parents of families with teenagers.
- 5) Parents with severely mentally ill children which works with KMHS, but CPS is rarely called on to respond to these situations. They are rare.
- 6) Child Family Voluntary Services which is reconciliation voluntary services where they are trying to put a family back together.

DCFS and KMHS complete a joint assessment if the children are placed in Kitsap County. If the parent goes into adult services at KMHS, and CPS has sent them they will be denied services. This is not good. Citing CPS is a sure fire way not to get services. If an applicant is not covered by Medicaid or the Affordable Care Act he/she can be denied services. When there are co-morbidity issues they get parents involved with Pathways. This works well. KMHS therapists don't have time to help parents with court appearances. They never have enough resources.

There is a need to do cross training. DCFS looks at the individual within a family. KMHS is more client centered.

KMHS has branched into Evidence Based Practices. This teaches parents to interact with children positively. An effort is made to partner with parents rather than being draconian.

A strength of the KMHS staff is being quite responsive. Some KMHS staff are former employees. They ask questions. Pathways is an incredibly good program at KMHS once parents get involved. Parents with recovery and meds have gotten their kids back.

The needs to be a better placement of autism patients at KMHS. Autistic children have a terrible time getting a good placement. "Our foster care services are extremely limited." There can be 7 placements in 30 days. "We need to do everything possible to keep children with parents as long as they are safe.... Failed adoptions are not about children failing, it is parents who have failed." Adopted kids are too frequently stigmatized. Children can be diagnosed with Reactive Attachment Disorder---actually parents have reactive attachment disorder.

71% of the clients involve poverty---lack of community and disparagement of poor. Typically, the poor don't know how to access resources or natural supports or connections. Racial minorities, including African Americans face harder issues.

Many people are poor yet raise children safely.

10-20% of seen parents are mentally ill. 70-80% parents have PTSD or depression but don't meet criteria for KMHS

KITSAP COUNTY HEALTH DISTRICT

The mission is to prevent diseases and to protect residents.

Many of health district clients do go to KMHS. Pregnant women or women come in for services. The shared clients get care through KMHS. Mental health access is a community wide issue. Accountable Communities of Health. Kitsap Adverse Childhood Experiences-how childhood trauma affects life. The health district relies on the evaluation published as ACES (Adverse Childhood Experiences---linked adverse child hood experiences with mental illness, physical health, chemical dependency and relational health.)

The strengths of KMHS include empathy. The staff is in touch with what's happening with research. KMHS staff are In touch with the community. They are passionate about their work at KMHS. The interviewee finds them to be very authentic partners and very responsive. KMHS is innovative. They are able to Implement the CMS grant---mental, physical and chemical health.

More attention needs to be given, by KMHS, to the chronically homeless people who are mentally ill. There needs to be expansion into the schools including elementary level. The interviewee wishes they could see non Medicaid people (more of them anyway).

The health district rarely work with individuals. The health district works on a systems level trying to change people's health throughout the county.

The health district interviewee said, "We need housing for chemically dependent people."

BREMERTON SCHOOL DISTRICT

The Bremerton School District's primary purpose is the education of children and all that that entails. There is high poverty. Lots of transients.

The school district has a great relationship with KMHS. The district mainly accesses KMHS through the Madronna Day Treatment program. It was very small—2-3 kids at a time for kids with significant mental health issues. Now BSD elementary (Sequoia) and middle school (Evergreen) day treatment program that replicates Madronna Day Treatment program.. The idea is to move the kids back into the school system in classes attended by the majority of students. The counselors reinforce therapy while working in the schools helping kids with their school work.

The strengths at KMHS, from the Executive Director Joe Rozsak on down is that they are all players to make sure things work. They are very responsive to BSD needs. KMHS needs more people and resources. The interviewee is very pleased with KMHS as "They do wonderful things in the community."

In reflecting on improvements the interviewee said that there are no glaring things. The county-wide 1/10th of 1 percent tax enables one school to share a middle health professional in the two highest poverty schools in Bremerton.

It's getting younger and younger that kids experience trauma.

NAMI FAMILY MEMBERS

There were no representatives from NAMI Kitsap despite formal invitation and attempts to broker members months in advance.

KMHS

ENTRANCE INTERVIEW

The KMHS managers present were asked to identify new services and programs added within the past two years that promote recovery. There have been a number of changes which include: access department personnel services, a new PACT team which will grow from 1 ½ to 12 full time peers and parent partners (parent partners are family members and there is one peer per team). There are two monthly meetings of peer support specialists. To promote recovery KMHS now has collaborative documentation whereby clients participate in document creation or review about their session. This summarizing helps with the treatment plan. There has been training on using more recovery oriented language. Now open access for screening and if accepted the setting of appointments between 9-4 here and the Port Orchard office.

KMHS has adopted trauma informed care within the agency among clinical and non-clinical staff. 7 domains. There is a reduction in restraints being used in the inpatient unit. There is an Intent is to be a tobacco free campus. KMHS is moving toward wellness. KMHS assists people who are not sure about

funding. There is a Race to Health Grant. The focus on whole health including WHAM training. Staff is helping clients with co- morbidity, obesity, tobacco cessation and diabetes. KMHS is working closely with Peninsula Community Health Services. The vitals of shared clients are entered into the KMHS system. The goal is with releases to automatically get PCHS records such as primary care doctor reports. Harrison health care clinics are being helped by a KMHS staff person who helps primary care providers with KMHS and non KMHS clients.

There are now 5 certified instructors in Mental Health First Aid. Now youth too. The instructors go to schools in the community and associations concerned with kids. KMHS has a Veterans Mental Health First Aid too.

KMHS is working on development of a crisis triage center. KMHS is waiting for approval/direction from the county commissioners with a hoped for opening in July 2016. 1-5 It will be a 1-5 day voluntary respite facility. There will be full services, including a peer specialist and nurse provider. Hopefully, the clients will hook up with services and housing rather than escalate to needing higher end services.

KMHS is notified immediately when a client is in the Harrison emergency department. There is a collaborative conference with the hospital about high end users.

A psychiatric ARNP serves as a consultant to primary care providers—about 34%. The ARNP does education with primary care providers.

The agency has a disaster plan which is also part of the community's plan which is led by the health district. KMHS is the lead mental health provider. KMHS is the lead Red Cross agency for the mentally ill in a disaster. KMHS is a designated shelter.

KMHS posted 143 positions last year. New hires include a ARNP and psychiatrist. Phone interviews are being done with prospective ARNPs. KMHS added 60 positions in past year. 20% or so growth. The sought after workforce is not readily available due to demand from other agencies. It is hard to hire those with chemical dependency experience. KMHS has a Training Academy which teaches screening, briefing, intervention, referral and treatment (SBIRT). Primary care providers can get SBIRT.

Lots of turnover in 24 hr service.

ACCESS TEAM

Those who seek services through the Access team must be new or a reactivation if they came back within a year of their last date of services.

As mentioned above KMHS has moved from setting appointments to largely walk-in screening at set hours in Bremerton and Port Orchard.

The team loves the variability, not knowing what any day will bring and having to prioritize. Normally, after screen a first appointment is offered with two weeks unless the individual is in immediate danger to themselves or others or is psychotic.

The team sometimes is frustrated because they have to turn down people for services. KMHS is able to refer people to other agencies or providers that are appropriate for their insurance coverage. Medicare prospective patients are often underserved in Kitsap County.

Only select Medicare are served on a sliding scale if they meet additional criteria. Private insurance company customers are not accepted by the Access Team. Medicaid and Washington Apple Health customers are accepted.

CHILD AND FAMILY OUTPATIENT-COMMUNITY SUPPORT

Without specific numerical itemization new services or approaches added within the past two years that promote recovery include:

Child and Family Race to Health. Added several integration, COD, substance abuse, and trauma services and codes for documentation. Added 2 or 3 positions. Behavioral and health integration is more prevalent. Now when there is a high needs family or child another team member can make a house call. One autistic child poses challenges for ADA documentation and services. One client has reduced his or her ER visits. The challenged for the Integrated philosophy is highlighted by medically complex kids. One family is being medically served by 4-5 clinics.

The team likes the experience of parents seemingly coming alive when their child receives services. There is some medical coordination work by the team and lots of issues with kids struggling with identity. All our kids are fabulous. "I like being a helper." "I like the team we have." "I love working with the acute patients." Some kids come in almost nonverbal and when they leave they are a changed person. They gain an internal understanding of what their issues are. Every step within a family can be an improvement for the other kids. (This team is impressed with Toby Bingham.)

The Child and Family-Support team would like to remove barriers that come with separate funding silos. SAMSA and the Center for Medicaid and Medicare have rules that are at odds with best practices. There needs to be more communication with providers and health care teams. Some parents questioned, Why does KMHS need to know about physical needs? KMHS got push back from integrated approach. At time the interviewees are going to see more people with health care needs in families that lack the skills to deal with children. The kids need education and empowerment. There is a need to try and bring down high caseloads. So many families are fraught with poverty and transportation problems. Some families don't want home visits. This team sometimes sees kids in school. These KMHS find financing the insurance for their cars is difficult.

These two teams are part of the Department of Children and Family Services:

1. Community support team (who we interviewed) which serves 335 kids and family members.
2. In Home Team which serves 225 kids and family members

INDIVIDUALIZED TREATMENT COURT (ITC)

Both the ITC and the Drug Court now serve juveniles.

The interviewees most enjoy being able to bring a lot of creativity. They are able to work with kids who have not had resources or services from the past.

It is felt that the court might need an additional or part-time therapist. They are not able to make many house calls at present. The need is felt to strengthen the team approach.

Attending to juveniles in the drug court is optional for the therapist but mental health therapist mandatory for mental health treatment court. The same therapist serves both through the 1/10th of 1% county wide sales tax.

One child wants exercise and diet and KMHS has a staff person who can help.

Typically this court is diversion from detention but includes sanctions or rewards. The therapist can see them even if detained. Even felony charges can be wiped out with completion of the treatment program.

YOUTH & ADULT INPATIENT UNIT

New approaches in this unit include:

A no smoking policy. No longer have a group weekly.

There is the aforementioned trauma informed care. There is a reduced use of restraints and seclusion throughout the campus. KMHS is using courtyard and patio alternatives. KMHS has been revising admission protocols. Is there a welcoming feeling? How do we engage with you? Private belongings are searched while the client watches. There are potential ways to reduce trauma with the physical search. Furniture has been redone and KMHS is looking at more inviting furniture for the TV room. This unit is making multipurpose rooms. They are creating an environment where people feel safe and wanted. Starting in June, Kitsap Home Health Care will train staff, including supervisors, for some needs of the AIU patients—bathing, clothing, dressing, and special needs of patients using wheel chairs. The intent is always for dignity. Teaching and coaching.

The age criterion for the YIU stretches from 8 years old and up 18. How do help them feel safe and comfortable. Try to address needs with individualize care. Again there is the model of Trauma Informed Care.

The therapists really enjoy that sometimes a former client on the street will say thank you on the street.

One team member said they, "See them at their worst, see them at their best." Staff is thinking of the child's past. They are trying to make an impact on child who would otherwise be in detention. The average stay is 7-10 days, 2 weeks. Occasionally letters or phone calls or providers compliment the YIU.

One staff member would like a separate or larger building to be able to separate the kids into age groups. Sometimes older kids will help the younger kids.

The inpatient unit does a lot of detoxification. The 1/10 of 1% tax will provide a detox unit. They will be able to treat drug and mental illness problems at the same time. There is a need for more housing. Sometimes a client is stabilized as an inpatient but with no place for them to live—no roof or warm meal. Sometimes clients are released to homeless shelter—"don't like that." They need stable sleep patterns.

Sometimes patients are transferred to Western State Hospital then they come back to face jail or the AIU again due to repeated decompensation. It can be a vicious circle. The creation of a Crisis Triage Center will have 16 beds for 1-5 day stays with a subunit detox.

Our PACT teams are reducing the number needing AIU.

SCHOOL BASED PROGRAMS

Our ESD –Olympic Services District is financed by the 1/10th of 1 % county-wide sales tax—in part.

The Evergreen Middle School is for those with a mental illness is housed at Mountain View Middle School. Sequoia Elementary is housed at Crown Hill Elementary School. The counselors or therapists are trying intervention in the traditionally taught students instead of the more restrictive Sequoia. Sequoia is going to cut back from the 16 students this year to 12 next year with more staff out in the traditional schools keeping busy-- identifying behaviors, mindfulness. Individual therapy, group therapy, behavior management, and conversations about mental health. This staff is trying to do more family based work. They have even done intakes at restaurants. They have invited family members to sessions too. Trying to do classroom observation.

The 1/10th sales tax also funds a therapist working within two South Kitsap School District schools.

Altogether the 1/10th sales tax finances 5 full time therapists and one part time for the school children.

The therapists enjoy seeing the children make progress—they even helped one student cease having night terrors. . Another student was able to successfully attend a general education classroom and sit for 3 hours—evidence that his/her program works. These kids have emotional problems. One therapist remarked, “We’re here to change lives and make a difference.” Sometimes the therapist do counseling with school staff, offering support, ideas and encouragement presumably. By treating they kids now School Based Programs may be preventing future suicides.

Those involved with the school based programs would like to see more resources. There is a need for services and materials for parents. There is a need for a drop in center or health center for counseling, classes, groups including one for parents who have children with similar problems. “We need better facilities,” was one remark. Many students are also clients at KMHS. There is poor interaction between school based programs staff and the medical team. It was suggested that a huddle system be developed for regular consultations between and among a child’s principal, medical provider, stakeholders, nurse, and therapist. One child on the morning of this QRT interview had medication problems. The therapist did not know which ARNP to contact.

RESIDENTIAL TREATMENT SERVICES (Keller House)

The biggest change has been peer support. 20 hr a week employee. Keller House is offering more community activities—YMCA, community garden at Blueberry Park, go to other parks and doing groups. Keller House prepares home cooked meals.

KMHS has also bought outdoor games, an Xbox, patio furniture, a barbeque set and items for residents to do artwork.

Most enjoy getting to know clients. Privilege of getting to know them. Neat role. Everyone gets along and respects each other on staff. Most enjoy working with clients. Able to get them to the next step. Last longer staying clean and sober. Cool when they see themselves in a new light. Watching them grow.

Try to be more trauma informed. Lots of training in trauma. Need more housing. So many come in homeless. More job training is necessary so people can feel more productive in their lives. No so

warehoused. Instead of a rigid schedule some clients are asked, "What time do you want to take medications?" Staff helps let past experiences inform what the past has done to their lives or interpretation of present events.

The average stay is 28 days. There are 5 long term beds. Some stay for as little as a weekend while others reside for a couple of months. Some come out of AIU not ready for community living in apartments or houses. Some are from WSH. Stable housing is so important. Residential Treatment Services connects them with other KMHS resources.

Keller House staff never use restraints.

There are 3 prepared meals a day. Snacks include servings of fresh fruit. Vegetables accompany meals.

PACT 2

The second PACT team started in August or September. The goal is recovery. Medication management is done with psycho-education, nurse integrating together each client's medical issues. These issues can include diabetes. Illness and recovery groups. 28 clients are on the caseload. PACT also helps clients with housing and food. They are trying to get up to 50 clients in a gradual process. The clients require a lot attention. CD is common for most of the clients. 10 employees are on the team, including a physician.

We have a diverse group who I enjoy. Enjoy we are so involved in client's life. A lot of clients are seen almost every day. The staff helps clients recognize signs of decompensation. The effort is to reduce usage of the AIU. PACT 2 serves clients 40 years and younger. The average age is 23. At present the oldest is 40 years old. Most have a forensic background (incarcerated) and some have a developmental disorder. The goal to get people out of being in and out of hospitals or the AIU and into the community as law abiding citizens. PACT is a 24/7 service. "We are on call after hours." A few clients are seen twice a day.

The PACT staff wishes for more housing for clients. They are trying to get an evening drop-in center. Some clients interact with the hospital and police because they have nothing else to do in evening. What's needed? Movies, cooking groups, and food skill building in the evening-socializing activities.

PACT desires more funding and less bureaucracy with DSHS and Social Security. Too much red tape. The clients deserve good housing. PACT is working on partnering with Kitsap Transit to get a van. A deal is so close that they are getting people approved for driving the van.

A Management and Recovery Program (UW) program being used.

73-80% of PACT work is in the community and not in KMHS offices. Clients, though, must come to KMHS to see a doctor.

That morning one staff member was working with a woman about weight reduction. They spent time on diet and side effects from the medications. "They always leave with a thank you very much."

Our goal is more self-reliance and not needing complete wrap around. Some PACT clients might be able to go back to AOP.

After 2 years benefit of PACT has been maximized with clients.

ADULT OUTPATIENT (AOP)

Every team has or will soon have a peer specialists. There is an emphasis here too on no smoking, There are medical assistants on all teams familiar with trauma informed care ,and supervisors trained to work with clinician on coping with home and work. Staff activities include Zuma, running and walking, and yoga to keep down the stress level. Now a diversity committee looks at holidays and HR puts out a monthly publication that talks about diversity.

The staff most enjoys coworkers and clients. People kind are kind to each other. 6 teams—1 with 2 people the other 5 teams have 13 full and part time staff each.

AOP staff would like to see community mental health go into section 8 housing, YMCA and other organizations to educate people about mental health. People might seek svcs earlier if people know they had treatable problem. AOP staff would love to see Mental Health First Aid in community not just at Keller House for \$30 each.

These are the groups and activities offered to clients: Pscyo- Education Group, DBT light, Assertive Skills, Mood Enhancement, Fixation, OCD, Self- Esteem, an Anger Management group that is based on materials from SAMSA, yoga, YMCA and a walking group.

Yoga, YMCA and walking group for clients.

The AOP now has 11-12 peer specialists.

OLDER ADULT SERVICES

Among the new activities is a Tai Chi class. The manager of Older Adult Services took on nursing medication management for clients some of whom have diabetes, co morbidity, pain, and are being encouraged to stop smoking and another group to moderate alcohol use. A Healthy Living Group educates about diabetes and health living. The Race to Health Program (grant) help people new to diabetes. Our psychiatrist calls primary care doctors.

All staff members who have master's degrees have been certified by the University of Washington (UW) in geriatrics education.

The manager, the interviewee, likes working with clients individually—brought a lot of joy. She juggles management with nursing. She attends the Long Term Care Alliance—monthly meeting among organizations for networking. She has spoken to Public Guardians about geriatric mental health, Adult Protective Services, Crisis Intervention Team trainings (CIT)—training police officers on depression dementia and delirium. She has spoken to UW and Pacific Lutheran University (PLU) nursing students about geriatric mental health.

The manager reports there is a 30% increase in intakes of people who never received mental health care but there is not enough housing. Serving more because boomers are aging. Too many housing units are not safe, not set up to ADA compliance, and two clients are living in a motel—one in wheel chair. One

motel mgmt. actually widened a door and carpet for wheel chair bound—no nursing home would take her because of mental illness. It is hard to find safe and affordable housing. Some ending up in Harrison for as long as 5 months. Three clients are living in cars. Two just got out of jails one is in Firs. There are bed bugs in some places.

Most of this team is over 60 and planning on retiring in a year or two. Should we not have a geriatrics team? How will be serve?

RECOMMENDATIONS

Have the Access Team take walk-ins as well as appointments.

Topics such as seasonal affective depression, anger management, mood enhancement, Mental Health First Aid, self- esteem should all be taken out into the community.

Enhance the lunches. Lunch was only a sandwich for the clients. They are so impoverished, lunch might be the only time they have for meat and vegetables. One client brought and opened a can of soup and had it warmed.

Open an additional agency on Bainbridge Island that will take Medicaid, Medicare and private insurance.

The therapists and others involved with the school based programs should be part of the KMHS huddles (medical, peer specialist, case manager, therapists). These huddles will be for public school students being served by Child and Family Services.

The Bremerton police officer was concerned that there have been releases from Harrison without the patients having been evaluated by a DMHP.

PACT team would like to see drop-in center for socialization in the evening.

Hoarding, depression and isolation are issues that could be better addressed by the agency and in the community.

Child and Family Services employees would like continued support for bringing down the caseloads.

Bed commitments made to Harrison Medical Center by the AIU and YIU can be more satisfactorily resolved sometimes. Youth Inpatient Unit. Adult Inpatient Unit.

There is a need for a large facility to house inpatients so they can have more activities and privacy.

The Department of Children and Family Services (DCFS) would like to see everyone at the table for permanency trainings and cross trainings among staff at Kitsap Mental Health Services (KMHS) and Child Protective Services (CPS).

FINAL REPORT

QUALITY REVIEW TEAM REVIEW OF JEFFERSON MENTAL HEALTH SERVICES

DECEMBER 3-5, 2014

The Quality Review Team of Kitsap, Jefferson and Clallam Counties met with ancillary providers on December 3 and employees of JMHS on December 4th and 5th. A summary of what the QRT learned is within this report.

JEFFERSON COUNTY PUBLIC HEALTH DEPARTMENT The primary mission of public health is “always working for a safer, healthier community.” With respect to the clients shared with JMHS these services are involved: “Family Planning Clients, CPS involved families, Families with the Nurse Partnership Program, Moms with postpartum depression, People who use the Syringe Exchange Program, School based Clinics—Mental Health, People with disabilities.”

A strength in working with JMHS is that nurses are “working as a team with a Counselor of a shared client.”

Some improvements that JMHS could make with Health Department clients include the need to serve people who don’t qualify even though they might suffer from a mental health condition such as postpartum depression. Postpartum depression screening needs to recognize that “Mom’s feel so guilty, they can’t find the words”

Another recommendation was to rectify bad matches with counselors at JMHS. A “wrong diagnosis at an early age” can follow the mutually shared client. JMHS is working on recruiting more CMHS credentialed clinicians as well as developing current clinicians with the CMHS credential who are interested in pursuing this credential to serve children specifically.

CHILDREN’S ADMINISTRATION/DCFS “The mission of the Children’s Administration (CA) is to protect abused and neglected children, to support families in caring for an parenting their own children safely, and to provide quality care and permanent families for children, in partnership with tribes, foster parents and communities. Child safety is the first and foremost responsibility and is at the core of all goals, objectives and tasks.”

“JMHS provides mental health evaluations, psychotherapy, and medication management for our children and parents. They also coordinate services with Safe Harbor to provide Co-Occurring Disorders Treatment (CODITS) for our parents.”

“JMHS therapists maintain open communication with CA social workers. They provide timely updates on child/parent attendance, engagement, and progress. They provide written reports and testimony in court. JMHS therapists arrange planning meetings at their facility or attend a CA shared planning meetings when requested. They work well with both parents and caregivers to address the needs of children. JMHS therapist’s professional insights and opinions are appreciated.”

JMHS needs a full time psychiatrist for the treatment of children

PORT TOWNSEND SCHOOL DISTRICT, SPECIAL PROGRAMS

The primary mission of the school district is to provide equal access to education. A goal is to create a functional student in preparation for college or employment. Special help in speech, language and occupational therapies are included.

JMHS provides day treatment which includes emotional, behavioral and academic assistance or instruction. Those students experiencing duress are helped. JMHS has the strengths of meeting student needs by being supportive when addressing emotional needs. JMHS is great at communicating with the school district.

An improvement JMHS could implement is ongoing meetings with the school district. The interviewee has met with the new JMHS executive director. He is thinking of a plan to work with JMHS to keep students in the public high school.

SHERIFF'S DEPARTMENT (Patrol and Jail)

The purpose of the sheriff's department is to protect and serve and with the new sheriff will include more community policing over a wider geographic area than was previously emphasized.

JMHS responds to calls. A DMHP responds to a crisis call from the jail or hospital within 2-4 hours. A strength of JMHS is their familiarity with the population the sheriff's office encounters.

An improvement for JMHS to consider is a quicker response with individuals who may be subject to being involuntarily treated. Some are detained in the local hospital for too long.

Normally, those jailed can get meds on the same day as detention or within 12 hours. Inmates being released from custody, who have a mental health condition, are driven to the door of KMHS. Currently out of the 50 prisoners, about 30 are mentally ill.

Western State Hospital returns clients, the ones who are going to be prosecuted, to the jail without medications. WSH provides a medication list. This WSH action strains the budget of the sheriff's department.

OLYCAP

Staff shared that they partner with JMHS to lead and engage the community to promote self reliance on behalf of those they serve mutually while embracing innovation and collaboration with the determination and commitment to build a healthier community. Identifying JMHS staff as being very dedicated to their clients, staff commended JMHS for consistently being good advocates. Continued partnership is key and it was requested that both agencies continue to communicate and broker together to fully support shared clients.

JEFFERSON MENTAL HEALTH SERVICES—December 4-5, 2014

Among the new services provided by JMHS is the inauguration of Frontier House which is the former Discovery School. This school currently serves seven students and can serve up to nine with severe emotional and behavioral needs. JMHS has clinicians, on a part-time basis, in all the schools.

Other new features a JMHS include 2 apartments at Port Hadlock which house three clients each without charge to the clients. The county mental health court is also a new resource.

With respect to a disaster plan JMHS must cover vulnerable people. In the event of a disaster JMHS will have staff at the emergency room and clinics. The hospital is within walking distance of JMHS.

Various members of the JMHS administration spoke to what they most enjoy about their work. The aspects most enjoyed are: crisis intervention, giving direct advice, instant gratification and the opportunities afforded by the Affordable Care Act (ACA) and state changes such as the integrating of physical, substance abuse and mental health care (a primary target).

It was remarked that these are some generalized Jefferson county needs: residential, crisis and building a skill center .

JMHS has the goal of addressing the question “How can we make JMHS better?” There is a desire to get away from silos and enact greater efficiency with EHR documentation which it is felt distracts from active treatment.

JMHS CRISIS SERVICES

The representatives from crisis service enjoy both the people they work with and the clients. They enjoy resolving problems especially when seeing successes. “Being able to serve,” is an expressed source of pride.

In terms of needed changes, housing is a huge need for the Medicaid population suffering from mental health conditions. 90% of JMHS clients are low income so they are in need of transitional or permanent housing. Many of the homeless don't have social supports such as friends. They depend on food stamps. Their fixed budget needs are high given their low income. People are going to the hospital to meet needs that can, if there were resources such as adequate housing, be met in other ways.

When involuntarily committed some clients are transported, with the administration of psychotropic medication, to as far as Yakima (a destination for three in the last six months). Although the agency as a great relationship with KMHS sometimes clients are in the local hospital for 12-14 hours.

There is a desperate need for payee services.

JMHS places all case managers as within crisis/access services.

The crisis team employs their time meeting these services: case management, answering phones (crisis line), Harbor House, CODIT, mental health, jail, referrals, connecting with doctors by making appointments, hospital daily follow-up and referrals to Olycap.

JMHS HARBOR HOUSE

Over an excellent tasty lunch the QRT met with clients. The poverty of the clients impacted the team (one has no plumbing). In talking with a client he remarked that “they really care about us.” Hopefully, one client’s rendition of a rumor will prove true—the addition of a new shower area at Harbor House. Harbor House serves breakfast and lunch, five days a week. The cook frequently brings clothing for the clients from the Seventh Day Adventist church. She also tries to send the clients home with food for the evening.

JMHS CO-OCCURRING SERVICES

A new service of JMHS is CODIT—co-occurring disorder treatment. JMHS is partnering well with Safe Harbor in meeting the needs of chemically dependent clients. Cognitive Behavioral Therapy (CBT) is a favored evidence based practice to help clients “find their gifts and inner strengths.” Positive thoughts can change behavior. A therapeutic goal is to change negative to positive behavior.

JMHS employees enjoy working with the clients, including one-on-one time that may include walks, going to the park or social security. Whatever the needs are. There are also groups that work as a cohesive team, one employee remarking that it is nice to have a forum—a WRAP group.

At JMHS about “60%” of the clients experience mental illness and substance abuse at the same time.

What employees find is that there is not enough staff to meet the community mental health needs. It was remarked that “clients don’t get quality—there are not enough of us.”

JMHS ADULT OUTPATIENT SERVICES

The new service or approaches cited were CODIT and the access crisis team. One employee has a caseload of 80 clients. The Veterans are typically 100% disabled.

Members of this department love their co-workers, like diversity of life circumstances among clients and the range of ages, and service to the community. They engage in case management with medical providers (prescribers). Some clients come from traumatic backgrounds.

There is a desire for more groups (DBT, motivational interviewing, problem solving—solution focused, and a men’s group).

There was regret that so many employees have left during the past few years.

The homeless are only able to secure shelter at night from Thanksgiving to about March 1. (Some of the local churches sponsor the shelters on a alternating one week basis. The sheriff's office will on occasion open the lobby of the jail for overnight stays.)

It can take two weeks for an intake, first visit, to occur. At the time of the interview, early December, appointments with prescribers were "out to the end of January." JMHS administration efforts were being made to ensure intakes were meeting compliance for turn-around time as well as onboarding a new full-time Psychiatric ARNP as of December 15, 2014 and increasing other ARNPs prescribing time to assist with clients obtaining medication management services in a more timely manner.

JMHS CHILDRENS OUTPATIENT SERVICES

All patients get therapy with some also getting medication management at JMHS. (The aforementioned Frontier House school has one teacher and four case managers to educate the current seven students who are between the ages of 8-18.)

One employee in this service uses the book titled " Teaching Responsible Behavior." This resource is for DTORF-R which are therapeutic techniques to enable learning—developmental teaching and therapy.

What is most enjoyed is: the team approach, that no two days are the same, and building relationships. The desire is to create predictability and safety in the lives of the children. The younger a mentally ill client gets treatment, the better they will do.

Improvements desired include more money for prevention and increased staff of clinicians in the schools. This unit laments that kinship care of children is sometimes "really tough " and that lots of the children are not only living poverty, but are drug exposed (some in the womb--prenatally).

JMHS MEDICAL SERVICES

A new service or approach is that Harbor House has improved day treatment for adults. Between 8am-12pm there are discussion groups. There were groups in the past, but now there is an additional groups leader who is a case manager. (Clients are also coached on preparing well cooked meals). Peer counselor services are involved. There are now five prescribers available, but not exclusively, for the Medicaid population. There can be a two month wait to see a prescriber. JMHS is actively recruiting Psychiatric ARNP prescribers to meet the shortage of prescribers due to Medicaid expansion under the ACA.

This section enjoys working with the clients by helping them so they feel better when they leave a session.

The comment was made, "It would be so nice to get medications without prior authorizations. We want what works." It can take three hours to get prior authorizations which is a waste of time and money. It was also noted that Apple Health can be difficult to work with.

It was remarked to the QRT that “The medical team does not have direction or support.” For recently released patients, from residential treatment, including hospitals, they are given two appointments per month. The Executive Director appointed an Interim Medical Support Supervisor to assist with medication monitoring and provide leadership to that team. The Executive Director is working closely with JHC to provide a possibly joint MD Psychiatrist in providing leadership and better care coordination for the Jefferson county area population.

I was also remarked that individuals ought to hve a prescriber appointment within two weeks of intake. Many prospective clients are referred to primary care providers or family doctors. (The QRT does not know the frequency of these referrals for the Medicaid clients applying for services.)

This section looks forward to the integrated care model offering primary care to Harbor House clients.

RECOMMENDATIONS

1. There is a need for a crisis stabilization center where clients can be treated and housed overnight.
2. There is a need for more transitional or permanent housing units for the Medicaid clients of JMHS.
3. There is a need to shorten the time between being initially being committed and actually placed in a treatment bed in a residential mental health unit.
4. There was a stated need to establish more groups beyond what is currently provided. JMHS is working to reinstate DBT group work in February 2015 for clients with a clinician.
5. Explore and secure adequate payee services for clients.

WEST END OUTREACH SERVICES

QRT Biennial Review

August 4th-6th, 2014

BACKGROUND INFORMATION

The Quality Review Team conducted its biennial qualitative review of West End Outreach Services from August 4th through August 6th, 2014 in Forks, WA. The purpose of the review was to assess the quality of services that have been performed over the past two years and four months.

Both an Ombudsperson and a PRSN representative accompanied the four person team. An organizational chart provided information on WEOS personnel changes since the last review.

Review of Exhibit N report and MSHIP satisfaction indexes in conjunction with 2012 QRT report assisted team with preparing for both ancillary and on site interviews.

Ancillary Providers

Ancillary provider interviews were held at the DNR's Crescent Room on August 4th including the Area Administration on Aging, Forks Police Department, Department of Children and Family Services, and Forks General Hospital. Additional interviews with the Quillayute Valley School District, Clallam County Sherriff's Office and the Clallam County Housing Authority were conducted at a later time via teleconferencing.

Site Visits

The West End Outreach Service onsite interviews were held on August 5th and August 6th in a conference room at WEOS. The QRT met with WEOS management and other staff during the Entrance Interview.

Departments and groups interviewed included Crisis and Emergency Services; Adult Day Treatment and Employment Services; Child and Family Services; Native American and Hispanic Services; Co-Occurring Disorders Program; Medical Services; PATH (Program for Assertive Transition from Homelessness) and Housing services.

Hope Center Visit

The QRT enjoyed a delicious lunch of roast beef, stuffing, gravy, two different macaroni salads, and watermelon at the Hope Center where there was an opportunity to meet with staff and clients to gain first hand perspective on services and satisfaction.

ANCILLARY PROVIDERS—FINDINGS

Area Administration on Aging

The representative informed the team about efforts to serve geriatric population of Clallam County with primary mission is to keep folks out of institutions. The catchment area includes Neah Bay, Queets, La Push, Forks and also some clients in Port Angeles. Of the sixty to seventy client caseload, ten or twelve are seen by WEOS. At the present time, her clients have sixty miles allotted per month for transportation by caregivers for shopping, medical appointments, support groups, hairdressers, etc. (this might soon increase to 90 miles.)

Therefore, she thinks it would be an improvement to have WEOS provide more services in the homes of her clients.

Since the changes at WEOS, she knows of (only) three or four employees. She believes there is “no communication” where as before she walked and discussed her clients with former WEOS employees. In the past, there was a support group lunch held which was organized by WEOS employees.

Quillayute Valley School District

Clallam County Housing District

Department of Children and Family Services

The primary mission of DCFS is to protect children from abuse and neglect. WEOS does counseling and outpatient work for some of the DCFS clients. He told us: “If something is going on, she (his lead Forks DCFS person) will tell me immediately.” Since his last visit to Forks two years ago the “dialogue” has improved. There is a “different sort of relationship than we’ve ever had before” and he “wouldn’t change a thing.”

If someone sees signs of abuse or neglect with children, they are obliged or referred to call “intake workers” who are all over the state. Every couple of hours, staff (in Forks case, Port Angeles) is monitoring the electronic folders set up by the caller. The law requires them to send a DCFS representative with or without a police officer to the home within 24 hours for an emergency or 72 hours in a non-emergency.

Beginning this October 1st, “Family and Assessment Response” (FAR) will put evidence-based contracts into place. Throughout WA, two-thirds of new referrals--because of mental health problems and drug and alcohol neglect--will be placed in “intensive family

preservation services.” FAR, hopefully, will reduce the number of children removed from their families: “We don’t do a good job in raising kids in the foster care system.”

Forks Police Department

The mission is to provide peacekeeping in Forks. WEOS provides counseling for drug addiction. With the Involuntary Treatment Act, the police take people to the emergency room where they are seen by a WEOS Designated Mental Health Provider (DMHP.)

Strengths of the WEOS staff are that they are “extremely familiar with their clients; they know patient whereabouts; are extremely educated, follow protocols and go through hoops.” This officer sees dual disorders and believes that Forks is “running short of places to go to get clean and sober.” The officer believes after that the underlying issue of mental health can be taken care of. Our interviewee is aware of Narcotics Anonymous and the IOP—Intensive Outpatient Program. He told the QRT that Meth use has decreased, but there has been a large increase in heroin use.

The officer has a tight relationship with two of the Outreach Staff—referring to one as the “absolute best.” One officer is on duty all the time. There are five officers, a Sergeant, and a Chief. One of the five officers is female and she is a “child forensic interviewer.”

Forks Hospital

The mission of the Forks Hospital is to take care of patients. WEOS provides mental health and chemical dependency counseling. Their team handles voluntary and involuntary commitments. “Two years ago there were issues; now there is more collaboration.” There is “more emphasis on what is right for the patient.”

Since the hospital sometimes holds patients for up to five or six days there is a need for an ITA Court in Forks so that these people don't have to travel to Port Angeles for the Superior Court to decide if they can be released or need to be detained further. Also, more money is needed so DMHPS don't have to be on call for such lengthy periods of time.

WEST END OUTREACH SERVICES--FINDINGS

Entrance Interview

The first new service or program that was mentioned was the hiring of a Peer Support Specialist who spent the morning at the QRT interviews. At Hope Center many changes have occurred: training clients to help them pass the Food Handlers Licenses, WRAP groups (Wellness Recovery Action Plan), cooking classes, a Wednesday trip, and every week a client-driven focus support group to determine client needs and desires.

The agency has experienced "substantial" staffing changes; attached to this report is the new organizational chart. As of next week WEOS will be short one therapist, but the level of case managers is "o.k." "We are operating lean and mean."

"There has been a broad dispensation of housing knowledge to case managers. Also, specializations of helping clients apply for Social Security and Unemployment Benefits have been established. One therapist has been trained to help clients with anxiety and depression.

The QRT learned of the recent Hospital District-Wide Disaster Drill in which the Hope Center was opened up to give information and provide services. There is a hospital pharmacy and case managers routinely take medications to some of their clients.

Crisis and Emergency Services

“We have a good crisis team.” There are three DMHPS now, and one more certification coming in November. “Advance Directives, Crisis Plans and Least Restrictive Alternatives are in place to solve recovery.” “Forks has all the pieces right here.” “Having an R.N. at WEOS is critical for relapse prevention.” The Co-Director of WEOS engages with the PCP, Case Workers, Social Workers, Emergency Room Nurses, and the Police concerning mental health. The QRT was told that the Director handles more of the Co-Occurring Cases. There are “professionals out at La Push.”

The Co-Director is waiting to hear how the WA State Supreme Court rules on “psychiatric boarding.” He thinks there is a need to detain ITA people in the Emergency Room for up to seventy-two hours or until a bed is open at “Kitsap, Skagit, Yakima, or Fairfax.” The fact that the ITA Court is in Port Angeles presents a “huge task” of transport, and he has lobbied for that responsibility to be delegated to District Court. At the present time, the Superior Court issues an LRA option.

“Positive satisfaction, collaboration, and getting into ‘center balance’ were why interviewees enjoy their work. There is a need for a supervised setting before returning home. Continued re-making of state laws makes it “frustrating to manage it all.” There is a need in the community for greater awareness of mental illness. However, with each rephrasing of symptoms on the phone, the descriptive language of each caller improves.

Adult and Outpatient Services/Employment

Forty-five clients are assigned to the Hope Center where there are three case workers. From fifteen to twenty clients show up for the Thursday required meeting and lunch. Four-ten hour days allow for coordination of care “morning huddle” one hour meetings at 8:00a.m. Therapists sometimes assign clients to case worker “specialists: DVR, sexual abuse, and DSHS. There are four “Protective Payee” clients. Case managers as well as the Co-Director and CDP go to

Primary Physicians to report that a drug isn't working. Currently the DVR has assigned employment services to "Concerned Citizens," a local non-profit agency.

Relations between the courts and WEOS have improved and the district court hears their cases first. A priority is: "working to become a fully co-occurring program" where mental health issues are treated along side chemical dependency problems.

"Positive Parenting Program" was cited as a new service for clients with children ages two through eighteen. "PFR" is for newborns through age three. WA has new "Family Funds" which provide housing for families. The WEOS contracted six months ago with the Kitsap Mental Health Service for use of their twenty-four hour crisis line; interpreters are available here through the "excellent" Peninsula Language Line. Posters around Forks advertise this service.

From this team, the QRT heard: "Seeing progress, shifts in perspective, and decrease in conflict"; "engaging clients, getting out of hopelessness, someone is listening with no judgment"; "awesome—sense of community"; "I just feel real good about it...the client shows up and the human interaction is so powerful;" "I feel connected to clients and where they want to go"; "there is a consciousness of wrapping around the family to give them what they need"; also, these therapists and case workers enjoy "being around a team of professionals."

"The building blocks are there." However, apparently, because of lack of funding, it has been two years since the WEOS sent a therapist to the schools, where the "students might find more formalized WRAP programs useful." There is a need to "teach the community that no one is immune" from mental health or chemical dependency. Also, "educating the community about teen suicide, which starts at a young age, is important." The interviewees told the QRT that improvements are needed when the "kids get mandated by the courts." It "wears on self-esteem" and they develop a fear of getting off of probation. The Behavioral Health Team (?) help "at risk" youth regarding truancy and breaking the law.

Minority Services (Hispanic and Native American)

Two case workers were interviewed each specializing in a particular culture. They go out to weekly luncheons and other gatherings of tribes and families and informally speak about parenting issues. Spanish bingo is enjoyed at the Hope Center.

For WEOS clients, including couples, there are groups on mental health and chemical dependency. There is a strong ethic that alcohol should not be drunk around children.

Their empathic listening includes “how would the client like to be helped.” “I am in awe at the clients’ strengths.” We were told that more outreach is needed—the agency could send a therapist to the Hoh.

Co-occurring Disorders Program

The QRT were told by the interviewees that clients were not classified as “addicts”, but as “co-occurring.” Mental health and drug issues are worked on at the same time.

“Smoking joints, heroin, and other (narcotic) drugs affect mental health medications.”

Also, on occasion, clients were dismissed from drug rehabilitation programs because of disruptive behaviors. “For years there was a battle between mental health and chemical dependency.” COD treatment services receive referrals from mental health. DSHS and the Department of Transportation currently help with alcohol and drug testing.

Syboxone is a drug which eliminates heroin urge. The doctors here don’t prescribe it because they have to be certified and no one is.

Medical Services

The nurse who is the Co-Director of the WEOS told the QRT that there is “always a shortage of physicians” here. For six months the agency has not had “Tele-psych” where

the clients see and speak with the psychiatrist over a camera/television system. WEOS has 258 clients; of these 110 to 125 are Medicaid patients who need prescriptions. When the Tele-psych system started up recently with a psychiatric ARNP from the Port Angeles Behavioral Health System, there were 50 patients who needed her help. The Co-Director met with each client before their interviews for one hour to help in filling out a three page form. Now, the ARNP sees a new patient for 90 minutes and an established client for 30 minutes. She sees patients once a week from 9:00a.m. to noon and from 1:30 to 4:30.

There are three services generally needed here: when medications are lost; when side effects are deleterious; and when prescriptions are needed. The staff nurse has over 30 years of psychiatric experience and places "faith and trust" in the client. He believes that often patients know which drugs they have tried and have been successful with. Once a week encrypted e-mails pass among himself, the PBHS psychiatrist and the Tele-psych ARNP.

There is a need for better long-range planning at the hospital. The Co-Director recognizes that the WEOS is a financial drain, and suggests that "perhaps a separate accounting system" be set up. Twenty per cent of WEOS clients are privately paying. If staff keeps with the four/ten hour days, there might be a need for two extra Fridays off each month.

Path Program and Housing Services

Two highly enthusiastic housing representatives spoke with the QRT. They told us that their six month waiting list was "amazing." They do intake information, crisis contact in English and Spanish, and provide information to veterans. "We are always working on employment. The caseload is sixty to seventy and there are two or three more every week; we hear from our clients once a week." "Housing is done well with grants; we are an asset to WEOS." There are two emergency shelters donated by the Peninsula Housing Authority—two trailers. Both are fully furnished and are available to a family and a

single occupancy for up to ninety days. Both representatives believe that “housing is not contingent on good behavior.”

There are “quick results” in housing and a home leads to “minimizing alcohol.” They would like to see a change in the community perception of low income housing. Also, they believe that there are “never enough” vouchers. More affordable housing is needed in Forks—especially for someone single, with mental health issues, and a criminal background. The Forks City Planner and Mayor have suggested senior housing as a potential project.

RECOMMENDATIONS

- Improve Communication with the Area Administration on Aging—explore potential of re-establishing cross system luncheon or regular opportunity for agencies to consult.
- Provide a Mental Health First Aid program for the Forks community. This would involve hiring a trainer from Port Angeles, extending invitations to certain members of the community and/or publicizing the program to everyone.
- Encourage the “Housing Department” to continue with their fine work—whether it be additional housing for the mentally ill, more vouchers, or a senior housing project.
- Although WEOS Co-Director is working to find a medical person to replace himself, the importance of this cannot be over-emphasized--ideally, a primary prescriber who wants to live and work here, shared between the hospital and clinic.

PRSN Review Tool: Intake

Review Period	
PRSN Reviewer	
Provider	
Client ID	

Intake Report

	Score	Possible Points	Percentage	Comments
The intake includes the presenting problems as described by the individual and others providing support to the individual, with consent if age 13 or older (under age 12 with agency discretion).		0		
There is sufficient information to demonstrate medical necessity.		0		
The intake includes sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM) criteria.		0		
The intake includes a recommendation of a course of treatment.		0		
The intake includes input from people who provide active support to the individual, if the individual so requests, or if the individual is under thirteen years of age.		0		
The intake is culturally and age relevant.		0		
Children only: The intake contains a developmental history.		0		
The intake includes the current physical health status, including any medications the individual is taking.		0		
If the individual does not have a PCP, they are referred to one. If there is a PCP, the name is documented.		0		
The intake documents history of substance abuse (including tobacco) or problem gambling and treatment.		0		
The intake documents any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition.		0		
The intake indicates whether they are under the supervision of the department of corrections.		0		
There is an identification of risk of harm to self and others, including suicide/homicide and referral to crisis services if appropriate.		0		

Treatment Plan Report/DLA-20 Report

The plan was initiated with at least one goal identified by the individual, or their parent or other legal representative if applicable, at the first session following the intake evaluation.		0		First goal may be in prog note instead.
The full plan must be developed within thirty days from the first session following the intake evaluation.		0		

Progress Notes Report

Date of Request for Services				
Date of Intake				
Days Between Request and Intake	0			
Date of First Routine service				
Days Between Request and First Routine Service	0			
Enter 1 if the service occurred within 28 days, 0 otherwise				
If routine service did not occur within 28 days there is adequate documentation explaining why (zero, 2, or n/a)		0		
If the client did not receive a first routine appointment within 28 days, engagement efforts were adequate and appropriate to the Consumer		0		

PRAT Report

If the current PRAT is an initial one completed upon client enrollment, rate this item. Assigned Level is appropriate for client's diagnosis, GAF/CGAS score, symptomatology, and service needs and adheres to the guidelines in the current PRSN's Levels of Care.		0		
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EPSDT (Complete this section if client is under age 21)

Evidence that facilitation of EPSDT services occurred for all children (0-21) adhering to the periodicity schedule, while brokering with multiple system providers to meet the identified needs of the child/family.		0		
Documentation exists that demonstrates communication with referral source (EPSDT medical provider), specifically written notice provided that includes at minimum: date of intake, diagnosis and level of care assignment.		0		
Written notification to child's medical provider (for children referred without EPSDT) requesting that documentation be provided that a Healthy Child screening has been completed or that one will occur. NA if client does not have a PCP.		0		
If no medical care provider is identified by enrollee, then a copy of EPSDT rights contained in the MHD benefits booklet is provided as well as assistance with selection/accessing of medical provider. NA if client has PCP.		0		
Develop an Individual Service Team (IST) including identified formal systems and natural supports for children authorized for Level II services and involved in two or more service systems (cross-system involved.)		0		
There is a cross-system Individual Service Plan (ISP) which addresses overall needs of both the child and family across life domains for cross-system Level II clients.		0		

Community Support (LRA) Scores (Only Consumers on LRAs)

Either the individual service plan or a separate plan specifically addresses the conditions of the LRA order and plan for transition to voluntary treatment.		0		
Consumer has signed LRA rights.		0		
If the consumer is on a 90-day or a 180-day LRA, the consumer has been evaluated monthly by an MHP with regard to release from or continuation of an involuntary treatment order.		0		
If the consumer is on an LRA they receive receives psychiatric medication services at least once every seven days for the first 14 days following discharge from the inpatient facility, unless the attending physician determines another schedule is more appropriate and documents this in the record and at least once every 30 days after that (unless otherwise changed by the prescriber).		0		

Other Comments:

Add additional comments here:

PRSN Review Tool: Reauth

Review Period	
PRSN Reviewer	
Provider	
Client ID	

Treatment Plan Report/DLA-20 Report (Review after reading intake)

Treatment plan goals based on the intake assessment and diagnosis (or based on an updated assessment of consumer).		0		N/A if no treatment plan
The treatment plan was reviewed every 180 days.		0		N/A if no treatment plan
The 180 day review includes a narrative justification for continued treatment at the level of care requested.		0		N/A if no treatment plan
Demonstrates the individual's participation in the development of the individual service plan using quotes from the individual. 0 = No evidence, 1 = Quotes in review only, 2 = Quotes in treatment plan problem statement or goal.		0		N/A if no treatment plan
Includes treatment goals that are measurable.		0		N/A if no treatment plan
Identifies medically necessary interventions, mutually agreed upon by the individual and provider, for this treatment episode.		0		N/A if no treatment plan
The person has a crisis plan (2 if yes, 0 if person meets PRSN criteria for crisis plan requirements but does not have one. Otherwise, N/A if not required)		0		Adult: Any of these in last 2 years: Inpatient stay, suicide attempt, violent act; Or, ITA eval in last 6 months; Or, current S/I or H/I; Or in residential services; Or assigned clinician/assessor believed it is necessary. Child: Same as above or child's living situation is at risk.
N/A if not present. If present, does the crisis plan describe interventions that include resources of 1) the individual (such as coping skills), 2) natural supports (i.e. friends family, neighbors), and 3) institutional/systems (i.e. calling crisis clinic) as appropriate?		0		
Coordination for those with complex medical needs is tracked through the treatment plan and progress notes.		0		N/A if no treatment plan (no longer a 1x year requirement for all consumers. Instead focuses on those with complex medical needs).

Progress Notes Report

If a service occurs, the service is an intervention on the treatment plan.		0		
Notes identify treatment goal being addressed, and this goal is reflective of treatment plan.		0		
The notes document the consumer's response to treatment and their progress toward the goals on the treatment plan.		0		
The consumer is receiving other services listed in WAC 388-877A-0100 (2) and is therefore not "meds only".		0		MEDICAL SERVICES
The individual or if applicable, their parent/guardian provided informed consent for new medications.		0		MEDICAL SERVICES
The clinical/medical record contains both the name and purpose of the medication prescribed, and clinical support for any change in medication and/or dosage.		0		MEDICAL SERVICES
The medical provider assessed the individual for side effects of prescribed medications and interactions between medications.		0		MEDICAL SERVICES
The medications prescribed have been reviewed by the prescriber at least every 3 months.		0		MEDICAL SERVICES

PRAT Report

If the current PRAT is for a continuing/renewed benefit, rate this item. Assigned level is appropriate for client's diagnosis, GAF/CGAS score, symptomatology, and service. Criteria used to determine re-authorization of an existing benefit adheres to guidelines in current PRSN Levels of Care. Continuation of service at assigned level is justified by documentation in chart of the client's clinical presentation as described in the treatment notes.

0

The frequency of service and type of service utilized is the best fit for this client, given the documented description of their clinical presentation in the treatment notes, and in the intake if it was completed within the previous year.

0

Note: Can be used to indicate under/over utilization, even when the PRAT is adequate.

EPSDT (Complete this section if client is under age 21)

Evidence that facilitation of EPSDT services occurred for all children (0-21) adhering to the periodicity schedule, while brokering with multiple system providers to meet the identified needs of the child/family.

0

Documentation exists that demonstrates communication with referral source (EPSDT medical provider), specifically written notice provided that includes at minimum: date of intake, diagnosis and level of care assignment.

0

Written notification to child's medical provider (for children referred without EPSDT) requesting that documentation be provided that a Healthy Child screening has been completed or that one will occur. NA if client does not have a PCP.

0

If no medical care provider is identified by enrollee, then a copy of EPSDT rights contained in the MHD benefits booklet is provided as well as assistance with selection/accessing of medical provider. NA if client has PCP.

0

Develop an Individual Service Team (IST) including identified formal systems and natural supports for children authorized for Level II services and involved in two or more service systems (cross-system involved.)

0

There is a cross-system Individual Service Plan (ISP) which addresses overall needs of both the child and family across life domains for cross-system Level II clients.

0

Community Support (LRA) Scores (Only Consumers on LRAs)

Either the individual service plan or a separate plan specifically addresses the conditions of the LRA order and plan for transition to voluntary treatment.

0

Consumer has signed LRA rights.

0

If the consumer is on a 90-day or a 180-day LRA, the consumer has been evaluated monthly by an MHP with regard to release from or continuation of an involuntary treatment order.

0

If the consumer is on an LRA they receive receives psychiatric medication services at least once every seven days for the first 14 days following discharge from the inpatient facility, unless the attending physician determines another schedule is more appropriate and documents this in the record and at least once every 30 days after that (unless otherwise changed by the prescriber).

0

Other Comments:

Add additional comments here:

PRSN Review Tool: Crisis Services

Review Period	
PRSN Reviewer	
Provider	
Client ID	
Date of Service	

Documentation for Phone Call Only Crisis Contacts

Documentation includes source of referral/identity of caller.		0		
Documentation includes nature of the crisis.		0		
Documentation includes whether the individual has a crisis plan.		0		
Documentation includes the outcome including, basis for decision to not respond in person, follow-up contacts made, referrals made.		0		

Clinical Record (All Face to Face Reviews)

If the consumer has an Advance Directive, it is followed as nearly as possible considering the circumstances.		0		
Did follow-up services recommended by the crisis worker/DMHP occur as evidenced by documentation?		0		
The outcome of the intervention/crisis response is clearly documented.		0		
Evidence of collaboration with consumer and others identified by the consumer as needed.		0		
Is there appropriate referral/coordination with other systems/settings?		0		
There is a written plan delineating how to resolve the crisis if the client was not hospitalized. N/A if person was hospitalized.		0		
Were safety needs and risk factors adequately addressed?		0		
Were services provided in the least restrictive setting?		0		
Children only: If NOT detained: o Documentation that a minor's parent (if child age 13-17) was informed of the right to request a court review of the decision not to detain.		0		

Inpatient Justification and Follow-up (Inpatient Reviews Only)

Was the person detained or hospitalized voluntarily, or was an LRA revoked?				
If the person was willing to go to the hospital, but was detained, there is adequate justification for not allowing him/her to go voluntarily?		0		
Is the presence of a mental disorder adequately justified?		0		
Is the cause for detention/hospitalization adequately identified?		0		
Less restrictive alternatives were adequately investigated and documented.		0		
Contact with the liaison or hospital treatment team occurs within three working days of an enrolled consumer's admission to the hospital. Contact must include a provisional placement plan for the enrollee to return to the community that can be implemented when the enrollee is determined to be ready for discharge.		0		
If a request for inpatient services has been denied by the PRSNs ASO (CommCare,) the denial is reviewed by a physician within 3 working days.		0		

Additional Questions (High Utilizer Reviews Only)

Were services between hospitalizations adequate to the person's needs?		0		
Did the person have a follow-up medication management appointment?		0		
The person has a crisis plan (2 if yes, 0 if person meets PRSN criteria for crisis plan requirements but does not have one. Otherwise, N/A)		0		Adult: Any of these in last 2 years: Inpatient stay, suicide attempt, violent act; Or, ITA eval in last 6 months; Or, current S/I or H/I; Or in residential services; Or assigned clinician/assessor believed it is necessary. Child: Same as above or child's living situation is at risk.
N/A if not present. If present, does the crisis plan describe interventions that include resources of 1) the individual (such as coping skills), 2) natural supports (i.e. friends family, neighbors), and 3) institutional/systems (i.e. calling crisis clinic) as appropriate?		0		
If the client has a crisis plan, is there evidence it was utilized?		0		
Is discharge prolonged due to difficulty securing appropriate placement? (for example specialized care: Geriatric, DD, Foster Care)		0		
Have intensive community based treatment modalities been fully exhausted?(i.e. wraparound, PACT)		0		

Peninsula RSN E&T Chart Review: 2014-15

Date of Review				
Adult or Child				
Reviewed by				
Client ID				
Admit Date				
	Actual Score	Possible Score	Percentage	Comments
E&T Admission and Intake				
The consumer received a medical evaluation within 24 hours of admit (licensed physician, ARNP, PA-C). WAC 388-865-0541 (2)				
There is a psychosocial evaluation by a MHP WAC 388-865-0541 (2)				
There is an initial treatment plan WAC 388-865-0541 (2)				
There is an admission diagnosis and information that the diagnosis was based upon. WAC 388-865-0541 (2)				
Adult Seclusion and Restraint (complete only if there was an episode of seclusion or restraint)				
Authorization from a physician was obtained within 1 hour of initiating seclusion or restraint. WAC 388-865-0545 (1)				
The consumer was 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. WAC 388-865-0545 (2)				
There is documentation of staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record. WAC 388-865-0545 (3)				
If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician assessed 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. WAC 388-865-0545 (4)				
All assessments and justification for the use of seclusion or restraint are documented in the consumer's medical record. WAC 388-865-0545 (5)				

Children: Seclusion and Restraint (complete only if there was an episode of seclusion or restraint)				
Authorization from a physician was obtained within 1 hour of initiating seclusion or restraint. WAC 388-865-0546 (1)				
The child was not restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. The child was directly observed every fifteen minutes and the observation recorded in the consumer's clinical record. WAC 388-865-0546 (2)				
If the restraint or seclusion exceeded twenty-four hours, the consumer was examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours was recorded in the consumer's clinical record over the signature of the authorizing physician. This procedure must be repeated for each subsequent twenty-four hour period of restraint or seclusion. WAC 388-865-0546 (3)				
E&T Documentation and Treatment Planning				
There is evidence the plan was developed collaboratively with the consumer (consider if client is voluntary/involuntary). 388-865-0547 (2)				
There is a discharge plan including plan for follow-up where appropriate. 388-865-0547 (4)				
There is documentation of the course of treatment. 388-865-0547 (5)				
Involuntary Consumers: There is documentation of daily contact with a MHP for the purpose of observation, evaluation, release from involuntary commitment to accept voluntary treatment, and discharge from the facility to accept voluntary treatment upon referral. 388-865-0547 (6)				

Consumer Rights and Medication Rights				
Med Rights: (a) The prescriber attempted to obtain informed consent for medications. 388-865-0570 (1)				
(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. 388-865-0570 (1)				
(c) Of the reasons why any anti-psychotic medication is administered over the consumer's objection or lack of consent. 388-865-0570 (1)				
If the physician administered anti-psychotic medications over a consumer's objections or lack of consent all of the following were present: A second opinion is documented OR, an emergency existed requiring the involuntary medication (likelihood or hard to self/others, AND no alternative to anti-psychotic medications). WAC 388-865-0570 (2)				
Children: Special Considerations				
Is there documentation that a Children's MH Specialist evaluated the child within 24 hours of admit? WAC 388-865-0575 (3)				
If child was voluntarily admitted without parent consent, the parent is notified within 24 hours of admit. WAC 388-865-0575 (8)				
The child was evaluated by the facility, including the need for CD treatment, need for restricting the right to communicate with parents. WAC 388-865-0575 (10)				
The child was advised of their rights in accordance with RCW 71.34. WAC 388-865-0575 (10)				
Information concerning treatment of the child was only disclosed only in accordance with RCW 71.34.340 WAC 388-865-0575 (16)				



PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: COMPREHENSIVE INFORMATION PLAN
FOR PRSN DELIVERY SYSTEM AND
SERVICES

Policy Number: 2.06

Reference: DSHS Contract, WAC 388-865-0221, -0330;
42 CFR 438.100(b) (2&3)

Effective Date: 9/2005

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: General Information Requirements
- PRSN Member Handbook

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to plan and implement actions which ensure to the extent possible, individuals eligible for mental health services are notified of the existence, availability, and services within the PRSN. In part, the PRSN and/or the network providers or subcontractors will advise Medicaid and non-Medicaid individuals eligible for mental health services about their rights, promote access to individuals who are of limited proficiency in English, encourage stigma reduction activities and support recovery and resiliency.

INFORMATION PLAN

The Peninsula Regional Support Network (PRSN) is committed to developing and utilizing a comprehensive information plan that includes benefit information, services available, how to access services, enrollee rights and responsibilities, and accommodations available for diverse populations (including other languages than English) within the region. The PRSN and/or the providers will incorporate use of media, stigma reduction activities, and plan for ongoing evaluation of the strategic

information plan. The information plan includes the following areas that are addressed on an ongoing basis:

DSHS Benefit Booklet

1. The PRSN will provide the Department the information necessary to update the Department of Social and Health Services (DSHS) Benefits Booklet for Medicaid enrollees.
2. The PRSN and the network providers will provide a copy or access to the electronic version of the DSHS Benefit Booklet produced by the Department to Medicaid enrollees receiving services. The written booklet will be provided at any time, upon enrollee request.
 - The DSHS Benefits Booklet (electronic version) is also listed on the PRSN website.
3. The booklet serves as a mechanism to inform enrollees of their benefits, rights, and responsibilities.
4. The booklet can be downloaded from:
<http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml>

PRSN Service Description

1. The PRSN has designed a member handbook. It contains the following information:
 - A brief overview of the PRSN values, function, and service delivery model.
 - Core network provider names, addresses, and phone numbers.
 - A description of Medicaid/non-Medicaid covered services and how to access them. Recipient's responsibility when attempting to access out of the area services, including a statement about what constitutes out of the area services.
 - A brief description of Ombuds, parent advocacy, and NAMI advocacy resources.
 - PRSN office contact information.
 - How to file a network agency and PRSN grievance, and DSHS fair hearing.
 - How to access the handbook in alternative/translated formats and cultural service delivery considerations.
2. The PRSN website makes general information easily accessible. The current PRSN mission, brochure, handbook, and manual are listed,

- The PRSN website is located at <http://www.kitsapgov.com/hr/wsolympic/prsn/prsnmain.htm>

Consumer Notification of Rights, Responsibilities, and Grievance

Distribution of Information

The Washington State Department of Social and Health Services (DSHS) distributes an enrollee benefits handout to Medicaid individuals at the time of enrollment. This booklet provides individuals general information about rights, access, crisis information, and the Regional Support Network system.

The PRSN and/or the providers provide information to individuals eligible for mental health services by distributing informational material at a wide variety of locations accessed on a regular basis by individuals who may qualify for services. Providers also have the information available to handout prior and during an intake assessment. Provider brochures will be located in various publicly accessible and conspicuous office locations, as will brochures describing the function of the Ombuds program.

The PRSN informational material as described above includes:

1. Information advising individuals eligible for mental health services of their rights and responsibilities. When contractually required, the network providers and subcontractors will have the rights conspicuously posted in lobby areas in the DSHS designated seven languages.
2. Information advising individuals eligible for mental health services of their right to file grievance procedures with Ombuds assistance, the right to express dissatisfaction with services at the provider and PRSN level, as well as the DSHS Fair Hearing processes. Information will inform individuals that Ombuds support is available when pursuing grievances and fair hearings. The Ombuds toll free number will be listed.

Access to Mental Health Services

Telephone Directory

The PRSN, the network providers and subcontractors, including the Ombuds, will maintain telephone number listings and identification of service, in all major area telephone directories, including a toll free number and crisis line access numbers.

Internet Website Directory

The PRSN maintains a website that provides links to all our core network provider homepages.

The PRSN website also provides direct links to the PRSN Consumer Handbook, State Benefits Booklet, PRSN Grievance brochure, and Advance Directive information.

Area Resource Directories

The PRSN, the network providers and subcontractors, including the Ombuds, will refer individuals to the local 211 for listing of services and telephone numbers for commonly used services in the local area.

Services for Diverse Populations

The PRSN network providers and subcontractors are required to provide interpreter services for enrollees with a primary language other than English for all interactions between the individual and the network provider/subcontractor, including, but not limited to: customer service, all appointments for any covered service, crisis services, and all steps necessary to file a grievance or appeal.

DSHS Targeted Diverse Populations

The Washington State DSHS benefits booklet is sent to Medicaid individuals at the time of enrollment. The benefits booklet can be downloaded in the targeted languages through the <http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml> website.

1. The PRSN will provide translated information on access to care, Medicaid and non-Medicaid covered services, member contact information for provider network, Ombuds program and description and contact information, PRSN office contact information, consumer rights, and how to access the material in alternative formats (such as Braille and large print).
2. DSHS has targeted the following seven languages for rights to be posted and all written PRSN informational material (as listed above) to be translated into:
 - Cambodian
 - Chinese
 - Korean
 - Laotian
 - Russian
 - Spanish
 - Vietnamese
3. Information on how to access written material in an alternative language must be provided prior to conducting an intake evaluation.

PRSN Additional Targeted Diverse Populations

The PRSN distributes Performance reports to each provider and the Quality Improvement Committee quarterly. The y review reports illustrate the percentage of diverse populations served and compares it to current census information within each provider catchment area. The reports are used to calculate other diverse population than recognized by DSHS within our catchment area and evaluate if the diverse populations within the area are underserved. When an underserved population is identified, the PRSN and the providers develop strategies to improve access for that group.

Network Provider Service Descriptions

Brochures

The PRSN requires the network providers, subcontractors, and Ombuds to:

1. Publish their own informational brochure listing address, phone, and services specific to their individual agency.
2. Publish brochures in English. The brochures will be published in Spanish and Tagalog in areas where there is a population of 500 or greater (per census information), whose primary language is Spanish or Tagalog located within the provider's catchment area. As additional primary languages are identified for a census population of 500 or greater, the brochures will be published and distributed in those areas.
3. Distribute the brochures as described above.

Notices

1. The PRSN requires the providers, subcontractors, and Ombuds to:
 - Make bulletin boards and other adequate space available for posting information, legal notices, hours of operation, services and service locations, benefit opportunities, grievance procedures, interpretive or other special population rights, notifications, and other contractual material that may be useful for the consumer population and general public.
 - Post notices, rights, advocacy groups and grievance information prominently.
2. The PRSN provides Notice of Action (NOA) written notification to Medicaid enrollees for intended authorization decisions that meet the definition for an action. All NOA material is accompanied with information about the PRSN Appeal process.

3. The PRSN provides written notification to individuals stating the disposition of a grievance and resolution of an appeal filed with the PRSN.
4. The PRSN provides written notification to non-Medicaid individuals seeking outpatient services through the PRSN and *do not* meet entrance criteria.

Written Materials

The PRSN network providers, subcontractors, and Ombuds will give each consumer written materials available in English or other alternate languages, as defined above in the DSHS targeted and PRSN additional targeted diverse populations, which include:

1. A statement of services provided by the agency or organization, and how to access.
2. Consumer rights and responsibilities.
3. Agency/PRSN grievance procedures, including how to file a concerns at various levels (such as through the provider, Ombuds, PRSN, and a state administrative hearing through the Department).
4. Ombuds Services.
5. HIPPA Privacy Statements.
6. Signs of mental illness.
7. How to request information in another format/language.

Media

The PRSN and/or the provider network will utilize various forms of the media to provide PRSN mental health service information:

1. Inform the public about services available for individuals with mental illness, including information about statewide access criteria.
2. Notify the public regarding upcoming events, speakers, workshops, conferences, support groups and the meetings of the local and National Alliance for the Mentally Ill (NAMI).
3. Reduce stigma by providing informational articles/videos, regarding mental illness, recovery, and services.
4. Information may also be distributed through other postings or programs including through radio spots, speakers bureaus accessing service clubs, newspapers,

newsletters, magazines, posters, billboards, flyers, internet website postings and any other means deemed useful.

Ancillary and Allied Cross System Information Sharing

The PRSN, network providers, and subcontractors are committed to building partnerships with social service providers across the region to share information and coordinate services to meet the needs of individuals with mental illness.

1. The PRSN, network providers, and subcontractors will encourage allied providers to distribute our informational materials that publicize mental health services, rights, educational/anti-stigma campaigns and accompanying information.
2. The PRSN is committed to informing the allied systems of services, upcoming events, workshops, and trainings, and resources in the community to support the treatment of individuals with mental or emotional disturbances.
3. The PRSN is committed to establishing and maintaining working agreements with allied systems. Reference the PRSN Cross System Working Agreements.

PRSN Information Plan Evaluation

The PRSN will review and evaluate this plan on an annual basis to assess the following:

1. Using the provider quarterly performance reports, to determine if information reaching the designated populations and locations.
2. Have other organizations or services been developed that we need to target with information on mental illness and services to the mentally ill?
 - In 2012 with 211, the requirements for a local resource directories at each network agency was deleted.
3. Using 2010 or more current census data, determine if the information need to be translated in any other language to meet the need of any specific population in the area.

PRSN PLAN MONITORING

The PRSN Comprehensive Information Plan is mandated by federal and state statute and contract.

1. This plan will be reviewed, and updated, at least annually.

2. This plan will be monitored through use of the PRSN:
 - Monthly Ombuds Activity Reports
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Biennial Provider Quality Review Team On-site Review
 - Grievance Tracking Reports

2. Any area of the plan not meeting plan expectations, the PRSN shall implement a Corrective Action Plan. Reference PRSN Corrective Action Plan Policy.

— NOTAS —

Peninsula Regional Support Network
614 Division Street—MS23
Port Orchard, WA 98366-4676
360-337-4604 o, para llamadas gratuitas, 800-525-5637



Peninsula Regional Support Network

*Servicios de Salud Mental para la Comunidad en
los condados de Clallam, Jefferson y Kitsap*

Plan de Salud Prepagado para Pacientes Internos (PIHP)

Manual para los Miembros

Revisado en 11/7/2013

Servicios Públicos de Salud Mental para Beneficiarios con Medicaid y sin Medicaid

Administrado por el Departamento de Servicios Sociales
de Kitsap County

GUÍA DE REFERENCIA PARA UN CONTACTO RÁPIDO

Peninsula Regional Support Network

360-337-4604 ó 1-800-525-5637

<http://www.kitsapgov.com/hr/wsolympic/prsn/prsninfo.htm>

Jefferson Mental Health Services

360-385-0321 ó 1-877-410-4803 Servicios/Crisis

<http://www.jeffersonmhs.org/>

Kitsap Mental Health Services

360-373-5031 Servicios; 1-800-843-4793 Crisis

<http://www.kitsapmentalhealth.org/home.aspx>

Peninsula Behavioral Health

360-457-0431 Servicios; 360-452-4500 Crisis

<http://www.pcmhc.org/>

West End Outreach Services

360-374-6177 Servicios/Crisis

<http://www.forkshospital.org/westendoutreach/index.html>

Servicio de Ombuds de Bridges Mental Health

360-692-1582 ó 1-888-377-8174

<http://www.kitsapdrc.org/Ombuds.php>

Oficina de Salud Mental de Asociaciones con el Consumidor

1-800-446-0259

NAMI Washington

1-800-782-9264

http://www.nami.org/MSTemplate.cfm/Site=NAMI_Washington

INSTRUCCIONES POR ANTICIPADO PARA ATENCIÓN PSIQUIÁTRICA

¿Qué es una instrucción por anticipado?

Una instrucción por anticipado es un documento legalmente válido que permite a una persona especificar qué tratamiento desea recibir, o no recibir, en el caso de que no pueda tomar decisiones para el tratamiento más adelante.

Muchas personas con enfermedad mental son personas altamente capaces que experimentan momentos cuando se quebranta su capacidad para tomar decisiones. La planificación por adelantado les permite mantener el control de sus vidas durante estos episodios de enfermedad y evitar completamente las crisis de salud mental. Una instrucción por anticipado ofrece esta oportunidad para planificar.

Beneficios de las instrucciones por anticipado

Una instrucción por anticipado:

- Preserva la dignidad y autodeterminación de las personas con enfermedad mental.
- Proporciona una oportunidad para que las personas expresen sus deseos y tomen una responsabilidad activa para su tratamiento.
- Promueve una relación compartida entre el cliente y el proveedor.
- Permite a la familia y los amigos apoyar mejor a una persona en crisis.
- Fomenta la atención individualizada, de modo que un consumidor pueda especificar:
 - ♦ Los tipos de medicamentos que son útiles o perjudiciales
 - ♦ Las personas a las que se notificará o se les permitirá visitar si se hospitaliza
 - ♦ Medidas para el cuidado de los niños o los animales domésticos
 - ♦ Los tipos de tratamiento que han sido útiles en el pasado

¿Cómo hago para preparar una instrucción por anticipado?

- Lea la ley en línea en <http://www.leg.wa.gov>. Siga los enlaces a Laws & Agency Rules. Busque en el Código Revisado de Washington el RCW 71.32.
- Converse con su administrador de casos de salud mental, su terapeuta o psiquiatra
- Llame al Servicio de Ombuds de Bridges Mental Health: 1-888-377-8174
- Llame a la Red de Apoyo Regional de la Península: 360-337-4604 ó 1-800-525-5637
- Llame a la Oficina de Salud Mental de Información al Consumidor: 1-800-446-0259

Los reclamos relacionados con obedecer instrucciones por anticipado para una atención psiquiátrica se pueden presentar ante el Departamento de Salud o el Departamento de Servicios Sociales y de Salud del estado.



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ELEGIBILIDAD PARA SERVICIOS DE SALUD MENTAL

El Plan de Salud Prepagado para Pacientes Internos (Prepaid Inpatient Health Plan - PIHP) de Península Regional Support Network - PRSN es el sistema de salud mental financiado por el estado en los Condados de Kitsap, Clallam y Jefferson y es responsable por la administración de estos servicios. Proporciona a sus miembros beneficios para la salud mental para pacientes externos y autorización psiquiátrica para pacientes hospitalizados.

Usted es elegible para inscripción si:

- **Recibir beneficios de Medicaid; o si no tiene Medicaid, satisface los criterios de acceso, y existen recursos adicionales disponibles; y**
- **Reside en Kitsap, Clallam o Jefferson County.**

Para acceder a los servicios en PRSN, llame al proveedor en su área como se lista en este manual. En una crisis, llame al número para crisis del proveedor que figura en la siguiente página o llame al 911.

Cobertura fuera del área

Cobertura fuera del área significa cualquier servicio de salud mental fuera de Clallam, Jefferson o Kitsap County.

Si es beneficiario de Medicaid, es su responsabilidad ponerse en contacto con la agencia de la red asignada para su área de residencia (véase la lista en la contracubierta) para obtener la autorización de cualquier cobertura fuera del área.

Si usted vive en otro condado y recibe beneficios de Medicaid, pertenece a un PIHP diferente y debería ponerse en contacto con los proveedores de salud mental de la comunidad en ese condado para determinar su elegibilidad.

SATISFACCIÓN DEL CLIENTE

Si tiene una preocupación acerca de la calidad de los servicios o del acceso a los servicios bajo el Plan de Salud Prepagado para Pacientes Internos (PIHP), puede ponerse en contacto con: los servicios Ombuds, llamando al 360-692-1582 o a la línea para llamadas gratuitas 1-888-377-8174, o la Oficina de Información al Consumidor en Olympia al 1-800-446-0259, o la oficina administrativa de PRSN/PIHP al 1-800-525-5637 o al 360-337-4886.

Los servicios de Ombuds se ofrecen sin cargo para el consumidor o posible consumidor. Las personas que tienen dificultad para acceder a los servicios, que tienen quejas o reclamos, o necesitan ayuda para registrar audiencias justas, deben llamar a servicios de Ombuds de PRSN al 360-692-1582 o al 1-888-377-8174.



DISPONIBILIDAD DE IDIOMAS

Los proveedores de la red de PRSN están obligados a ofrecer servicios de intérprete para los miembros con un idioma principal diferente del inglés, para todas las interacciones entre el miembro y el proveedor de la red, incluyendo, pero no limitados a: servicio al cliente, todas las citas para cualquier servicio cubierto, servicios para casos de crisis y todos los pasos necesarios para presentar un reclamo o apelación, sin costo alguno para el miembro.

El PRSN proporcionará información traducida sobre los servicios cubiertos y no cubiertos por Medicaid; signos de enfermedad mental; y el Manual para Miembros de PRSN, el cual incluye: acceso a la atención, información de contacto para el miembro para los proveedores de la red, descripción del programa Ombuds e información de contacto, información de contacto de la oficina de PRSN y derechos del usuario. A solicitud, se proporcionará esta información en los siguientes idiomas, sin costo alguno para el miembro:

- Camboyano
- Chino
- Inglés
- Coreano
- Laosiano
- Ruso
- Español
- Vietnamita

La información sobre cómo acceder a documentos escritos en un idioma alternativo, o en formatos alternativos (tales como Braille), se le debe proporcionar antes de llevar a cabo una evaluación para la admisión.

El PRSN se asegurará de la capacidad de comunicación para proporcionar adaptación a los miembros, incluyendo Teletipo (TTY) y otros dispositivos electrónicos.

Folleto de Beneficios del Departamento de Servicios Sociales y de Salud (DSHS)

El PRSN y los proveedores de la red le proporcionarán una copia del Folleto de Beneficios de DSHS producido por la División de Salud Mental para los inscritos en Medicaid que reciban los servicios. Se proporcionará este folleto a solicitud en cualquier momento y en los idiomas descritos anteriormente.

El folleto le informará sobre sus beneficios, derechos y responsabilidades y se lo puede descargar de:

<http://www1.dshs.wa.gov/Mentalhealth/benefits.shtml>.



COORDINACIÓN DE LA ATENCIÓN PARA POBLACIONES ESPECIALES

El PRSN supervisa los servicios de salud mental y la coordinación de la atención para los niños, minorías étnicas, personas con incapacidades y adultos mayores. La coordinación del proceso de atención incluirá la identificación, evaluación, planificación del tratamiento y dirigirá el acceso a los especialistas. El PRSN mantiene y distribuye dentro de nuestra red, un directorio de Especialistas de Salud Mental disponibles, para proporcionar consulta para las poblaciones especiales. Las recomendaciones de los especialistas están incorporadas dentro de la planificación del tratamiento y la prestación de servicios para la salud mental.

Definiciones para poblaciones especiales

El PRSN define a un niño o adolescente como una persona por debajo de los 18 años de edad. Para la población de Medicaid, un niño se define como una persona por debajo de los 21 años de edad.

El PRSN define a un incapacitado como una persona con una incapacidad que no sea una enfermedad mental, incluyendo una incapacidad de desarrollo, un impedimento físico grave, o un impedimento sensorial.

El PRSN define a una minoría étnica como cualquiera de los siguientes grupos generales de la población; afroamericanos, indios americanos, nativos de Alaska, indios canadienses, asiáticos/isleños del pacífico o hispanos.

El PRSN define a un adulto mayor como una persona que tiene 60 años de edad o mayor

Cuando se proporciona servicios de salud mental a personas que son también miembros de poblaciones especiales, el PRSN y el proveedor de la red son responsables de coordinar la atención con las siguientes entidades, según se apliquen a su caso individual:

- Otros profesionales de atención a la salud mental de la red
- Otros profesionales de atención a la salud mental fuera de la red
- Especialistas de salud mental
- Proveedores de sistemas relacionados
- Escuelas
- Proveedores de atención médica primaria



PRSN AUTORIZADO PROVEEDORES DE SALUD MENTAL DE LA COMUNIDAD

East Clallam County

Peninsula Behavioral Health

118 East 8th Street

Port Angeles, WA 98362

360-457-0431 ó 800-799-1337 Servicios

360-452-4500 Crisis

West Clallam County

West End Outreach Services

530 Bogachiel Way

Forks, WA 98331

360-374-6177 (Servicios o Crisis)

Jefferson County

Jefferson Mental Health Services

884 W Park

Port Townsend, WA 98368

360-385-0321 ó 877-410-4803 (Servicios o Crisis)

Kitsap County

Kitsap Mental Health Services

5455 Almira Drive NE

Bremerton, WA 98311-8330

360-373-5031 TDD 360-478-2715

Servicios de emergencia 360-373-3425

Clínica para Crisis 360-479-3033 o 800-843-4793

Desde North Kitsap 360-535-5400

Desde Bainbridge Island 206-694-4655



Se dispone de servicios para crisis las 24 horas del día, los 7 días de la semana. Para las horas de funcionamiento que no son para crisis, por favor póngase en contacto con el proveedor de salud mental individual en el número local.

DESCRIPCIÓN DE LOS SERVICIOS

El PRSN está dedicado a crear y apoyar al sistema de tratamiento de salud mental que promueva un paso hacia la recuperación y resistencia individual. Entendemos que la salud mental es un elemento esencial de la salud general y que las personas pueden recuperar y lo hacen.

Servicios básicos

Como miembro de PIHP, usted tiene derecho a un plan de atención a la salud mental que puede incluir:

- Intervención en caso de crisis
- Asesoramiento para la admisión
- Aprobación de servicios psiquiátricos para pacientes hospitalizados
- Referencias
- Servicios interpretativos, cuando es necesario

Su primera visita con un proveedor de servicios de salud mental puede involucrar una evaluación de selección. Esta evaluación se utiliza para determinar si usted satisface los criterios para los servicios. Estos criterios exigen que usted tenga un diagnóstico de salud mental cubierto y una puntuación de impedimento funcional, según lo determine un Profesional de Salud Mental. Si los servicios son Médicamente Necesarios y usted cumple con los criterios de acceso de PRSN, se identificarán en su Plan de Servicio Individualizado. Si los servicios no están indicados, se le podría proporcionar referencias a otros recursos de la comunidad.

Servicios Médicamente Necesarios son aquellos que están razonablemente calculados para prevenir, diagnosticar, corregir, curar, aliviar o evitar el empeoramiento de las condiciones que ponen en peligro la vida, causan sufrimiento o dolor, tienen como consecuencia una enfermedad o deformidad, amenazan con causar o agravar un impedimento, o causar deformidad o mal funcionamiento físico. Para ser médicamente necesario, no debería haber otro servicio que pueda ser igualmente efectivo, más conservador, sustancialmente menos costoso, curso de tratamiento disponible o adecuado para un beneficiario. El curso del tratamiento pudiera incluir una simple observación o, cuando sea apropiado, ningún tratamiento en absoluto.

DETECCIÓN DEL FRAUDE Y ABUSO A MEDICAID

Si usted está preocupado con el Fraude y Abuso a Medicaid dentro de la red, puede hacer una denuncia anónima en cualquiera de los siguientes números telefónicos:

- Funcionario de Observancia de PRSN: (800) 525-5637
- Funcionario de Fraude a Medicaid: (360) 586-8888
- Oficina del Fiscal General del Estado de Washington:
Office of Attorney General
PO Box 40116
Olympia WA 98504-0116

Esto ofrece una manera simple de informar las actividades que podrían implicar violaciones al Código de Conducta Ética o prácticas comerciales sospechosas, tales como conflictos de interés, referencias a sí mismos, o cualquier otra conducta que pudiera ser una violación de la ley.



Servicios básicos

Los servicios básicos, si se autorizan, podrían incluir cualquiera de lo siguiente:

Servicios de asesoramiento

- Tratamiento breve y específico
- Asesoramiento individual y en grupo

Servicios de rehabilitación intensiva

- Administración de casos
- Evaluación psiquiátrica
- Prescripción y supervisión de medicamentos
- Atención individualizada y personalizada
- Prácticas Basadas en Evidencia y Modalidades de Tratamiento (usted puede pedir una guía de tratamiento especializado y médicos capacitados en su área local poniéndose en contacto con la oficina de PRSN).

Servicios especializados

Los servicios especializados, si están autorizados, pueden incluir cualquiera de los siguiente:

- Servicios de apoyo residencial
- Programas estructurados durante el día
- Servicios para MICA (Mentalmente enfermos/Químicamente adictos)
- Servicios de evaluación y tratamiento (Servicios para adultos y adolescentes)
- Prácticas Basadas en Evidencia y Modalidades de Tratamiento (usted puede pedir una guía de tratamiento especializado y médicos capacitados en su área local poniéndose en contacto con la oficina de PRSN).

Autorización para los servicios

El PRSN exige una autorización previa para los servicios para pacientes externos y residenciales. Autorizamos los servicios apropiados para las circunstancias de cada individuo y en el nivel de atención menos limitativo, de manera que las personas puedan permanecer en sus comunidades y actuar en el nivel más alto posible.

Proporcionamos un rango de programas y servicios, tanto tradicionales innovadores, lo cuales atienden las necesidades de la persona en su conjunto, hacia los objetivos de buena salud, rehabilitación y recuperación.



VALORES DE PRSN

- Valoramos las fortalezas individuales y familiares al mismo tiempo que nos esforzamos por incluir su participación y expresión en cada aspecto del cuidado y el desarrollo de normas y procedimientos.
- Valoramos y respetamos la cultura y las diferentes cualidades de cada individuo.
- Valoramos los servicios y la educación que promueven recuperación, resistencia, reintegración y rehabilitación.
- Trabajamos en sociedad con socios aliados de la comunidad para proporcionar continuidad y cuidado de calidad.
- Tratamos a las personas con respeto, compasión, e imparcialidad.
- Valoramos el continuo mejoramiento de servicios.
- Valoramos la flexibilidad y creatividad al satisfacer las necesidades de cada individuo.

Peninsula Regional Support Network (PRSN) no discrimina en base a la raza, color, origen nacional, sexo, edad, religión, credo o incapacidad en el suministro de todos sus servicios, actividades, ayuda financiera y otros beneficios.

Servicios adecuados para la edad y la cultura

El PRSN valora y respeta la cultura y cualidades diferentes de cada miembro. El PRSN y nuestra red de proveedores de salud mental se comprometen a ofrecer servicios adecuados para la edad y la cultura.

Adecuados para la edad y la cultura significa:

- El reconocimiento de las necesidades y costumbres de desarrollo y socioculturales únicas de los seres humanos que están en diferentes edades, específicamente aquellas de los niños y adultos mayores;
- La capacidad de atenderle de una manera que sea sensible a sus necesidades únicas de desarrollo;
- El reconocimiento de las creencias, costumbres y tradiciones que surgen de su grupo social/cultural y/o étnico auto-identificado; y
- La capacidad para atenderle de una manera que sea sensible a sus antecedentes culturales únicos.



- Proporcionar información sobre los recursos y derechos de los clientes.
- Recomendar cambios para corregir un problema o evitar incidentes futuros.
- Mantener la confidencialidad.

¿Qué es lo que no puede hacer el servicio de Ombuds?

- Proporcionar asesoramiento para salud mental ni servicios de administración de casos.
- Obtener información a su nombre sin su consentimiento por escrito.
- Asegurar cualquier resultado específico.
- Dar consejo legal o actuar como su abogado.
- Hacer cumplir una recomendación

¿Qué es lo que usted puede hacer para ayudar al servicio de Ombuds a resolver su preocupación o reclamo?

- Estar preparado para informar el QUIÉN, QUÉ, DONDE y CUANDO del problema.
- Suministrar al servicio de Ombuds cualquier información por escrito que pudiera tener.
- Considerar cuál sería una solución justa. ¿Qué es lo que desea del proveedor?
- Mantener al servicio de Ombuds informado sobre cómo se le puede ayudar y dónde se le puede encontrar.



RECURSOS DE NAMI

El PRSN también apoya a los afiliados de NAMI (Alianza Nacional para los Enfermos Mentales). Todos los condados tienen grupos de apoyo mensuales para las personas que buscan servicios, los miembros de la familia y los miembros de la comunidad interesados en participar y proporcionar apoyo. Por favor póngase en contacto con los grupos de apoyo para obtener información adicional sobre las reuniones.

- NAMI Clallam County: 360-452-5244
- NAMI Jefferson County: 360-379-6434
- NAMI Kitsap County: 360-377-2910



Un Ombuds para la salud mental se encuentra disponible para ayudarle



PUENTES PARA EL SERVICIO DE OMBUDS PARA SALUD MENTAL

Atiende a los Condados de Clallam, Jefferson y Kitsap
360-692-1582 Línea para llamadas gratuitas: 1-888-377-8174

¿Qué es el servicio Ombuds?

El Estado de Washington ha establecido un servicio de Ombuds independiente para recibir las quejas y reclamos de los clientes de salud mental financiados con fondos públicos.

¿Cuál es el propósito?

El servicio de Ombuds recibe los reclamos concernientes a la calidad del servicio y la satisfacción del cliente y ayuda a resolverlos rápida y confidencialmente. El objetivo principal del servicio de Ombuds es ayudar a que los proveedores y clientes trabajen juntos para asegurar un servicio de calidad digno.

¿Quiénes son elegibles?

Los residentes de los Condados de Clallam, Jefferson y Kitsap que son elegibles para recibir, o están recibiendo, servicios de salud mental financiados con fondos públicos pueden usar el servicio de Ombuds. Las inquietudes o preguntas de los miembros de una familia y otras partes interesadas también pueden ser dirigidas al servicio de Ombuds.

¿Hay honorarios?

No hay ningún honorario asociado con este servicio.

¿Qué puede hacer el servicio de Ombuds por mí?

- Escuchar su problema, cuando esté relacionado con los servicios en la agencia de salud mental financiada con fondos públicos.
- Analizar lo que implica y ayudarle a determinar una solución apropiada.
- Investigar los hechos, registros, leyes, normas y procedimientos.
- Proporcionar ayuda para resolver el problema en un nivel informal, si es posible.
- Ayudarle en el proceso del reclamo y la queja. Y, si es necesario, hacer el seguimiento para ver que los reclamos se resuelvan y usted se mantenga informado del proceso.

DECLARACIÓN DE DERECHOS DEL CLIENTE DE PRSN SERVICIOS AMBULATORIOS

Revisado en agosto de 2013. Implementado el 1 de septiembre de 2013.

1. El derecho a recibir información sobre las opciones y alternativas de tratamiento disponibles presentadas de la manera apropiada de acuerdo con la condición y la capacidad de entendimiento de la persona inscrita.
2. El derecho a participar en las decisiones relacionadas con su atención médica, incluido el derecho a negarse a cualquier tratamiento propuesto de acuerdo con el Capítulo 71.05 del RCW (Código Revisado de Washington) y 71.34 del RCW, y del CFR (Código de Reglamentaciones Federales) 438.100(iv).
3. El derecho a no ser sometido a ninguna forma de restricción o reclusión utilizada como medio de coacción, disciplina, conveniencia o represalia, según lo especificado en otras reglamentaciones federales sobre el uso de restricciones y reclusión.
4. El derecho a recibir la atención y el tratamiento de calidad correspondientes, empleando las alternativas menos restrictivas disponibles.
5. El derecho a recibir servicios de emergencia, de urgencia o de crisis.
 - ♦ Para los beneficiarios de Medicaid, usted tiene el derecho de recibir servicios de estabilización posteriores a la hospitalización.
6. El derecho a ser tratado con respeto, dignidad y privacidad; sin embargo, el personal podrá realizar registros razonables para detectar y prevenir la posesión o el uso de contrabando en las instalaciones.
7. El derecho a recibir servicios independientemente de su raza, credo, nacionalidad, religión, sexo, orientación sexual, edad o discapacidad.
8. El derecho a practicar la religión que elija, siempre que la práctica no vulnere los derechos y el tratamiento de otras personas ni el servicio de tratamiento. Cada uno de los participantes tiene el derecho de negarse a tomar parte en cualquier práctica religiosa.
9. El derecho a no recibir ningún tipo de acoso sexual.
10. El derecho a no ser explotado, lo que incluye la explotación física y económica.
11. El derecho a solicitar una segunda opinión de un profesional de atención médica calificado sin costo alguno.

12. El derecho a recibir los servicios de un intérprete certificado de un idioma o lenguaje de señas, y materiales escritos en otros formatos para adecuarse a una discapacidad de conformidad con el Título VI de la Ley de Derechos Civiles.
13. El derecho a una adaptación razonable en caso de una discapacidad física o cognitiva, capacidad limitada para comunicarse, dominio limitado del idioma inglés y diferencias culturales.
14. El derecho a planificar su atención y a participar en la elaboración de su plan de tratamiento individual que aborde sus necesidades específicas.
15. El derecho a recibir acceso directo a profesionales de salud mental para los beneficiarios con necesidades especiales de salud mental.
16. El derecho a que toda la información clínica y personal se trate de acuerdo con las reglamentaciones de confidencialidad estatales y federales.
17. El derecho a revisar su historia clínica en presencia del administrador o de la persona designada, y a tener la oportunidad de solicitar modificaciones o correcciones. Usted puede solicitar una copia de sus registros y se le informará el costo de copiado.
18. El derecho a recibir una explicación de todos los medicamentos recetados, incluido el efecto previsto y los posibles efectos secundarios.
19. El derecho a esperar que toda investigación en la que usted acepte participar se realice de acuerdo con todas las leyes aplicables, incluidas las reglas de DSHS sobre la protección de los sujetos humanos de la investigación, tal como se especifica en el WAC (Código Administrativo de Washington) 388-04.
20. El derecho a elegir un proveedor de atención primaria ambulatorio en el momento de la inscripción, a cambiar de proveedor de atención primaria durante los primeros 90 días y una vez durante cualquier período de 12 meses por cualquier motivo, y en cualquier momento por una causa justificada (WAC 388-865-0345).
21. El derecho a preparar una directiva anticipada, en la que indicará su elección y preferencia con respecto al tratamiento de su salud física y mental si no se encuentra en condiciones de tomar una decisión informada.
22. Para los beneficiarios de Medicaid, el derecho a recibir todos los servicios que sean médicamente necesarios para satisfacer sus necesidades de atención. En caso de que hubiera un desacuerdo, usted tiene derecho a una segunda opinión de:
 - ♦ Un proveedor dentro de la red de asistencia regional acerca de qué servicios son médicamente necesarios; o bien

- ♦ Para los consumidores no inscritos en un plan de salud prepago, de un proveedor contratado por el Departamento de Servicios Sociales y de Salud (DSHS).
23. Si actualmente está recibiendo beneficios de Medicaid, no se le facturará por los servicios cubiertos de Medicaid.
 24. El derecho a recibir una copia de los procedimientos de queja y reclamo contra una agencia si la solicita, y a presentar una queja o un reclamo ante la agencia o Península Regional Support Network (PRSN), si corresponde, si considera que sus derechos han sido vulnerados.
 25. El derecho a presentar una queja de Audiencia Justa ante el departamento cuando sienta que la agencia ha violado un requisito del WAC que regula a las agencias de atención médica. El derecho a solicitar una audiencia administrativa ante DSHS sin primero acceder al proceso de reclamo de PRSN.
 26. El derecho a presentar un reclamo contra una agencia o PRSN ante la oficina de Defensoría (Ombuds' Office), PRSN o el proveedor, si considera que sus derechos han sido vulnerados. Si presenta un reclamo contra una agencia o PRSN, no recibirá ningún tipo de represalia. La oficina de Defensoría podrá, si lo solicita, ayudarlo con la presentación. El número de teléfono de la oficina de Defensoría es el 1-888-377-8174.
 27. El derecho a que un profesional de salud mental o una agencia de la red le asesore o represente con respecto al CFR 438.102(i-iv), sin restricciones de PRSN.
 28. Para los beneficiarios de Medicaid, el derecho a una apelación de la Notificación por cualquier rechazo, finalización, suspensión, reducción de los servicios o desacuerdo con su plan de atención, y a continuar recibiendo servicios hasta que se tome una decisión sobre su apelación.

Para presentar una Apelación usted puede:

 - ♦ Comunicarse con la oficina de Defensoría o contar con un representante para que le ayuden a presentar una Apelación y a atravesar el proceso de Apelación.
 - ♦ Presentar una Apelación contra PRSN en PRSN llamando al 1-800-525-5637.
 29. A recibir información sobre la estructura y el funcionamiento de PRSN. El derecho a solicitar un directorio de proveedores de la agencia disponibles en PRSN que proporcionen servicios en otros idiomas además del inglés.
 30. A ejercer libremente todos y cada uno de los derechos, sin que dicho ejercicio afecte en forma negativa el tratamiento proporcionado por el proveedor, PRSN o DSHS.





PENINSULA RSN

FISCAL MANAGEMENT POLICIES AND PROCEDURES

Policy Name: THIRD PARTY LIABILITY AND
COORDINATION OF BENEFITS

Policy Number: 8.03

Reference: 42 CFR 438.208; DSHS contract

Effective Date: 10/2005

Revision Date(s): 1/2014

Reviewed Date: 1/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan

PURPOSE

To ensure that the Peninsula Regional Support Network's (PRSN) contracted community mental health agencies determine if an enrolled person has third party insurance before using public funds to provide services and to coordinate services and assign benefit coverage to third party payers when appropriate.

All funds recovered by the PRSN or network providers from third party resources are used as supplemental income to support the delivery of public mental health services.

DEFINITIONS

Third party liability refers to situations when an enrolled member also has behavioral health coverage with an insurance provider, other than Medicaid. The third party may be liable for paying some or all of the service cost.

Third parties include but are not limited to: private health insurance companies, Medicare, court judgments, or work related health insurance.

PROCEDURE

1. **Determination of Benefits:** Contracted providers within the PRSN will inquire about a person's health insurance coverage during the initial intake process. Should an individual have third party coverage, the network provider is responsible for contacting the third party to verify benefits.
2. **Billing Requirements:** If it is determined that the individual has third party insurance, the network provider must maintain proper documentation in the clinical file to demonstrate that the third party has been assigned responsibility for the covered services provided and has been properly billed.
 - Third party payers shall be recorded in ProFiler, with the appropriate primary insurance flagged.
3. **All third party revenue must be pursued prior to PRSN funding assignment. PRSN must be the payer of last resort.**
 - a. Providers must submit a bill to the third party whenever third party benefits are available.
 - b. Documentation that such billing occurred must be present in the clinical file.
 - Such documentation must include a copy of the Remittance Advice or Explanation of Benefits (EOB) from the third party payer.
4. **Emergency Situations:** Emergency services shall be provided regardless of payment source, and prior to coordinating with third party payers.
5. **Coordination of Benefits:** Except in emergencies, the provider must refer the individual seeking services to a provider recommended by the third party payer for services covered by the third party payer.
 - When a third party payer requires utilization of a service provider outside the PRSN service network, the PRSN contracted provider shall coordinate care with the outside service provider in order to maximize therapeutic benefit.
6. **Community mental health agencies contracted with the PRSN shall maximize the availability of third party payments by applying for preferred provider status with third party health plans when possible.**

MONITORING

This policy is a mandate by contract and federal regulation.

1. This policy will be monitored through use of PRSN:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Annual PRSN Provider Fiscal Review
 - Annual Provider Quality Chart Review

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan policy.



PENINSULA RSN

FISCAL MANAGEMENT POLICIES AND PROCEDURES

Policy Name: FISCAL MONITORING OF NETWORK

Policy Number: 8.05

Reference: WAC 388-865-0270, -0325; DSHS contract

Effective Date: 1/1/2008

Revision Date(s): 1/2014

Reviewed Date: 1/2014

Approved by: PRSN Executive Board

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a standardized process for network provider and subcontractor fiscal reviews. This fiscal review is in addition to other PRSN monitoring activities.

PROCEDURE

1. The PRSN fiscal reviews will:
 - a. Monitor subcontractors financial systems.
 - i. Expenditure reports will be tracked back to the contractor accounting records
 - ii. Allocation of costs between programs and cost centers will be reviewed
 - iii. Internal agency practices will be reviewed to ensure sufficient checks and balances.
 - b. Be conducted on-site annually by the PRSN and Kitsap County accounting staff.
 - c. Utilize a standard protocol that documents strengths, suggested recommendations for improvements, as well as findings.
2. For identified area of deficiencies or areas of improvement, a final report and corrective action plans will be required within thirty (30) days.

MONITORING

1. This policy is mandated by contract or statute. This policy will be monitored through use of PRSN:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Annual PRSN Provider Fiscal Review
 - Review of previous provider corrective action plans
2. If a provider performs below expected standards, a corrective action will be required for PRSN approval. Reference PRSN Corrective Action Plan policy.

INTERLOCAL AGREEMENT
For the
SALISH BEHAVIORAL HEALTH ORGANIZATION
9-18-15 DRAFT

ARTICLE I. PURPOSE OF AGREEMENT

The undersigned parties hereby establish a Behavioral Health Organization (BHO) for the purpose of planning, establishing and operating a comprehensive Behavioral Health system pursuant to RCW 70.96A, 71.24, 71.34, 71.05, and 2SSB 6312 of the 2014 Legislative Session and related regulations.

ARTICLE II. MEMBERSHIP

This organization shall be named the Salish Behavioral Health Organization (hereinafter referred to as the BHO) and shall consist of the following parties:

KITSAPCOUNTY
Kitsap County Courthouse
614 Division Street
Port Orchard, Washington 98366

CLALLAM COUNTY
Clallam County Courthouse
223 East Fourth Street
Port Angeles, Washington 98362

JEFFERSONCOUNTY
Jefferson County Courthouse
Jefferson and Cass Streets
Port Townsend, Washington 98368

JAMESTOWN S'KLALLAM TRIBE
1033 Old Blyn Hwy.
Sequim, WA 98382
360 683-1109

ARTICLE III. AREA TO BE SERVED

The geographical area shall consist of:

- a. Kitsap County – 392.70 square miles;
- b. Clallam County – 1,752.50 square miles;
- c. Jefferson County – 1,805.20 square miles;

ARTICLE IV. CERTIFICATION OF AUTHORITY

Parties, by signatures, certify that they possess full legal authority, as provided by federal, state, tribal and local statutes, charters, codes or ordinances, to enter into this agreement and to provide services pursuant to RCW 71.24, 71.34, 70.96A, and 71.05.

ARTICLE V. POWERS, FUNCTIONS AND RESPONSIBILITIES OF BEHAVIORAL HEALTH ORGANIZATION

The BHO shall exercise such powers, functions, and responsibilities as necessary for the planning, establishing and operating of a comprehensive behavioral health system in accordance with RCW 71.24, 71.34, 70.96A, and 71.05, and related regulations.

ARTICLE VI. BEHAVIORAL HEALTH ORGANIZATION BOARD

There shall be a BHO Board (hereinafter referred to as the Board), which shall constitute the executive body of the Salish BHO. The Board shall exercise all executive powers, functions, and responsibilities necessary for conducting the BHO, except those expressly delegated by the Board to their contractors, subcontractors, grantees, subgrantees, agencies, organizations, or individuals, for all activities established pursuant to RCW 71.24 and regulations promulgated thereto. The Board shall establish rules and procedures (bylaws) as necessary for conducting meetings, to include the following:

- a. **Membership:** The Board shall be composed of one elected Commissioner from each of the three aforementioned counties (with a specific Commissioner as alternate member for each County), one Elected Tribal Official representing the various tribes in the three counties, one non-voting representative from the Salish Behavioral Health Organization Advisory Board for a total of four (4) voting members.
- b. **Voting:** Each member of the Board shall have one vote. All decisions of the Board shall be made by no less than a majority vote of a quorum at a meeting where a quorum is present.
- c. **Quorum:** A quorum shall consist of a total of not less than three (3) members representing three of the four (4) parties to this agreement.
- d. **Chair, Vice-Chair, Second Vice-Chair and Third Vice-Chair:** The board shall elect a Chair, a Vice-Chair, a Second Vice-Chair and a Third Vice-Chair by a majority vote at a meeting where a quorum is present, for a term of service not to exceed one (1) year. Officers of the Board shall be comprised of one elected member from each county and from the tribe serving as the Tribal Liaison, and officers shall rotate annually through ascension.
- e. **Quality Assurance:** Members of the Board may attend the Quality Improvement Committee of the Salish BHO. A member of the Quality

Improvement Committee shall report to the Board at each of their regular meetings and Quality Improvement Committee agenda notices shall be forwarded to the Board.

- f. **Meetings:** The Board shall meet at such times and places as determined by the Board. In the absence of the Chair, the Vice-Chair shall preside over meetings. In the absence of the Chair and Vice-Chair, the Second Vice-Chair shall preside over meetings. In the absence of the Chair, Vice-Chair, and Second Vice-Chair, the Third Vice-Chair shall preside over meetings. In the absence of the Chairman, Vice-Chair, Second Vice-Chair and Third Vice-Chair, a Chair pro tem shall be elected by a majority of the members present to preside for that meeting only.
- g. **Powers, Functions, and Responsibilities:** In accordance with an agreement between the BHO and counties and the BHO and participating tribes within the three counties, the Board's powers, functions, and responsibilities (either jointly with the counties and participating tribes or independently) include, but are not limited to:
- (1) Establishing, policies, priorities, goals, and objectives of the BHO and the programs and services to be operated by the BHO in cooperation with the agencies, entities or individuals providing or implementing the programs and services,
 - (2) Establishing and implementing policies and procedures for planning, administering, monitoring and evaluating programs and services.
 - (3) Oversee the Implementation and enforcement of quality assurance policies..
 - (4) Establish and oversee financial management policies and procedures in order to prevent financial harm to the BHO and its constituent entities, for example, bankrupt contractors or cost-overruns.
 - (5) Reviewing and approving of comprehensive plans and modifications thereto.
 - (6) Approving applications for funds to be submitted and all contracts and agreements related thereto with the Department of Social and Health Services of Washington State and other departments and agencies of state, local or participating tribal government as may be required.
 - (7) Undertaking such other functions as may be deemed appropriate for the discharge of the BHO's duties and responsibilities under law and regulations.
 - (8) Delegating such functions and responsibilities, along with adequate funding, to agencies, individuals or subcommittees as deemed appropriate for effective administration.
 - (9) Approving all BHO-wide grants, subgrants, contracts and agreements.
 - (10) Appointing all advisory board members pursuant to nomination and appointment process established by the BHO. The advisory board shall be composed of equal numbers of individuals from each of the

three counties, and two additional at large tribal representatives, and at least 51% of its membership shall be made up of consumers or parents or legal guardians of individuals with lived experience with a behavioral health disorder.

- (11) Taking no action that would in any way limit service agencies from applying for and receiving grants from outside sources which are designed to enhance their ability to provide local services.

g. Conflict of Interest:

- (1) Each member of the Board must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests. Members of the Board must act within the best interests of the BHO and the Consumers served.
- (2) If a conflict of interest, or the appearance of a conflict of interest, becomes evident, the Board member shall announce the conflict and refrain from debate and voting on that issue.
- (3) If a conflict of interest, or the appearance of a conflict of interest, becomes evident, the Board member shall assign the matter to others, such as an alternate commissioner from their jurisdiction who does not have a conflict of interest.

ARTICLE VII. GRANT RECIPIENT AND ADMINISTRATIVE ENTITY

The Kitsap County Board of Commissioners is hereby designated as the grant recipient and administrative entity of the BHO, and shall exercise such duties and responsibilities as prescribed by the agreement, RCW 71.24, and the regulations promulgated thereof. This will include authority to:

- a. Receive and disburse funds in accordance with grant agreements and contracts with the State of Washington, to include the execution of all contracts. Funds shall be administered in adherence with applicable Washington Administrative Code, and any policies or regulations established by the financial administrator (Kitsap County) for the BHO.
- b. Carry out all necessary functions for operation of the program including, but not limited to:
 - (1) Executing grants, subgrants, contracts, and other necessary agreements as authorized by the Board necessary to carry out BHO functions.
 - (2) Employing administrative staff to assist in administering the programs authorized by the Board.
 - (3) Organizing staffing and hiring qualified persons for that staffing as authorized by the Board.
 - (4) Developing procedures for program planning, operating, assessment and fiscal management, evaluating program performance, initiating any

necessary corrective action for subgrantees and subcontractors, determining whether there is a need to reallocate resources, as directed by the Board, and modifying grants, consistent with goals and policies developed by the Board.

- c. Subcontract to the signatory counties such functions as may be deemed appropriate by the Board. This may include planning and providing services directly or subcontracting for local services within the counties' funding allocation.

ARTICLE VIII. ALLOCATION OF FUNDS

All funds granted to the BHO under RCW 71.24 or any other legislation shall be allocated and expended among participating counties and tribes for programs and services for which they are intended according to state, tribal and federal formula, approved plans, grants, and all pertinent laws and regulations.

Funds currently received by each county, or providers located in each county, shall be allocated by the BHO for services within that county. Millage, mental health sales tax, current expense contributions to mental health programs by county government, and ITA maintenance of effort funds shall be retained by each county and dispensed by the Board of Commissioners thereof, provided, however, that current ITA maintenance of effort funds must continue to be appropriated for ITA services.

New funds which become available as a result of attaining BHO status shall be allocated according to state formula criteria to fund programs in each of the three counties including those of participating tribes. However, by majority vote when a quorum is present, the Board may redirect funds when deemed appropriate for region-wide services or to fund particular programs in individual counties.

ARTICLE IX. LIABILITY

- a. **Sovereign Immunity:** Each party to this Agreement consents to a limited waiver of sovereign immunity for enforcement of the provisions of this Agreement, and this Agreement only, against it by any other party or parties to this agreement. For this purpose only, each party consents to the personal jurisdiction of the Tribal Courts and the courts of competent subject matter jurisdiction of the State of Washington.
- b. **Joint and Several Liability for Contract Oversight:** Each party to this agreement is responsible for overseeing the operations of the BHO to provide services under RCW 71.24 and the regulations enacted thereto. The parties shall be jointly and severally liable for debts, liabilities and obligations incurred by the BHO which arise under RCW 71.24 and state regulations, and with respect to the grants, contracts or agreements administered thereto.
- c. **Hold Harmless: Indemnification:** Each party to this Agreement agrees to defend and indemnify the other parties and their elected and

appointed officials, officers and employees against all claims, losses, damages, suits and expenses, including reasonable attorneys' fees and costs, to the extent they arise out of, or result from, the negligent performance of this Agreement by the indemnitor or its elected or appointed officials, officers and employees. The indemnitor waives its immunity under Title 51 (Industrial Insurance) of the Revised Code of Washington solely for the purposes of this provision and acknowledges that this waiver was mutually negotiated. This provision shall survive the expiration or termination of this Agreement.

- d. **Purchase of Independent Insurance:** Kitsap County, as the administrative entity, shall obtain and maintain throughout the term of this Agreement, general liability and professional liability or malpractice (errors and omissions) insurance coverage in the amount of not less than \$20,000,000 per occurrence for any acts or omissions occurring in behalf of, or related to, the member or BHO's actions or responsibilities related to the provision of services under this Interlocal Agreement. This policy shall name each County or municipal member as an insured and each other member as an additional insured. This coverage shall be the primary coverage in order to shield the individual interests of each member related to the provision of services, whether administrative or contractual, covered by this agreement.
- e. If the professional liability insurance policy to be purchased and maintained by Kitsap County and described above is issued on a "Claims-Made" basis, then each policy must have a Retroactive Date of, or prior to, the effective date of this Interlocal Agreement. Furthermore, for each such "Claims-Made" policy purchased and maintained by Kitsap County, a Supplemental Extended Reporting Period ("SERP") shall be purchased at the sole expense of Kitsap County, with an Extended Reporting Period of not less than three (3) years. In the event the Claims-Made policy is cancelled, non-renewed, switched to an Occurrence form, retroactive date advanced or there is any other event triggering the right to purchase a SERP policy during the term of this Agreement, then Kitsap County agrees its insurance obligation shall survive the completion or termination of the term of this Interlocal Agreement for a minimum of three (3) years.

The BHO shall assure the coverage applies to claims after termination or expiration of the Agreement that relate to services provided under this Interlocal Agreement and any other agreements of the BHO. The BHO shall be solely responsible for any premiums or deductible amounts required under such policies; however, said costs or normal business expenses to be paid out of available BHO funds. Evidence of such insurance shall be promptly provided to any member upon its written request. BHO shall not permit such policy(ies) to lapse without first providing each member at least thirty(30) calendar days written notice of its intention to allow the policy(ies) to lapse. Each Board member shall be a covered insured for any and all official acts performed by such individual under this agreement.

Any coverage for third party liability provided by any Memorandum of Coverage or program of joint self-insurance provided to Jefferson and/or Clallam Counties by a Ch. 48.62 Risk Pool shall be non-contributory to the insurance otherwise mandated by this section and the insurance otherwise mandated by this section shall be deemed primary for all claims, demands, actions or lawsuits generated against the BHO, the Counties, the Tribes and the providers of the services or programs funded by the BHO.

ARTICLE X. DURATION AND RENEWAL OF AGREEMENT

- a. This agreement shall take effect upon the date of its execution and shall remain in effect from until December 31, 2018.
- b. This agreement may be amended from time to time only in accordance with the Interlocal Cooperation Act.
- c. This Agreement shall remain in effect until terminated pursuant to the terms of Article XI, below.

ARTICLE XI. TERMINATION

- a. **Prior Notice:** Any party hereto shall have the right to withdraw from this BHO at any time, **provided** that the remaining members of the BHO shall have received written notification of the party's intention to withdraw at least 120 days prior to the proposed effective date of such withdrawal; and **provided further**, that such notification is received at least 120 days prior to the expiration of the current fiscal grant-year period.
- b. **Return of Funds:** In the event that a party withdraws from the BHO, such funds which are budgeted for services in that jurisdiction shall be deleted from the BHO budget through contract amendment. These funds shall be returned to DSHS, which shall then become responsible for service delivery in that jurisdiction.
- c. **Access to Services:** If a party withdraws from the BHO after a BHO-wide service is established within that party's jurisdiction, said service shall be made available to the remaining parties on a contractual basis. If such service is located within the jurisdiction of remaining parties, it shall be available to the withdrawn party on a contractual basis.
- d. **Disposal of Fixed Assets:** If a party withdraws from the BHO, such fixed assets of the BHO as may be located within that jurisdiction shall be returned to the BHO for use, while fixed assets not purchased with BHO funds shall vest with the withdrawing party.

Upon the dissolution of the entire BHO, ownership of such fixed assets as may have been purchased with state funds shall revert to the state.

We, the undersigned, do hereby ratify this agreement and the terms and conditions herein, and do hereby undertake to conduct this BHO for providing community behavioral health services in Kitsap, Clallam, and Jefferson Counties and in tribal jurisdictions within those counties according to law and regulations.

Effective this _____ day of _____, 2015

KITSAP COUNTY BOARD OF COMMISSIONERS

Approved this _____ day of _____, 2015

Robert Gelder, Chair

Edward E. Wolfe, Commissioner

Charlotte Garrido, Commissioner

ATTEST:

Dana Daniels, Clerk of the Board

CLALLAM COUNTY BOARD OF COMMISSIONERS

Approved this _____ day of _____, 2015

Jim McEntire, Chair

Mike Chapman, Commissioner

Bill Peach, Commissioner

ATTEST:

JEFFERSON COUNTY BOARD OF COMMISSIONERS

Approved this _____ day of _____, 2015

David Sullivan, Chair

Phil Johnson, Commissioner

Kathleen Kler, Commissioner

ATTEST:

Carolyn Avery, Deputy Clerk of the Board

JAMESTOWN S'KLALLAM TRIBE

Approved this _____ day of _____, 2015

W. Ron Allen, Tribal Chair/CEO

BHO Pre-Delegation Review Tool

Agency: _____ Date: _____

Please submit a copy of :

- Most current fiscal audit and certificate of insurance
- Last Administrative Review Summary Report and CAPs
- Current organization chart and list of Board of Directors
- Current licenses
- IS Disaster Recovery Plan
- IS Data Security Plan

#	ITEM	Y/N	COMMENTS
1. Administrative Services			
a	Provider keeps telephone logs to track type of call, date and attempted resolution.		
b	Provider understands the grievance system, including <ul style="list-style-type: none"> • Formal processes with timelines, • The need to maintain confidentiality for all grievances, appeals and state fair hearings, • The need retain documentation of grievances, appeals and state fair hearings separate from the client's clinical record. 		
c	Provider is able to comply with BHO grievance system including responding to the grievance in a timely, thorough and accurate manner.		
d	Provider is able to submit detailed data reports to the BHO regarding all grievances and fair hearings.		
e	Provider is able to comply with "all applicable state and federal laws".		
f	Comply with state and federal non-discrimination policies (such as Title IV or the Civil Rights Act of 1964, Age Discrimination Act of 1965, Rehabilitation Act of 1973, Title II and II of American with Disabilities Act) and DSHS Administrative policies.		
g	Provider has completed ADA building accessibility assessment and is in compliance (BHO Rights).		
2. Utilization and Quality			

#	ITEM	Y/N	COMMENTS
a	Provider has a comprehensive utilization management process that identifies patterns of service utilization by all clients, and includes strategies to ensure that the right services are provided at the right time in the right place (e.g., type, duration, intensity and frequency).		
b	Provider has a utilization management process reviews access and length of stay, continuity of care, care coordination, quality of care, clinical consultation, and outlier identification and management.		
c	Provider has a Quality Management Plan that reflects applicable WACs and Contract terms.		
d	Provider's quality management plan demonstrates implementation of agency Quality Management policies and procedures to ensure continued assessment and improvements in the agency, and measure overall system effectiveness (42 CFR 438.240.a.2).		
e	Provider is able to participate in an on-going BHO quality assurance projects, implementation of PIPs and regional performance measures and conduct client survey and report on all quality assurance activities in a semi annual report.		
f	Ensure provider is responsible for collecting Critical Incident information and Sentinel Events, per BHO contract and policy.		
3. HIPAA			
a	Provider is able to comply with HIPAA Federal Regulations, Washington Administrative Code, BHO Privacy Statement/Practices, BHO contract requirements and agency HIPAA security policies.		
b	Provider can demonstrate compliance with HIPAA physical and technical security and privacy requirements.		
c	Provider can demonstrate that staff have signed statements that are maintained on file acknowledging understanding and agreement to abide by HIPAA requirements.		
d	Agency staff has received annual HIPPA training. New staff receives training within 30 days of start date.		
4. Fiscal			
a	Provider has the ability to submit an annual report on the provided BHO template that reconciles the expenditures shown on the agency's audit to the DBHR Budgeting, Accounting and Reporting System (BARS) expenditure categories.		
b	Provider has the ability to submit a quarterly Revenue and Expenditure Report following BARS supplemental instructions.		

#	ITEM	Y/N	COMMENTS
c	Provider has the ability, expertise and tools to successfully manage a ***case rate payment system.		
d	Agency shall certify that no federal funds payable under this contract will be paid by or on the behalf of Agency, to pay any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress, or an employee of member of Congress in connection with the awarding of a federal contract, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.		
e	Provider can verify there are no Physician Incentive Plan(s).		
f.	Provider has a process to identify third party sources of revenue for services provided under the BHO contract.		
5. Client Rights and Access			
a	Provider ensures that a client's understanding of rights is documented in the clinical record with client signature.		
b	Provider has posted general enrollee rights in all prevalent languages.		
c	Provider ensures that clients are able to understand the information provided to them, including clients with communication barriers and sensory impairments.		
d	Provider has posted "point to language" signs in reception/lobby area and keeps a log of all client requests for interpreter services.		
e	Provider has a documented policy or practice that demonstrates second opinion appointments occur within 30 days, when requested.		
f	Provider has a documented policy or practice that demonstrates choice and change of providers is provided, when requested.		
g	Provider has a documented policy or practice that demonstrates the ability to secure "restricted access" clinical charts.		
h	Provider has a documented policy that demonstrates clients have access and right to review their clinical file.		
i	Provider can documented process or process to demonstrate how a disclosure from 'Release of Confidential' information is documented?		
j	Provider has posted Advance Directive information.		
k	Provider can ensure that all timeliness requirements for emergent, urgent and routine clinical care are met.		

#	ITEM	Y/N	COMMENTS
l	Provider has a mechanism to ensure tracking of all requests for services even when no further service actually occurs.		
m	Provider utilizes and documents to mental health access to care standards and/or ASAM levels of care to determine scope, duration and intensity of services.		
n	Provider has ability to offer mental health assessment by MHP and/or substance use disorder assessment by CDP within 10 business days of request or document for the delay and has the ability to provide the intake assessment at the client's residence, E&T, hospital or other community location, as needed.		
o	Provider ensures that the first routine appointment occurs within 28 days from date of intake.		
p	Provider ensures they have clinical staff trained in evidence based practices for the treatment of chemical substance abuse disorder and/or mental health diagnoses and other practice guidelines as identified by the state or BHO.		
q	Provider ensures a process for co-occurring screening and assessment in compliance with RCW 70.96C.		
r	SUD Provider can demonstrate a process to ensure priority population is being served in a timely manner by clinicians who have specialized expertise with the population.		
s	Provider confirms a policy or documented process to routinely confirm staff has all necessary licenses, certifications and/or permits as required by law.		
t	Provider has a transition plan for those clients expecting to be engaged in treatment on April 1, 2016 to include, but no limited to, gathering information on: what services are being provided, planned treatment end date, services provider information, treatment location, administrative records and individual client transition plans.		
6. Compliance and Program Integrity			
a	Provider ensures compliance by having written policies and procedures that articulate their desire to comply with applicable Federal and State program integrity standards including 42 CFR 438.608 (a), 42 CFR 455 and 42 CFR 1000-1008.		
b	Provider is able to comply with the BHO's Medicaid Fraud and Abuse Plan.		
c	Provider monitors and tracks reports of allegations of Medicaid Fraud or Abuse from agency.		
d	Provider has posted a Medicaid Fraud Control Unit (MFCU) HOTLINE Reporting flyer.		
e	Provider has a mechanism to ensure Federal Exclusion website searches that are conducted upon hire, continue every month following.		
f	Provider will ensure monthly Federal Exclusion attestations are submitted in a timely manner.		
g	Provider maintains a current list of all staff that includes name, DOB, and SS number and has a .y to verify and monitor staff credentials.		

#	ITEM	Y/N	COMMENTS
h	Provider has a mechanism that if an employee or subcontractor is found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with BHO/PIHP funded services.		
i	Provider can demonstrate evidence of staff training in fraud and abuse and agency Compliance Committee meetings.		
7. Information Systems			
a.	Provider can satisfactorily meet IS Disaster Plan contract requirements		
b.	Provider can satisfactorily meet IS Data Security contract requirements		
c.	<p>Provider possesses the following information management capabilities:</p> <ul style="list-style-type: none"> • Collect, document, report and maintain data on clients and services provided; • Collect, document, report and maintain staff data; • Establish and maintain the capability for technical interface with the County IS and provide regular daily transmissions of data in the format specified in County IS policies; • Maintain current, complete and accurate information in the County IS through regular review, audit and corrections; • Respond to reports and data processes as required and necessary; • Maintain data quality; and • Maintain data security. 		
d	Review agency process for segregating DSHS and non-DSHS data/ information.		
e	Verify Safety and Violence Prevention training occurs annually.		
8. Coordination and Integration *** Informational only ***			
a	My agency has an Electronic Medical Record in place.		
b	My agency is dually licensed to provide mental health and substance use disorder services.		
c	<p>My agency has staff that is dually licensed/certified to provide both mental health and substance use disorder treatment.</p> <ul style="list-style-type: none"> • If the answer is yes, how many staff are dually licensed/certified? 		
d	My agency has partnership(s) in place with community mental health agencies.		
e	My agency has policies and procedures in place to get a person into mental health treatment when needed.		
f	My agency has policies and procedures in place regarding the coordination of care for		

#	ITEM	Y/N	COMMENTS
	individuals who are also receiving mental health treatment from another agency.		
g	My agency has partnerships(s) in place with primary care/community health clinic		
h	My agency has policies and procedures in place regarding the coordination of care with primary care and other medical professionals.		



PENINSULA RSN

NETWORK MANAGEMENT POLICIES AND PROCEDURES

Policy Name: SUBCONTRACTUAL DELEGATION AND ASSESSMENT

Policy Number: 9.04

Reference: DSHS Contract, Subdelegated Contracts,
42 CFR 438.206, 230

Effective Date: 7/2005

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: HIPAA Business Associates Addendum
- Plan: Quality Management Plan
- Policy: Corrective Action Plan
- Tool: Delegation and Assessment Tool

PURPOSE

The Peninsula Regional Support Network (PRSN) enters into contracts with qualified network providers and monitors for compliance. The PRSN oversees and is accountable for all the functions performed by the subcontractor performing the PRSN required Pre-Paid Inpatient Health Plan (PIHP) functions on an ongoing basis.

DEFINITIONS

To subdelegate means an entity authorized to act as representative for another; a deputy or an agent. In this policy it refers to an entity or organization that is contractually responsible for conducting the PRSN Pre-Paid Inpatient (PIHP) functions.

PROCEDURE

The PRSN maintains a subcontractual delegation relationship for the operation of the PRSN:

- Information Systems Network, via Profiler and access to Provider 1 regional program
- Authorization and Utilization Management functions, including customer service functions, authorization determinations for all PRSN services (that require authorization), conducting the service denial notifications and appeal process on behalf of the PRSN, and entering prior authorization inpatient information into Provider 1.

PRSN Information Technology and Systems Network Subdelegated Responsibilities

The subdelegated contractor must meet all the requirements as identified in the standards requirements (listed below), and in addition the following:

1. The existing network contractor responsible for Information Services has been successfully managing a large Information Technology (IT) and Information Systems (IS) network in compliance with state requirements for over twenty (20) years. The operational duties include:
 - a. System available during normal business hours, core data transfers, and system back-up duties. Core data will be transmitted daily to State, encounter data submitted on a monthly basis, resolving error reports
 - b. Develop a system security setup for each network agency
 - c. Setting up the necessary items to allow the state core data to be entered into Profiler system
 - d. Apply and provide technical assistance for training, patch and upgrade installations
 - e. Maintaining a functionally sound data base that includes archiving the data base, events, journals, and other files
 - f. Addressing an deficiencies as a result of an audit finding and implementing corrective action plans
2. The subdelegated contractor must meet all the requirements as identified in the standards requirements listed below.
3. The PRSN requires a formalized delegation agreement which is part of the contracting agencies contract with the PRSN. Reference KMHS contract, Attachment B: IT Statement of Work

4. The PRSN monitors contractor compliance through the standard processes listed below, in addition the PRSN uses the feedback provided from:
 - a. The Department of Behavioral Rehabilitation's (DBHR) Information Services division.
 - b. The annual DBHR's External Quality Review Organization (EQRO) RSN reviews. The EQRO monitors the regional IS compliance with regulations, functions, capacity, an overall performance. The PRSN will use the EQRO findings, in conjunction with the applicable IS items on the PRSN Subcontractors Delegation and Assessment Tool, to monitor delegated PIHP functions.
 - c. The PRSN Administrative Review of the network agency.

PRSN Authorization and Utilization Management Subdelegated Responsibilities

The subdelegated contractor must meet all the requirements as identified in the standards requirements (listed below), and in addition the following:

1. The PRSN contracts with an independent utilization management organization to conduct the inpatient, outpatient, residential, and intake assessment authorization determinations.
2. The subdelegated contractor has the responsibility of proving authorization determinations and the service denial notifications, including Notice of Action letters to Medicaid individuals when an adverse action occurs. The contractor must also provide the Appeals Review, on behalf of the PRSN, upon request.
3. The subdelegated contractor must maintain URAC and/or NCQA accreditation, state licensure, and comply with all federal and Washington State regulations.
4. The subdelegated contractor must maintain adequate number of staff to ensure compliance with contact including utilization care managers, clinical staff with expertise, and a Board certified Medical Director to meet the contracted federal and state authorization timeframes set before the PRSN as a PIHP.
5. The subdelegated contractor must use the PRSN medical necessity definition, Level of Care standards, state developed Community Psychiatric Inpatient authorization forms and procedures, and adhere to the PRSN Utilization Management Plan.
6. The subdelegate will participate, upon request, the PRSN Utilization Management or Quality Improvement Committees.
7. The subdelegate will supply, requested reports, data or information needed by the PRSN to assure and maintain compliance with all federal and state reporting requirements and standards. The required reports include, but are not limited to:

- a. Monthly authorization reports, including number of authorizations (Medicaid and non-Medicaid), type of authorization (outpatient, inpatient, residential, or intake), type of level, start and expiration date, number of denials, request and conducted Appeals, and other authorization information as requested.
 - b. Monthly report of flagged high user of crisis services) an high risk individuals (per PRSN definitions).
 - c. Quarterly trend report.
 - d. Other reports for review by the Utilization Management Committee or as requested by the PRSN.
8. The PRSN requires a formalized delegation agreement that is part of the contract with the utilization management organization.
 9. The PRSN will conduct the first delegation audit and review as soon as mutually agreed upon date (between the PRSN and the organization) can be established.
 10. The PRSN monitors contractor compliance through the standard processes listed below, in addition the PRSN uses the feedback provided from:
 - Feedback from the annual Department's External Quality Review Organization (EQRO) RSN reviews. The EQRO monitors the regional IS compliance with regulations, functions, capacity, an overall performance. The PRSN will use the EQRO findings, in conjunction with the applicable IS items on the PRSN Subcontractors Delegation and Assessment Tool, to monitor delegated PIHP functions.

Standard Requirements for PIHP Delegated Functions

1. Before any new subdelegation contracting decision is finalized, the PRSN will evaluate the prospective subcontractor's ability to perform the activities to be delegated. This is done in the following areas:
 - organizational capacity
 - clinical/ staffing capacity
 - quality improvement processes
 - HIPAA and Medicaid compliance
 - (IT, only) data security requirements
 - (ASO, only) authorization for services and utilization management
2. The standards requirements are as follows:

Organizational Capacity

Each prospective contractor or subcontractor must demonstrate the following, as the item applies to the delegated functions:

- Maintain licensing by the state as necessary
- Maintain written policies and procedures covering its adherence to contract and relevant regulations
- Have an adequate data system and staffing to participate in required data reporting; e.g., data on service authorizations, inpatient certifications, evaluation of MIS system, provision of data for PRSN quality management needs, and ongoing management data to monitor performance of delegated duties
- Maintenance of an internal quality management/quality improvement process and documentation of minutes for PRSN review
- Demonstration of a management team that is responsive to feedback from PRSN (and its Ombuds and Quality Review Team), allied providers, and service recipients
- Training and supervision with staff that reflect PRSN's mission and goals as well as adherence with contract and regulations
- Ongoing support for client rights, from provision of information on client rights to responsive action when feedback suggests there may be problems in this area.

Clinical/ Staffing Capacity

Each prospective contractor or subcontractor must demonstrate the following, as the item applies to the delegated functions:

- The availability of qualified staff to assume delegated functions; this includes mental health professionals with clinical expertise in treating children and adults, and a sufficient number of mental health specialists.
- Care management staff must show an understanding of State Access to Care guidelines, and familiarity with current best practices and promising practices.
- Hiring for clinical staff includes verification of licensure or certification, background checks, review of any loss of licensure or felony convictions, and reference checks.
- Competence in implementing delegated functions, as seen in concurrent and retrospective reviews of service authorizations, provider decisions regarding ongoing care, care coordination with allied providers, supervisory feedback to staff, and response to grievances.
- Effective use of training so that staff understand relevant clinical procedures and expected practice (e.g., use of Access to Care standards to determine eligibility for services).
- Openness to PRSN feedback on delegated functions and capacity to make changes in practice when requested.
- Availability of a physician to provide reviews to any inpatient denials and to provide second opinions when requested.
- Documentation of decision making associated with inpatient certification

- Effective medical records practices
- Timely communication with PRSN regarding delegated decisions;
- Participation in any training and feedback from PRSN regarding delegated functions.

Quality Improvement Processes

Each prospective contractor or subcontractor must demonstrate the following, as the item applies to the delegated functions:

- Implement and document a quality management/quality improvement process.
- Participates in PRSN's policies and procedures for grievances and fair hearings; they provide relevant information to enrollees at entry to services and participate actively in the resolution of enrollee grievances.
- Contractors are given feedback on quality issues by PRSN's Quality Review Team. Contractors respond appropriately and in a timely way to QRT recommendations for improvement.

HIPAA & Medicaid Compliance

Each prospective contractor or subcontractor must demonstrate the following, as the item applies to the delegated functions:

- Contractors comply with HIPAA standards
- Signed HIPAA Business Associates Agreement with PRSN
- Demonstrates effective medical records practices
- Update system to meet new regulations

IT: Data Security Requirements- see tool

ASO: Authorization for Services and Utilization Management - see tool

Standard Subdelegation Contract Requirements

1. The PRSN requires a formalized delegation agreement, which is part of the contract, with any organization or entity that provides subdelegated PRSN PIHP functions.
2. The contract, including the delegation agreement, between PRSN and the subdelegated contractor, will:
 - Specify the activities and reports responsibilities designated to the subcontractor; and
 - Provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

3. All subdelegated contractors will comply with the PRSN Compliance Plan and monitoring activities.
4. Sign the PRSN HIPAA Business Associates Addendum.

Standard Subdelegation Contractor Monitoring, Audits and Review

1. PRSN monitors current subdelegated contractor's performance on an ongoing basis and subjects them to formal annual reviews through contract monitoring and clinical service review, as well as ongoing concurrent reviews.
2. Before any new subdelegation contracting decision is finalized, the PRSN will evaluate the prospective subcontractor's ability to perform the activities to be delegated.
3. The PRSN uses the PRSN Subcontractor Delegation and Assessment Tool to conduct pre-evaluation and annual subdelegation contractor performance reviews.
4. The PRSN administrator, or his designee, will direct these monitoring activities.
5. Formal reports are shared with quality management committee, and with the PRSN Executive and Advisory Boards.
6. If the PRSN identifies deficiencies or areas for improvement, PRSN takes corrective action. The subdelegated contractor will respond to specified areas of non-compliance with a Corrective Action Plan (CAP). Any required CAP shall be submitted to PRSN no later than 30 days after the receipt of the audit results for approval. See the PRSN Corrective Action policy.
7. The subdelegation contracts, including the Agreement, have provisions for terminating the contractual relationship.



PENINSULA RSN

SUBCONTRACTUAL DELEGATION POLICIES AND PROCEDURES

Peninsula Regional Support Network-Items of Delegation

Activity	Delegated To:	Relevant Policies and Comments
Assign Levels of Care and request authorization for services.	Contracted Providers	7.01 Auth for OP Services 7.03 LOC 7.04 Intake Eval & Eval Services 7.05 PRAT 7.06 UM Plan 11.01 Access to Services, Timely
Authorization and re-authorization for inpatient, outpatient treatment services, and residential services	ASO Contractor- CommCare	7.01 Auth for OP Services 7.03 LOC 7.04 Intake Eval & Eval Services 7.05 PRAT 7.06 UM Plan 12.01 DSHS InPt Instructions
Assessments of consumers prior to determination of appropriateness of inpatient, outpatient, or residential services	Contracted Providers	7.01 Auth for OP Services 7.03 LOC 7.04 Intake Eval & Eval Services 7.05 PRAT 7.06 UM Plan
Adverse Determinations (Denials)	ASO Contractor- CommCare	6.03 Appeal Process 6.05 NOA Requirements 7.01 Auth for OP Services 7.03 LOC 7.06 UM Plan 12.03 Voluntary InPt Denials
EPSDT – Initial intake review and Level of Service assignment	Request made by Contracted Provider, CMHS Review by PRSN Contractor Child Mental Health Specialist	7.03 LOC 11.08 EPSDT Coordination
EPSDT – Coordination of Individual Service Teams	Contracted Providers Oversight by PRSN Childrens Services Manager	2.17 Special Pop- Coordination of Care for Children 11.08 EPSDT Coordination
Care Management: <ul style="list-style-type: none"> Assessment and Re-Assessment s Collaboration in authorizations required for extension, discharge and transfer needs 	ASO Contractor- CommCare	7.03 LOC 11.01 Access to Services, Timely 11.11 Housing Services 11.19 Primary & Hospital Coordination of Care 11.20 Special Healthcare Needs- Quality & Appropriateness 11.21 Special Healthcare Needs- Direct Care

Activity	Delegated To:	Relevant Policies and Comments
Inpatient, Outpatient, and Residential Services	Contracted Providers	2.08 Rehab & Integrated Care 2.11 Enrollee Rights 2.12 Consent for Treatment 2.13 Second opinion 2.16 Special Needs Accommodation Process 2.21 Recovery & Resiliency 3.02 Culturally Competent Services 3.03 Culturally Competent Service Structure 7.03 LOC 11.02 Access to Services Prior to Intake 11.03 Service Modalities- Outpatient 11.04 Service Modalities- Crisis 11.05 ISP 12.01 DSHS InPt Instructions 12.06 Admission & DC Coordination from InPt care
Appeals	ASO Contractor- CommCare, Medical Director	6.01 Complaint, grievance, Appeal, & Fair Hearing Req 6.03 Appeal Process 12.03 Voluntary InPt Denials
Fair Hearings	DBHR/ DSHS	6.01 Complaint, grievance, Appeal, & Fair Hearing Req 6.04 Fair Hearing
Communication with consumers - Provide Member Handbook	PRSN	2.06 Comprehensive Info Plan 2.07 General Info Req 2.07a PRSN Handbook
Communication with members – negative action	ASO Contractor- CommCare	7.01a PRSN Auth. Ltr 7.01c PRSN Ltr of Ineligibility 6.03a CommCare Appeal Acknowledgement Ltr 6.05a&b NOA Ltr, templates
Telephonic communication with consumers re: NOD/NOA	ASO Contractor- CommCare	6.01 Complaint, grievance, Appeal, & Fair Hearing Req 6.03a CommCare Appeal Acknowledgement Ltr 6.05a&b NOA Ltr, templates 12.03 Voluntary InPt Denials
Communication with consumers and providers	QRT Contractor	9.01 Monitoring Sufficiency 9.02 Monitoring Contractors 9.08 QRT

Activity	Delegated To:	Relevant Policies and Comments
Staff credentialing and licensure including MHP and MH Specialist	Contracted Providers	3.03 Culturally Competent Service Structure 3.03a Specialists Directory 3.03b Bilingual Directory 3.03c EBP Directory 3.07 Provider Staff Qualifications 3.08 Credentialing & Recredentialing
Monitoring a LRA or a Conditional Release.	Contracted Psychiatric Provider and Contracted Providers	9.07 Standard Chart Reviews 9.07a Intake & Reauth Standard Tool 9.07e Crisis Chart Review Tool
Ombuds Services	BRIDGES Ombuds Contractor	6.01 Complaint, Grievance, Appeal & fair Hearing Req 13.02 Ombuds Services
Data Submission to DBHR	KMHS- IT	4.01 Loading of State Enrollment Data 4.02 Data Transfer to the Department 4.03 IS Processing procedures 4.04 IS Encounter Submission 4.05 Data Error Resolution 4.06 Acceptance of Late MIS Data 4.07 Data System Backup & Recoverability
Maintenance of Profiler Regional EMR hardware and network	KMHS – IT	4.01 Loading of State Enrollment Data 4.02 Data Transfer to the Department 4.03 IS Processing procedures 4.04 IS Encounter Submission 4.05 Data Error Resolution 4.06 Acceptance of Late MIS Data 4.07 Data System Backup & Recoverability PRSN Subcontract

Activity	Delegated To:	Relevant Policies and Comments
Information Services - functions and responsibilities of PRSN staff PC & network	Kitsap County IT	4.01 Loading of State Enrollment Data 4.02 Data Transfer to the Dept. 4.03 IS Processing procedures 4.04 IS Encounter Submission 4.05 Data Error Resolution 4.06 Acceptance of Late MIS Data 4.07 Data System Backup & Recoverability PRSN Subcontract
RSN Software	KMHS – IT (subcontracted to UniCare)	4.01 Loading of State Enrollment Data 4.02 Data Transfer to the Department 4.03 IS Processing procedures 4.04 IS Encounter Submission 4.05 Data Error Resolution 4.06 Acceptance of Late MIS Data 4.07 Data System Backup & Recoverability PRSN Subcontract
Crisis Hotlines	Contracted Providers (subcontracted to Crisis Clinic of the Peninsulas)	11.01 Access to Services, Timely 11.04 Service Modalities- Crisis 11.06 Crisis Prevention Plan
After hours customer services – authorizations	ASO Contractor- CommCare	7.01 Auth for OP Services 7.06 UM Plan
Special Population Consult	Contracted Provider	2.17 Special Populations- Coordination of Care for Children 2.18 Special Populations- Coordination of Care for Older Adults 2.19 Special Populations- Coordination of Care for Disabled 2.20 Special Populations- Coordination of Care for Minorities 3.01 Availability of Services 3.02 Culturally Competent Services 3.03 Culturally Competent Service Structure 3.03a Specialists Directory 3.03b Bilingual Directory 3.03c EBP Directory

Activity	Delegated To:	Relevant Policies and Comments
Interpreter Services	PRSN Language Line for Contracted Providers use	2.14 Interpreter Services 2.15 Consumer Rights in Braille
Coordination of Care	Contracted Providers	2.17 Special Populations- Coordination of Care for Children 2.18 Special Populations- Coordination of Care for Older Adults 2.19 Special Populations- Coordination of Care for persons with Disabilities 2.20 Special Populations- Coordination of Care for Ethnic Minorities 2.21 Recovery & Resiliency 11.08 EPSDT Coordination 11.17 Notification of Primary MH Care Provider Termination 11.20 Special Healthcare Needs- Coordination of Care 11.21 Special Healthcare Needs- Direct Care 11.22 Special Healthcare Needs- Quality & Appropriateness 14.01 Working Agreements



PENINSULA RSN

CLINICAL POLICIES AND PROCEDURES

Policy Name: SERVICE MODALITIES – OUTPATIENT **Policy Number:** 11.03

Reference: DSHS Contract

Effective Date: 12/2012

Revision Date(s): 12/2012

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Culturally Competent Services
- Policy: Practice Guidelines
- Policy: Rehabilitative and Integrated Mental Health Treatment
- Policy: Levels of Care

PURPOSE

The Peninsula Regional Support Network (PRSN) shall ensure the full range of outpatient mental health services and modalities, as described in the Medicaid State Plan or Waiver are available within the PRSN to Medicaid eligibles. These services are available and provided based on the individual's needs, medical necessity, PRSN Level of Care criteria, and authorized service level. Additional criteria for non-Medicaid individuals include within available resources.

PROCEDURE

1. Outpatient mental health treatment services are a provision of services designed to help an individual attain goals as prescribed in their Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual. The services shall include participation with the individual, his or her family, or others at the individual's request that play a direct role in assisting the individual to establish and/or maintain stability in his/her daily

- life. Services shall be offered at the location preferred by the individual. This service is provided by or under the supervision of a mental health professional.
2. The following outpatient modalities must be provided if determined medically necessary (see contract exhibit for service definitions):
 - Brief Intervention Treatment
 - Day Support
 - Family Treatment
 - Group Treatment
 - High Intensity Treatment
 - Individual Treatment Services
 - Intake Assessment/ Intake Evaluation
 - Medication Management
 - Medication Monitoring
 - MH Services within Residential Settings
 - Peer Support
 - Psychological Assessment
 - Special Population Evaluation
 - Rehabilitation Case Management
 - Therapeutic Psychoeducation
 - Mental Health Clubhouse
 - Respite Care
 - Residential Services
 - Supported Employment
 3. For Medicaid eligibles: If it is determined a service/ modality is required but not available, the network provider shall purchase the medically necessary service/ modality for the duration that is medically necessary.
 4. For all clients: In addition to the required services/modalities, the network provider may provide or purchase:
 - Assistance with application for entitlement programs
 - Assistance with meeting the requirements of the Medically Needy spend down program; and
 - Services provided to Medicaid eligibles that are not included in the Medicaid State Plan or Waiver
 5. The PRSN network providers may share resources within the region to meet PRSN sufficiency standards.

MONITORING

1. This policy is a mandate by contract and statute. This policy will be monitored through use of PRSN:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Annual Provider Chart Reviews
 - Over and Under Utilization Projects
 - PRSN Grievance Tracking Reports

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.



PENINSULA RSN

CLINICAL POLICIES AND PROCEDURES

Policy Name: PRIMARY MEDICAL CARE PROVIDER
AND HOSPITAL EMERGENCY ROOMS,
COORDINATION OF CARE

Policy Number: 11.18

Reference: 42 CFR 438; DSHS Contract

Effective Date: 8/2005

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: EPSDT Coordination Plan and Requirements
- Policy: Service Modalities- Crisis Services

PURPOSE

The Peninsula Regional Support Network (PRSN) will ensure medically necessary services and care coordination between the network providers and a consumer's primary medical care provider and/or hospital emergency room medical providers/staff will routinely occur in order to address the complex needs that could potentially impact the individual's mental health and physical health recovery.

DEFINITIONS

A consumer is an individual authorized for outpatient services. A consumer could be a Medicaid recipient/ enrollee or non-Medicaid individual.

A primary mental health care provider (MHCP) is the individual with primary responsibility for implementing an individualized service plan for the authorized mental health services.

PROCEDURE

1. The PRSN understands that physical disorders and/or medical conditions can impede progress of a consumer's mental health recovery and overall well-being. Mental health disorders and/or mental illness may complicate an individual's ability to adhere to medical treatment plans.
2. The PRSN will promote communication and coordination of care with a consumer's Primary Medical Care Provider (MHCP) and the local hospitals' emergency room medical providers and staff through:
 - PRSN provided Early Periodic Screening and Diagnostic Testing (EPSDT) trainings to the network and, upon request, to the medical community
 - Biennial PRSN Quality Review Team (QRT) on-site provider reviews, standardized ancillary interviews with local hospital Emergency Room administrators
 - Contractually requiring network service providers to assign a MHCP, for individuals authorized for outpatient care, responsible for outreach and coordination of care with a consumer's primary medical care provider. Network providers are encouraged to obtain a signed Release of Information prior to coordination efforts.
 - The network provider will use best efforts to offer covered mental health services to an enrollee that they are aware has been recently treated in an emergency room for a psychiatric condition.
3. The PRSN will provide oversight and monitoring of the network providers primary MHCP and Crisis Response Teams who are responsible for coordinating the mental health care with the consumer's Primary Medical Care Provider and/or the local emergency room medical providers and staff.
 - a. The PRSN conducts annual chart reviews that monitor the following;
 - specific indicators of quality care
 - specific clinical elements (such as treatment plan coordination of care)
 - b. Trends identified from the data are used to target specific network trainings and community trainings (such as to local Emergency Rooms and the Early Periodic Screening and Diagnostic Testing "EPSDT" medical providers). The data is also presented before the PRSN Quality Improvement Committee (QUIC) and Clinical Directors.
4. The PRSN network provider primary MHCP is responsible for initiating the collaboration with the primary medical care provider.
 - a. The primary focus is to develop or modify the consumer's mental health treatment plan in order to effectively identify and address mental health

- symptoms that may complicate the consumer's integrated mental health and physical health recovery.
- b. The primary MHCP will exchange information with the primary medical care provider, sharing past, present and current treatment interventions, and providing a comprehensive case overview of the individual.
 - c. Mutually exchanged information includes:
 - current physical condition
 - medical history
 - demographic information
 - mental health and physical health assessments
 - treatment plan, with clearly stated measurable goals and objectives
 - significant progress notes
 - current diagnosis- mental health (multi-axial) and physical health
 - pharmacology
 - family and social assessments- mental health and physical health
 - any other relevant information
 - d. The PRSN network provider primary MHCP will initiate exchanging updated information with the primary medical care provider when there is a change in the treatment plan or change in the general condition of the consumer.
5. If the consumer does not have a primary medical care provider, the PRSN network provider primary MHCP will assist them with a referral to the appropriate community clinic, Medicaid plan or private insurance plan for local medical provider information and services.
 - The primary MHCP will provide assistance in completing the Medicaid or private insurance application, if needed.
 6. The PRSN Crisis Response Team will consult and assist the local hospital emergency room medical providers and staff with the development of an integrated medical and/or mental health treatment plan that will provide a coordinated and effective course of treatment for the consumer.
 7. The PRSN Crisis Response Team will collaborate with emergency room medical providers and staff to identify unique reasons for increased/decreased use of the local hospital emergency room.
 - The Crisis Response Team is responsible for initiating this communication with the local hospital emergency room.

8. The PRSN Crisis Response Team will consult and assist the emergency room medical providers and staff to identify appropriate community resources, remove barriers and problem solve difficult situations impacting the consumer.

MONITORING

This policy is mandated by federal statute and contract.

1. This policy will be monitored through use of PRSN:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Annual Provider Chart Reviews
 - Biennial Provider Quality Review Team On-site Review
 - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.



PENINSULA RSN

CLINICAL POLICIES AND PROCEDURES

Policy Name: SPECIAL HEALTHCARE NEEDS- DIRECT CARE, TREATMENT PLANNING AND ACCESS TO MENTAL HEALTH PROFESSIONALS

Policy Number: 11.20

Reference: 42 CFR 438.208, State Waiver

Effective Date: 8/2004

Revision Date(s): 12/2012

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Special Health Care Needs- Access, Quality and Appropriateness
- Policy: Special Health Care Needs- Services and Coordination of Care

PURPOSE

The Peninsula Regional Support Network (PRSN) shall ensure that services to individuals with special healthcare needs meet federal and state requirements.

DEFINITIONS

Washington State defines individuals with special health care needs as individuals who are eligible for public mental health services.

PROCEDURE

1. All individuals eligible for services in the PRSN under state eligibility guidelines have special healthcare needs.

2. Care for all individuals receiving treatment shall be delivered by or overseen by mental health professionals.
 - All initial intake assessments shall be conducted by a mental health professional.
 - All treatment plans shall be developed or reviewed by a mental health professional, and follow the PRSN Individual Service Plan (IST)/Treatment Planning Standards.
 - All outpatient services, including crisis services, shall be delivered by or supervised by a mental health professional.
3. Individuals with special health care needs must have direct access to a mental health professional (MHP) if services are not being delivered by a clinician with MHP credentials.
4. Medicaid enrollees with special health care needs shall have direct access to specialists.

MONITORING

1. The PRSN will monitor compliance through:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Annual Provider Chart Reviews
2. In addition, the Department will monitor compliance through licensing reviews.
3. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

PRSN Administrative Review Tool
Date: June 2, 2015

Pre-site activities:

- Review recent QRT recommendations, WSH & CLIP reports; review last Administrative Review Summary Report and CAPs
- Request current organization chart or staff phone directory- identify all DMHPs and recently hired (direct and non-direct) staff members
- Request an Intake packet of documents currently being used (new item)

Scoring range: 1-absent, 2-partially developed, 3-meets minimum requirements, 4- exceeds minimum requirements, 5- consideration for regional model

#	ITEM	SCORE	COMMENTS
1. Administrative Services			
a	Participation in local emergency/ disaster events Measure- Local FEMA Coordinator/ coordination efforts	3	Continued integrated efforts with KCDEM and county wide disaster preparation/ participation in exercises demonstrates excellent planning and integration with multiple community agencies.
b	Comply with PRSN Grievance Policy Measure- Review agency grievance policy and file for responsiveness	3	As evidenced by review of agency policies and procedure manual, specifically identified as Administrative Policy 22 through 22e. These policies align with PRSN Grievance policy and WACs. 22b-d are forms which appear easy to use.
c	Comply with "all applicable state and federal laws". Measure – Audit contract compliance and review policies and procedures for language.	3	As evidenced by random review of various policies and procedures throughout the manual. Also noted in interview with QA director that all policies and procedures were amended due to changes in WACs.
d	Comply with state and federal non-discrimination policies (such as Title IV or the Civil Rights Act of 1964, Age Discrimination Act of 1965, Rehabilitation Act of 1973, Title II and II of American with Disabilities Act) and DSHS Administrative policies. Measure – Review provider administrative policies and procedures for specific references to Acts	3	As evidenced by review of agency policies and procedure manual, specifically C1 and C1a. Also evidenced in the Employee Handbook. Clear language referencing compliance with all laws and rules.
e	Review DMHP safety policy; comply with state contract Marty Smith safety outreach protocols. Measure- Review agency policy	3	As evidenced by a review of agency policy and procedure manual.
f	Review agency process for segregating DSHS and non-DSHS data/ information. Measure- Agency policy and process for "flagging" payor source (frequency of	3	As evidenced by a review of agency policy and procedure manual.

#	ITEM	SCORE	COMMENTS
	verifying payor such as monthly, by whom at the agency, ect)		
g	Review agency policies, verify updated and reflect current practice/ acronyms (DBHR, Profiler, delete Ex. N reporting requirements, PCP coordination, etc.), and "review date" indicated Measure- Review agency RSN-related policies	3	As evidenced by random review of various policies and procedures throughout the manual. Also noted in interview with QA director that changes in WACs and contract language resulted in changes in policies and procedures to align with WACs and contract, e.g. transition age youth services.
h	Agency has been responsive to PRSN CAP requests and implementation the past 12 months (includes previous PRSN Admin. Review Summary, chart reviews, UMC and QUIC items, Fiscal Audits, etc.)	3	As evidenced by agency's responsiveness to CAPs.
2. General Services			
a	Mechanism to ensure enrollee notification/implementation of applicable (direct service related) changes in state law. Measure- Review agency policy and evidence (if applicable)	3	As evidenced by a review of agency policy and procedure manual.
b	Advanced Directives written information is available (42 CFR 438.6.i.3, PRSN Rights) Measure- Review written information in clinical chart, how information is made available/ distributed and internal agency tracking system.	3	Clinical examples reviewed and inspection of AD literature evident providing clients with opportunity effectively.
c	Maintain agency call logs that track date of call, type of call (information, requesting services, grievance) and date of attempted resolution. Measure- Evidence of agency call log	3	Inspection of database revealed consistent documentation and resolution.
d	Maintain log/ report for use of Interpreters. Measure- Evidence of tracking mechanism	3	Evidenced by review of current log which represented a chronological listing going back to invention and clearly identifies type, duration and frequency efficiently.
e	Comply with PRSN Seclusion and Restraint policy Measure- Review agency outpatient, residential, and inpatient policy (as applicable). Review agency incident reports for events that result in seclusion or restraint	3	As evidenced by a review of agency policy and procedure manual.
f	Ensure Intake packet includes current version of OP client rights. Measure- Request copy of intake packet; verify date on documents.	3	As evidenced by a review of agency intake packet

g	<p>Medicaid clients, only: Evidence of client notification of primary clinician terminated (no longer employed at agency) in clinical chart, within 15 days of separation.</p> <p>Measure- Review chart(s) of examples, verify written or verbal notification provided. (includes plan for re-assignment, new contact provider name, and who to contact with questions).</p>	3	Review of 4 clinical records completed which indicated successful and efficient transition in addition to solid policy.
h	<p>Medicaid clients, only: Evidence of agency process that allows agency clinician to advocate for Medicaid clients so that they are not denied, limited, or discontinued medically necessary mental health services.</p> <p>Measure- Review agency policy or protocol that provides outline of process.</p>	3	As evidenced by review of agency description of the process, e.g. Clinician initiates PRAT, can advocate with Supervisor (who must sign), UM committee during team meeting and Clinical Directors if necessary to support continuation of needed services. Supporting information can be sent to CommCare should they deny a request.
i	<p>Ensure formal Tribal Coordination Plans with each local Tribe or evidence of efforts to establish a Plan.</p> <p>Measure- Review formal and informal efforts to improve Tribal collaboration and communication.</p>	3	As evidenced by an interview with KMHS Executive Director and Chief Clinical Officer of agency. Interview noted KMHS attendance at routine and crisis planning meetings with tribes. In addition KMHS staff engage in case specific collaborative efforts to understand and address needs of tribal members who receive services at KMHS.
j	<p>Ensure provider is responsible for collecting Critical Incident information and Sentinel Events, per PRSN contract and policy</p> <p>Measure – Review of Provider Critical Incident policy and file for past 12 months for required documentation and analyze submitted reports to PRSN for trends</p>	3	Review of sentinel event log consistent with submission of required data to PRSN and evident of congruent record keeping.
3. HIPAA			
a	<p>Comply with HIPAA Federal Regulations, PRSN Privacy Statement/ Practices and agency HIPAA security policies</p> <p>Measure- Review agency policy and procedures, PRSN Privacy Statements made available, breach notification and log, disaster recovery and emergency operating mode (see HIPAA checklist)</p>	3	As evidenced by review of HIPAA Privacy and Security Policies, ensuring the Breach Log is actively used, staff interview, agency walk through and review of PRSN HIPAA policy assessment tool completed by LaVonne Fachner.
b	<p>Demonstrate compliance with HIPAA physical security and privacy requirements</p> <p>Measure- Private interview rooms, front reception privacy reminders, computer monitor privacy screens, log to track hardware disposal or movement (see HIPAA checklist)</p>	3	Discussed were the audits and monitoring of processes supported by KMHS' HIPAA policies such as, Client Privacy Rights, Notice of Privacy Practices, Disaster
c	<p>Demonstrate compliance with HIPAA security management requirements</p>	3	

	Measure- monitoring for log-in access, password management, risk assessment and implementation, training, regular review and evaluation (see HIPAA checklist)		Recovery Plan, Testing Disaster Recovery and Backup, HIPAA Breach Notification, HIPAA Facility Security IS, Password Complexity Rules, Computer System Security Policy, KMHS Security Overview, and the Risk Analysis Report and Work Plan.
4. Quality Assurance Activities			
a	Quality Management Plan is present and reflects applicable WACs and Contract terms. Measure- Review of agency QMP (see QA checklist)	4	As evidenced by review of quality policies A4, A4a, A4b and A4c, as well as an interview with LaVonne Fachner. The plan is comprehensive, integrates multiple agency systems, and includes client input as well as input from representatives throughout the agency.
b	Demonstrate implementation of agency Quality Management policies and procedures to ensure continued assessment and improvements in the agency, and measure overall system effectiveness (42 CFR 438.240.a.2) Measure- evidence that related policies, WAC and Contract terms that monitor, measure and ensure quality and improvement are put into practice (see QA checklist)	4	As evidenced by review of quality policies A4, A4a, A4b and A4c, as well as an interview with LaVonne Fachner. In the interview LaVonne discussed KMHS' recent quality improvement projects, such as the training academy program, the walk in access to care project and collaborative documentation to name a few.
c	Participate in an on-going PRSN quality assurance projects, implementation of PIPs and regional performance measures at the agency level Measure- Active participation on the QUIC, implementation of improvement projects, performance measure, and quality indicators.	3	As evidenced by review of meeting minutes, attendance and active participation in the PRSN regional quality improvement committees meetings and projects and an interview with LaVonne Fachner.
5. ADA Compliance			
a	Ensure ADA building accessibility compliance (PRSN Rights) Measure- Review Agency ADA self-assessment	3	Completed assessments of new properties including Port Orchard and Wheaton Way facilities.

6. Chart Specific items- General Services & Client Rights (Request 3 Charts for evidence of the following items)			
a	Purchase State Plan services, if the contractor is unable to provide the medically necessary mental health service. Measure- Review chart(s) of example(s) of purchased specialized services such as crisis/ respite services, diversion beds, or psychological assessments	3	Evidenced by inspection of clinical records and independent sub-contract (Children's Hospital) demonstrating successful brokering and provision of medically necessary services out of PRSN network.
b	Second opinion appointments occur within 30 days, when requested. • 2nd Intakes for non-Medicaid, within available resources. Measure- Evidenced by sample of clinical charts.	3	Review of numerous clinical records where second opinion appointments were provided efficiently.
c	Choice and change of providers is provided, when requested. Measure- Evidenced by sample of clinical charts. Review agency policy.	3	Demonstrated through review of 6 clinical records where transition was provided.
d	Review process for agency securing "restricted access" clinical charts. Measure- Review policy and current scenarios	3	Evidenced by review of solid policy and supported through effective practice demonstrating diligence in addressing this need.
e	Clients have access and right to review their clinical file. Measure- Evidenced by sample of clinical charts	3	Evidenced by review of policy and supported through evaluation of clinical record demonstrating efficient opportunity for client access to records.
f	Agency policy on individual requesting/ accessing medical records Measure- Agency policy	3	Evidenced by review of policy and supported through evaluation of clinical record demonstrating efficient opportunity for client access to records.
g	Release of Confidential information- how is disclosure documented? Measure- Review agency policy and mechanism, describe agency process	3	Review of policy and procedure clearly identify this process effectively.
h	Review targeted clinical charts- PIPs and new program development Measure- Follow up discussion from Entrance Interview. Interest in reviewing small sample of CIS, Young Transition Group Youth, or other new program services	3	Review of CIS, YTG and PIP targeted clinical records reveal solid clinical programming and supported by succinct policies/procedures.
7. Posted Information and Walk-through Activities (all items remain active items)			
a.	Ombuds Information available Measure- Brochures and/or flyer in reception/ main lobby, space used for Day Treatment/ Clubhouses, and out-stations	3	Inspection of lobbies/foyer area reveal adequate supply of brochures and posters present.
b	Posted "Point to Your Language" sign Measure- Posted in reception/ lobby	3	As evidenced by review of agency during walk through by PRSN staff.

c	Posted Advance Directive information Measure- Posted in reception/ lobby (new PRSN brochure dated 2/08)	3	As evidenced by review of agency during walk through by PRSN staff.
d	Posted general enrollee rights in all prevalent languages. Measure- Posted in publicly accessed areas, dated 8/19/2013	3	As evidenced by review of agency during walk through by PRSN staff.
e	PRSN or agency brochure / information explaining available benefits. Measure- Available benefits information is made available.	3	As evidenced by review of agency during walk through by PRSN staff.
f	DSHS/ DBHR Benefits booklet available in the intake meeting rooms. Measure- DSHS Medicaid booklet is made available	3	As evidenced by review of agency during walk through by PRSN staff.
g	Request medical records to explain/ walk through process when an individual requests to review their own medical record. Reference PRSN policy 2.12 Measure- Staff explain process	3	As evidenced by review of agency policies and procedures and when reviewed clinical records demonstrated efficient operational process.
h	Confirm contractor maintains all necessary licenses, certifications and/or permits as required by law. Measure - Provider will produce current licenses/ certifications (Case Management, E&T, Boarding House) and other applicable documents as requested.	3	As evidenced by review of agency postings on walls as well as review of electronic file which all required documentation was provided in e-file.
i	Posted Medicaid Fraud Control Unit (MFCU) HOTLINE Reporting flyer Measure- Posted MFCU Hotline flyer in common staff areas	3	As evidenced by review of agency during walk through by PRSN staff.
j	(KMHS, only) E&Ts walk- through for : <ul style="list-style-type: none"> • Posted Client Rights- OP and InPt • HIPAA Privacy Practices – private interview rooms, privacy screens, etc. • Ombuds Information – brochures or flyer posted • Security and Safety- review unit inpatient policy 	3	As evidenced by review of agency during walk through by PRSN staff.
8. Compliance			
a	Comply with PRSN Medicaid Fraud and Abuse Plan Measure- Review agency Plan for updates, such as PRSN Compliance Committee participation	3*	As evidenced by a review of Compliance Plan. *Recommend including verbiage in Compliance Plan which reflects participation in PRSN Compliance Committee.
b	Reports of allegations of Medicaid Fraud or Abuse from agency/ staff in the past 12 months Measure- Review agency training, internal tracking/ investigation system and tracking log.	4	As evidenced by review of Staff Compliance Committee Meetings, Staff Compliance Subcommittee meeting, Relias training format, and secure log for tracking any compliance concerns. Compliance efforts at KMHS include HIPAA. An interview with Elena provided much of the aforementioned information.

c	Ensure Federal Exclusion website searches that are conducted upon hire, continue every month following (compliments #9b- verifying in a personnel record) Measure- Interview with agency Compliance officer; verify monthly staff lists are archived.	4	As evidenced by review of agency HR process for recording each month the names of staff screened through OIG. Interview with Akiko provided much of the aforementioned information.
d	Ensure monthly Federal Exclusion attestations are submitted in a timely manner. Measure- Confirm timeliness of submitted monthly attestation letter;	4	As evidenced by a review of agency HR attestation letters submitted in a timely manner in the past 12 months.
e	Agency maintained list of management staff that includes name, DOB, and SS number. (Reference PRSN PIHP contract, Exhibit E 1.5.6) Measure- Confirm agency maintained list of management staff with information.	4	As evidenced by review of database in HR, and from interview with Akiko. Random review of at least management staff, specifically 3 names, DOB, and SS # were successful.
f	Provider has a mechanism that if an employee or subcontractor is found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with Peninsula RSN/PIHP funded services.	4	As evidenced by HR staff screening process through OIG and evidenced within the KMHS Compliance Plan.
g	Evidence of agency Compliance Committee meetings and available trainings to staff Measure- Review agency Compliance Committee meeting notes and training logs	3	As evidenced by review of agency Compliance Plan and agency Compliance Program. Review Compliance Subcommittee meeting notes, as well as Compliance Committee meeting (ELT) notes. Wide variety of topics for each committee were observed. Interview with Elena and HR provided clarifying information that an electronic (Relias) Compliance training is required annually for each staff.
9. Information Systems (Agency) New Section			
a.	Provider satisfactorily meets IS Disaster Plan contract requirements Measure- Review of agency IS Disaster Plan (see CMHA IS Disaster Plan checklist)	NA	New item. Deferred due to recent ISCA sub delegation review Oct 2014.
b.	Provider satisfactorily meets IS Data Security contract requirements Measure- Review of agency IS Data Security (see CMHA IS Data Security checklist)	NA	New item. Deferred due to recent ISCA sub delegation review Oct 2014.

#	ITEM	SCORE	COMMENTS
10. Personnel			
a	<p>Ensure number of qualified agency personnel, age appropriate, sufficient number, and access/ travel standards</p> <p>Measure- Review caseload numbers, availability to specialists, and travel standards</p>	3	As evidenced by review of agency specialist directory and interview with Akiko in HR. It is noted also that KMHS has opened a satellite office in Port Orchard, which addresses a 2013 Administrative Review recommendation to establish an outstation for individuals who reside in outlying areas of Kitsap Peninsula.
b	<p>Verify primary source verification for education and credentials (state licensure can substitute primary source documents)</p> <p>Measure- Random review of 10% of personnel files of recently hired staff for primary source verification check (see Personnel checklist)</p>	3	As evidenced by a review of 10 employee files.
c	<p>Random sample review of agency employee files for training and evaluation plans</p> <p>Measure- Random review of recently hired staff (see Personnel checklist)</p>	3	As evidenced by a review of 10 employee files.
d	<p>Signed statements are maintained on file acknowledging understanding and agreement to abide by HIPAA requirements.</p> <p>Measure – Random review of 10% of recently hired staff (see Personnel checklist)</p>	3	As evidenced by a review of 10 employee files.
e	<p>Agency staff have received annual HIPPA training. New staff receive training within 30 days of start date.</p> <p>Measure – Random review of 10% of recently hired staff (see Personnel checklist)</p>	3	As evidenced by a review of 10 employee files.
f	<p>Verify Medicaid fraud and abuse training.</p> <p>Measure – Random review of 10% of recently hired staff (see Personnel checklist)</p>	3	As evidenced by a review of 10 employee files.
g	<p>Verify Safety and Violence Prevention training occurs annually.</p> <p>Measure- Random review of 10% of recently hired staff & DMHPs (see Personnel checklist)</p>	3	As evidenced by a review of 10 employee files.
h	<p>DMHPs only: Evidence of deputized date for recently hired (previous 12 months) DMHPs.</p> <p>Measure – 100% review of all recently hired DMHPs (see Personnel checklist)</p>	3	As evidenced by a review of 10 employee files including all new DMHP hires.
i	<p>Verify no Physician Incentive Plan(s)</p> <p>Measure- Random review of Physician personnel records (FTE staff and contractors)</p>	3	As evidenced by a review the one physician contract.
j	<p>Random sample of Exit Interviews from recently departed staff (within the past 12 months)</p> <p>Measure- Random review Exit Interviews for trends</p>	3	As evidenced by a review a exit interviews over the last 2 years.

PRSN Administrative Review Tool
Date: July 30, 2015

Pre-site activities:

- Review recent QRT recommendations, WSH & CLIP reports; review last Administrative Review Summary Report and CAPs
- Request current organization chart or staff phone directory- identify all DMHPs and recently hired (direct and non-direct) staff members
- Request an Intake packet of documents currently being used (new item)

Scoring range: 1-absent, 2-partially developed, 3-meets minimum requirements, 4- exceeds minimum requirements, 5- consideration for regional model

#	ITEM	SCORE	COMMENTS
1. Administrative Services			
A	Participation in local emergency/ disaster events Measure- Local FEMA Coordinator/ coordination efforts	3	Review of policy, continued integration with Clallam County DEM and completion of recent mock drill demonstrate compliance and active preparation.
B	Comply with PRSN Grievance Policy Measure- Review agency grievance policy and file for responsiveness	3*	As evidenced by review of updated Grievance policy, grievance reporting documents. *Recommendation: include language in policy that there is no retaliation for filing a grievance.
C	Comply with "all applicable state and federal laws". Measure – Audit contract compliance and review policies and procedures for language.	3	As evidenced by review of Agency Administrative Policy A.4 and Code of Conduct
D	Comply with state and federal non-discrimination policies (such as Title IV or the Civil Rights Act of 1964, Age Discrimination Act of 1965, Rehabilitation Act of 1973, Title II and II of American with Disabilities Act) and DSHS Administrative policies. Measure – Review provider administrative policies and procedures for specific references to Acts	3	As evidenced by review of Non-Discrimination policy, Client rights. Previous recommendation followed as evidenced in policies and client rights.
E	Review DMHP safety policy; comply with state contract Marty Smith safety outreach protocols. Measure- Review agency policy	4	As evidenced by a review of agency policy and procedure.
F	Review agency process for segregating DSHS and non-DSHS data/ information. Measure- Agency policy and process for "flagging" payor source (frequency of verifying payor such as monthly, by whom at the agency, ect)	3	As evidenced by a review of agency policy and procedure.

G	Review agency policies, verify updated and reflect current practice/ acronyms (DBHR, Profiler, delete Ex. N reporting requirements, PCP coordination, etc.), and "review date" indicated Measure- Review agency RSN-related policies	3*	As evidenced by review of recently updated policy manuals. Terms are updated. *Recommendation - the manual depicting the policies and procedures regarding administration are somewhat disorganized.
H	Agency has been responsive to PRSN CAP requests and implementation the past 12 months (includes previous PRSN Admin. Review Summary, chart reviews, UMC and QUIC items, Fiscal Audits, etc.)	3	As evidenced by a review of agency policy and procedure.
2. General Services			
A	Mechanism to ensure enrollee notification/implementation of applicable (direct service related) changes in state law. Measure- Review agency policy and evidence (if applicable)	3	As evidenced by a review of agency policy and procedure.
B	Advanced Directives written information is available (42 CFR 438.6.i.3, PRSN Rights) Measure- Review written information in clinical chart, how information is made available/ distributed and internal agency tracking system.	3	Evidenced clearly by inclusion of intake materials consistently.
C	Maintain agency call logs that track date of call, type of call (information, requesting services, grievance) and date of attempted resolution. Measure- Evidence of agency call log	3	Review of database revealed a comprehensive and current log capturing all necessary data efficiently.
D	Maintain log/ report for use of Interpreters. Measure- Evidence of tracking mechanism	3	Inspection of log demonstrated consistent data entry and congruence with clinical documentation.
E	Comply with PRSN Seclusion and Restraint policy Measure- Review agency outpatient, residential, and inpatient policy (as applicable). Review agency incident reports for events that result in seclusion or restraint	3	As evidenced by a review of agency policy and procedure.
F	Ensure Intake packet includes current version of OP client rights. Measure- Request copy of intake packet; verify date on documents.	3	As evidenced by review of agency policy and procedure. Provision of intake packets for all three age groups revealed inclusion of current rights provided efficiently to each client upon enrollment.
G	Medicaid clients, only: Evidence of client notification of primary clinician terminated (no longer employed at agency) in clinical chart, within 15 days of separation. Measure- Review chart(s) of examples, verify written or verbal notification provided. (includes plan for re-assignment, new contact provider name, and who to contact with questions).	3	Evidenced by review of multiple clinical records demonstrating effective transition and support provided.

H	<p>Medicaid clients, only: Evidence of agency process that allows agency clinician to advocate for Medicaid clients so that they are not denied, limited, or discontinued medically necessary mental health services.</p> <p>Measure- Review agency policy or protocol that provides outline of process.</p>	3	As evidenced by a review of agency policy and procedure.
I	<p>Ensure formal Tribal Coordination Plans with each local Tribe or evidence of efforts to establish a Plan.</p> <p>Measure- Review formal and informal efforts to improve Tribal collaboration and communication.</p>	3*	As evidenced by review of agency service contract with Hoh, active 7.01 planning with tribes, participation in PRSN Inter-Tribal meetings.* Recommendation – complete update process.
J	<p>Ensure provider is responsible for collecting Critical Incident information and Sentinel Events, per PRSN contract and policy</p> <p>Measure – Review of Provider Critical Incident policy and file for past 12 months for required documentation and analyze submitted reports to PRSN for trends</p>	3	Review of policy and inspection of log demonstrated compliance and congruence with reports made to PRSN efficiently.
3. HIPAA			
A	<p>Comply with HIPAA Federal Regulations, PRSN Privacy Statement/ Practices and agency HIPAA security policies</p> <p>Measure- Review agency policy and procedures, PRSN Privacy Statements made available, breach notification and log, disaster recovery and emergency operating mode (see HIPAA checklist)</p>	3	As evidenced by review of the HIPAA Breach Notification Policy, Clallam County Hospital District #1 Computer and Network Use Policies and Procedures, Information System Policy, Minimum Necessary Policy, Security Policy, as well as an interview with Administrative Services Manager, Tanya McNeil.
B	<p>Demonstrate compliance with HIPAA physical security and privacy requirements</p> <p>Measure- Private interview rooms, front reception privacy reminders, computer monitor privacy screens, log to track hardware disposal or movement (see HIPAA checklist)</p>	3.5	As evidenced by a walk through of clinic, noting screens were turned away from the public, white noise machines outside offices and also through a review of the Clallam County Hospital District #1 Computer and Network Use Policies and Procedures, the Information System Policy and an interview with Forks Community Hospital Information Systems Manager and WEOS Administrative Services Manager.

C	<p>Demonstrate compliance with HIPAA security management requirements Measure- monitoring for log-in access, password management, risk assessment and implementation, training, regular review and evaluation (see HIPAA checklist)</p>	3*	<p>As evidenced by review of Clallam County Hospital District #1 Computer and Network Use Policies and Procedures, Risk Assessment, Risk Management Plan, Internal and External Disaster Policy, Information System Policy, as well as an interview with Forks Community Hospital Information Systems Manager and WEOS Administrative Services Manager. *Recommendation: Work with Forks Community Hospital Information Services department and KMHS to increase routine IS review of logs and develop scheduled monitoring for HIPAA security purposes.</p>
<p>4. Quality Assurance Activities</p>			
A	<p>Quality Management Plan is present and reflects applicable WACs and Contract terms. Measure- Review of agency QMP (see QA checklist)</p>	3	<p>As evidenced by a review of the Quality Management Plan, reviewing QM meeting notes and interviewing Administrative Services Manager, Tanya McNeil.</p>
B	<p>Demonstrate implementation of agency Quality Management policies and procedures to ensure continued assessment and improvements in the agency, and measure overall system effectiveness (42 CFR 438.240.a.2) Measure- evidence that related policies, WAC and Contract terms that monitor, measure and ensure quality and improvement are put into practice (see QA checklist)</p>	3*	<p>As evidenced by reviewing the QM plan, reviewing QM meeting notes and interviewing Administrative Services Manager Tanya McNeil.</p> <p>There is evidence from recent QM meeting notes that there is a training program in place and projects and processes are documented that focus on:</p> <ul style="list-style-type: none"> • Disaster preparedness • increase coordination with the court system, • increasing customer service, • increasing clinician productivity. • the prospect of moving towards walk-in intakes.

			*Recommendation: That WEOS move forward with the implementation of peer reviews of clinical charts which would generate measurable data for tracking purposes.
C	Participate in an on-going PRSN quality assurance projects, implementation of PIPs and regional performance measures at the agency level Measure- Active participation on the QUIC, implementation of improvement projects, performance measure, and quality indicators.	3.5	As evidenced through QUIC attendance and participation in the PIP. WEOS has been responsive to researching and reviewing data regarding the regional performance measures as requested by the QUIC
5. ADA Compliance			
A	Ensure ADA building accessibility compliance (PRSN Rights) Measure- Review Agency ADA self-assessment	3*	Review of current assessments demonstrate compliance. *Recommendation: complete new tool for remodeled meeting room.
6. Chart Specific items- General Services & Client Rights (Request 3 Charts for evidence of the following items)			
A	Purchase State Plan services, if the contractor is unable to provide the medically necessary mental health service. Measure- Review chart(s) of example(s) of purchased specialized services such as crisis/ respite services, diversion beds, or psychological assessments	3	Creative brokering with PBH to support WEOS client demonstrates provision as necessary .
B	Second opinion appointments occur within 30 days, when requested. • 2 nd Intakes for non-Medicaid, within available resources. Measure- Evidenced by sample of clinical charts.	3	Clinical cases reviewed capture efficient provision of second opinion as requested.
C	Choice and change of providers is provided, when requested. Measure- Evidenced by sample of clinical charts. Review agency policy.	3	Inspection of policy and supporting clinical records demonstrated efficient transition.
D	Review process for agency securing "restricted access" clinical charts. Measure- Review policy and current scenarios	3*	Discussion revealed several procedures enacted to develop blocks and effectively support securing of clinical records under such circumstances. *Recommendation: Develop policy to support practice.
E	Clients have access and right to review their clinical file. Measure- Evidenced by sample of clinical charts	3	Inspection of multiple clinical records demonstrate efficient policy and supported by effective practice.
F	Agency policy on individual requesting/ accessing medical records Measure- Agency policy	3	Evidenced by review of solid policy which clearly articulates process.

G	Release of Confidential information- how is disclosure documented? Measure- Review agency policy and mechanism, describe agency process	3.5	Comprehensive policy and subsequent tracking data spreadsheet indicate sophisticated mechanism in place to track/ retain essential information successfully.
H	Review targeted clinical charts- PIPs and new program development Measure- Follow up discussion from Entrance Interview. Interest in reviewing small sample of CIS, Young Transition Group Youth, or other new program services	3	Current and consistent participation in PIP demonstrates compliance in this area.
7. Posted Information and Walk-through Activities (all items remain active items)			
A	Ombuds Information available Measure- Brochures and/or flyer in reception/ main lobby, space used for Day Treatment/ Clubhouses, and out-stations	3	Ample supply of brochures existed in lobby as well as flyers posted on communication board.
B	Posted "Point to Your Language" sign Measure- Posted in reception/ lobby	3	Positioned effectively in lobby.
C	Posted Advance Directive information Measure- Posted in reception/ lobby (new PRSN brochure dated 2/08)	3	Numerous campaign materials identifying AD exist in waiting area/communication board.
D	Posted general enrollee rights in all prevalent languages. Measure- Posted in publicly accessed areas, dated 8/19/2013	3	Clearly displayed next to reception and easily accessible.
E	PRSN or agency brochure / information explaining available benefits. Measure- Available benefits information is made available.	3	Benefit booklets and supporting documents identifying PRSN and behavioral health benefits displayed in lobby.
F	DSHS/ DBHR Benefits booklet available in the intake meeting rooms. Measure- DSHS Medicaid booklet is made available	3	Medicaid handbooks readily available and displayed in lobby area.
G	Request medical records to explain/ walk through process when an individual requests to review their own medical record. Reference PRSN policy 2.12 Measure- Staff explain process	3.5	Consultation with medical records staff demonstrated reliable policy and procedure as well comprehensive tracking mechanism.
H	Confirm contractor maintains all necessary licenses, certifications and/or permits as required by law. Measure – Provider will produce current licenses/ certifications (Case Management, E&T, Boarding House) and other applicable documents as requested.	3	Inspection of all current licenses, certificates and permits demonstrate currently needed endorsements.
I	Posted Medicaid Fraud Control Unit (MFCU) HOTLINE Reporting flyer Measure- Posted MFCU Hotline flyer in common staff areas	3	Clearly posted in multiple locations and formats, this information was easily identifiable.
J	(KMHS, only) E&Ts walk- through for : <ul style="list-style-type: none"> • Posted Client Rights- OP and InPt • HIPAA Privacy Practices – private interview rooms, privacy screens, ect. • Ombuds Information – brochures or flyer posted • Security and Safety- review unit inpatient policy 	Na	

8. Compliance			
a	Comply with PRSN Medicaid Fraud and Abuse Plan Measure- Review agency Plan for updates, such as PRSN Compliance Committee participation	3	As evidenced by review of agency policies and procedures which compliment Forks Community Hospital and PRSN plans.
b	Reports of allegations of Medicaid Fraud or Abuse from agency/ staff in the past 12 months Measure- Review agency training, internal tracking/ investigation system and tracking log.	3*	As evidenced by interview with Director, Pam Brown who reported they have had not reports in the past 12 months. *Recommendation – include MCFU language in policies and procedures.
c	Ensure Federal Exclusion website searches that are conducted upon hire, continue every month following (compliments #9b- verifying in a personnel record) Measure- Interview with agency Compliance officer; verify monthly staff lists are archived.	3	As evidenced by WEOS monthly attestations. WEOS includes a list of staff names that are verified each month.
d	Ensure monthly Federal Exclusion attestations are submitted in a timely manner. Measure- Confirm timeliness of submitted monthly attestation letter;	3	As evidenced by a review of WEOS monthly attestations. WEOS includes a list of staff names that are verified each month.
e	Agency maintained list of management staff that includes name, DOB, and SS number. (Reference PRSN PIHP contract, Exhibit E 1.5.6) Measure- Confirm agency maintained list of management staff with information.	3	As evidenced by a review of WEOS list provided at time of review.
f	Provider has a mechanism that if an employee or subcontractor is found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with Peninsula RSN/PIHP funded services.	2	As evidenced by interview with Director, Pam Brown, WEOS uses WATCH background checks upon hire. Required mechanism has not been developed as yet. CAP required. Develop a mechanism to ensure requirement.
g	Evidence of agency Compliance Committee meetings and available trainings to staff Measure- Review agency Compliance Committee meeting notes and training logs	3	As evidenced by agency participation in PRSN Compliance Committee meetings. WEOS and Forks Community Hospital have implemented training opportunities, e.g. mandatory annual compliance training (electronic version) for all staff at WEOS.
9. Information Systems (Agency) New Section			
a.	Provider satisfactorily meets IS Disaster Plan contract requirements Measure- Review of agency IS Disaster Plan (see CMHA IS Disaster Plan checklist)		New item.

b.	Provider satisfactorily meets IS Data Security contract requirements Measure- Review of agency IS Data Security (see CMHA IS Data Security checklist)		New item.
10. Personnel			
a	Ensure number of qualified agency personnel, age appropriate, sufficient number, and access/ travel standards Measure- Review caseload numbers, availability to specialists, and travel standards	3	As evidenced by a review of agency personnel charts.
b	Verify primary source verification for education and credentials (state licensure can substitute primary source documents) Measure- Random review of 10% of personnel files of recently hired staff for primary source verification check (see Personnel checklist)	3	As evidenced by a review of agency personnel charts.
c	Random sample review of agency employee files for training and evaluation plans Measure- Random review of 10% of recently hired staff (see Personnel checklist)	3	As evidenced by a review of agency personnel charts.
d	Signed statements are maintained on file acknowledging understanding and agreement to abide by HIPAA requirements. Measure – Random review of 10% of recently hired staff (see Personnel checklist)	3	As evidenced by a review of agency personnel charts.
e	Agency staff have received annual HIPPA training. New staff receive training within 30 days of start date. Measure – Random review of 10% of recently hired staff (see Personnel checklist)	3	As evidenced by a review of agency personnel charts.
f	Verify Medicaid fraud and abuse training. Measure – Random review of 10% of recently hired staff (see Personnel checklist)	3	As evidenced by a review of agency personnel charts.
g	Verify Safety and Violence Prevention training occurs annually. Measure- Random review of 10% of recently hired staff & DMHPs (see Personnel checklist)	3	As evidenced by a review of agency personnel charts.
h	DMHPs only: Evidence of deputized date for recently hired (previous 12 months) DMHPs. Measure – 100% review of all recently hired DMHPs (see Personnel checklist)	3	As evidenced by a review of agency personnel charts.
i	Verify no Physician Incentive Plan(s) Measure- Random review of Physician personnel records (FTE staff and contractors)	n/a	No physician contracts
j	Random sample of Exit Interviews from recently departed staff (within the past 12 months) Measure- Random review Exit Interviews for trends	n/a	No employees left the agency since the last review.

- Inquire about how agency identifies/ confirm payor at time of service

JMHS Administrative Review Summary

Date: March 25, 2014

Scoring range: 1-absent, 2-partially developed, 3-meets minimum requirements, 4- exceeds minimum requirements, 5- consideration for regional model

#	ITEM	SCORE	COMMENTS
1. Administrative Services			
a	Participation in local emergency/ disaster events Measure- Local FEMA Coordinator/ coordination efforts		
b	Comply with PRSN Grievance Policy Measure- Review agency grievance policy and file for responsiveness		
c	Comply with "all applicable state and federal laws". Measure – Audit contract compliance and review policies and procedures for language.	3	As evidenced by review of P&P manual. Located in Purpose and Authority of Administrative Policies, chapter 2 (2.1)
d	Comply with state and federal non-discrimination policies (such as Title IV or the Civil Rights Act of 1964, Age Discrimination Act of 1965, Rehabilitation Act of 1973, Title II and II of American with Disabilities Act) and DSHS Administrative policies. Measure – Review provider administrative policies and procedures for specific references to Acts	3	As evidenced by review of P&P manual. Located in Purpose and Authority of Administrative Policies, chapter 2 (2.1)
e	Review DMHP safety policy; comply with state contract Marty Smith safety outreach protocols. Measure- Review agency policy		
f	Review agency process for segregating DSHS and non-DSHS data/ information. Measure- Agency policy and process for "flagging" payor source (frequency of verifying payor such as monthly, by whom at the agency, ect)	3	As evidenced by review of policy 4.1 and written process.
g	Review agency policies, verify updated and reflect current practice/ acronyms (DBHR, Profiler, delete Ex. N reporting requirements, PCP coordination, etc.), and "review date" indicated Measure- Review agency RSN-related policies	3*	As evidenced by review of agency Policy manual. Recommendations: <ul style="list-style-type: none"> • Add "Review Date" to each document. • Update Grievance policies.
h	Agency has been responsive to PRSN CAP requests and implementation the past 12 months (includes previous PRSN Admin. Review Summary, chart reviews, UMC and QUIC items, Fiscal Audits, etc.)	3	As evidenced by review of past submitted CAPs. Agency has been responsive to submitting CAPs. Discussed responsiveness to daily operations.

#	ITEM	SCORE	COMMENTS
2. General Services			
a	Mechanism to ensure enrollee notification/implementation of applicable (direct service related) changes in state law. Measure- Review agency policy and evidence (if applicable)		
b	Advanced Directives written information is available (42 CFR 438.6.i.3, PRSN Rights) Measure- Review written information in clinical chart, how information is made available/ distributed and internal agency tracking system.		
c	Maintain agency call logs that track date of call, type of call (information, requesting services, grievance) and date of attempted resolution. Measure- Evidence of agency call log		
d	Maintain log/ report for use of Interpreters. Measure- Evidence of tracking mechanism	3	As evidenced by review of agency logs for 2014 and 2013.
e	Comply with PRSN Seclusion and Restraint policy Measure- Review agency outpatient, residential, and inpatient policy (as applicable). Review agency incident reports for events that result in seclusion or restraint		
f	Ensure Intake packet includes current version of OP client rights. Measure- Request copy of intake packet; verify date on documents.	2.5	As evidenced by review of agency intake packet. The rights being used were from 2011. CAP Required: Agency agreed to update to current rights.
g	Medicaid clients, only: Evidence of client notification of primary clinician terminated (no longer employed at agency) in clinical chart, within 15 days of separation. Measure- Review chart(s) of examples, verify written or verbal notification provided. (includes plan for re-assignment, new contact provider name, and who to contact with questions).	3	As evidenced by review of review of multiple clinical records demonstrating efficient transition of clinical services and coordination of care.
h	Medicaid clients, only: Evidence of agency process that allows agency clinician to advocate for Medicaid clients so that they are not denied, limited, or discontinued medically necessary mental health services. Measure- Review agency policy or protocol that provides outline of process.	3	As evidenced by review of UM policy, submitted and approved last year. This language is referred to throughout the policy.
i	Ensure formal Tribal Coordination Plans with each local Tribe or evidence of efforts to establish a Plan. Measure- Review formal and informal efforts to improve Tribal collaboration and communication.	3.5	As evidenced by review of active participation and coordination efforts this past year: 7.01 planning meetings, local PRSN Inter-Tribal meetings, draft MOU with Jamestown, and formal contract with Port Gamble.

#	ITEM	SCORE	COMMENTS
j	<p>Ensure provider is responsible for collecting Critical Incident information and Sentinel Events, per PRSN contract and policy</p> <p>Measure – Review of Provider Critical Incident policy and file for past 12 months for required documentation and analyze submitted reports to PRSN for trends</p>	3	<p>As evidenced by review of agency file. JMHS over-reports: Every incident is sent to the PRSN office.</p>
3. HIPAA			
a	<p>Comply with HIPAA Federal Regulations, PRSN Privacy Statement/ Practices and agency HIPAA security policies</p> <p>Measure- Review agency policy and procedures, PRSN Privacy Statements made available, breach notification and log, disaster recovery and emergency operating mode (see HIPAA checklist)</p>	2.5	<p>As evidenced by review of HIPAA, Disaster Recovery, Disaster Planning and Administrative Safeguard, Data Management and Media Re-use policies, as well as staff interview with Tonya Ferguson (HR Director) and Sam Markow (CEO).</p> <p>CAP Required:</p> <ol style="list-style-type: none"> 1) Although the HIPAA policy includes Omnibus Final Rule updates and Business Associate Agreement (BAA) requirements (including a template) there was no evidence to support the current use of this policy with known vendors and subcontractors. A current list of BAAs with agreements to meet Omnibus Final Rule standards needs to be completed. 2) Although the Disaster Planning and Administrative Safeguard policy states annual testing and an evaluation of the disaster recovery plan occurs, there was no evidence to support the current practice of this policy. Testing dates and results need to be documented.

#	ITEM	SCORE	COMMENTS
b	Demonstrate compliance with HIPAA physical security and privacy requirements Measure- Private interview rooms, front reception privacy reminders, computer monitor privacy screens, log to track hardware disposal or movement (see HIPAA checklist)	3*	As evidenced by review of HIPAA, Disaster Recovery, Disaster Planning and Administrative Safeguard, Data Management and Media Re-use and Facility policies, as well as staff interview with Tonya Ferguson (HR Director) and Sam Markow (CEO). Recommendations: <ul style="list-style-type: none"> • The Facility Policy is dated October 2006. It should be updated and reviewed regularly. • Develop a list of all personnel (and any contractors) with access to the facility and review regularly. • Develop a list of all personnel with access to ePHI and review regularly.
c	Demonstrate compliance with HIPAA security management requirements Measure- monitoring for log-in access, password management, risk assessment and implementation, training, regular review and evaluation (see HIPAA checklist)	2.5	As evidenced by review of HIPAA, Disaster Recovery, Disaster Planning and Administrative Safeguard, Data Management and Media Re-use policies, as well as staff interview with Tonya Ferguson (HR Director) and Sam Markow (CEO). CAP Required: <ol style="list-style-type: none"> 1) Although Disaster Planning and Administrative Safeguard policy includes IS security there is no evidence to support the current use of this policy. While JMHS contracts with a vendor for Information Systems policies that address HIPAA compliance are still required. A policy to address IS Security and documentation of the dates of audits, monitoring and tests, as well as the results of tests and any modifications as a result of said tests. This should at a minimum include assess audits, data back-up tests and tracking audits of IS devices. (continues to next page)

#	ITEM	SCORE	COMMENTS
c	(Continuation of previous question) Demonstrate compliance with HIPAA security management requirements Measure- monitoring for log-in access, password management, risk assessment and implementation, training, regular review and evaluation (see HIPAA checklist)		2) Although the Disaster Planning and Administrative Safeguard policy states that all encryption is done through a vendor JMHS must have a policy or written procedure to describe their strategies for protecting and transferring encrypted ePHI on hard drives, laptops, and other portable devices. Recommendations: <ul style="list-style-type: none"> • Strengthen the risk analysis document to include fax usage, portable devices and hardware. • HIPAA training policy states that re-training occurs every three years. PRSN policy and recommendation is for yearly HIPAA training.
4. Quality Assurance Activities			
a	Quality Management Plan is present and reflects applicable WACs and Contract terms. Measure- Review of agency QMP (see QA checklist)	3	As evidenced by review of QM plan, Quality Management Committee meeting notes and an interview with Tonya Ferguson and Sam Markow.
b	Demonstrate implementation of agency Quality Management policies and procedures to ensure continued assessment and improvements in the agency, and measure overall system effectiveness (42 CFR 438.240.a.2) Measure- evidence that related policies, WAC and Contract terms that monitor, measure and ensure quality and improvement are put into practice (see QA checklist)	3*	As evidenced by review QM meeting minutes from January and February 2014. Recommendation: <ul style="list-style-type: none"> • Include measures tracked (raw data) into the QM meeting notes for review, discussion and to monitor and document improvement.
c	Participate in an on-going PRSN quality assurance projects, implementation of PIPs and regional performance measures at the agency level Measure- Active participation on the QUIC, implementation of improvement projects, performance measure, and quality indicators.	3	As evidenced by successful implementation and sustainability of the Weight Monitoring PIP and active participation in QUIC meetings.
5. ADA Compliance			
a	Ensure ADA building accessibility compliance (PRSN Rights) Measure- Review Agency ADA self-assessment	3	As evidenced by review of current ADA self assessments that have been previously completed.

#	ITEM	SCORE	COMMENTS
6. Chart Specific items- General Services & Client Rights (Request 3 Charts for evidence of the following items)			
a	Purchase State Plan services, if the contractor is unable to provide the medically necessary mental health service. Measure- Review chart(s) of example(s) of purchased specialized services such as crisis/ respite services, diversion beds, or psychological assessments	3	As evidenced by review of charts that demonstrated item, examples included purchasing psychological testing, bus fare and gas cards for clients.
b	Second opinion appointments occur within 30 days, when requested. • 2nd Intakes for non-Medicaid, within available resources. Measure- Evidenced by sample of clinical charts.	3	As evidenced by review of charts that demonstrated second opinions provided efficiently upon request of client.
c	Choice and change of providers is provided, when requested. Measure- Evidenced by sample of clinical charts. Review agency policy.	3	As evidenced by review of charts that demonstrated choice and change of providers when requested.
d	Review process for agency securing "restricted access" clinical charts. Measure- Review policy and current scenarios	3	As evidenced by interview of staff and review of procedure.
e	Clients have access and right to review their clinical file. Measure- Evidenced by sample of clinical charts	3	As evidenced by review of charts that demonstrated item.
f	Agency policy on individual requesting/ accessing medical records Measure- Agency policy		
g	Release of Confidential information- how is disclosure documented? Measure- Review agency policy and mechanism, describe agency process		
h	Review targeted clinical charts- PIPs and new program development Measure- Follow up discussion from Entrance Interview. Interest in reviewing small sample of CIS, Young Transition Group Youth, or other new program services	Not Scored	Comments: Continued enhancement of Child and Family team meetings for level 2 multisystem clients, adoption and integration of WISE guiding principles and further development of Transition Age Youth program/ services are all highly recommended.
7. Posted Information and Walk-through Activities (all items remain active items)			
a.	Ombuds Information available Measure- Brochures and/or flyer in reception/ main lobby, space used for Day Treatment/ Clubhouses, and out-stations	3	As evidenced by review of inspection of lobby and foyer which adequate supply were clearly available to clients and families.
b	Posted "Point to Your Language" sign Measure- Posted in reception/ lobby	3	As evidenced by review of inspection of lobby and foyer where placard is clearly placed.
c	Posted Advance Directive information Measure- Posted in reception/ lobby (new PRSN brochure dated 2/08)	3	As evidenced by review of inspection of lobby and foyer which adequate supply were clearly available to clients and families.
d	Posted general enrollee rights in all prevalent languages. Measure- Posted in publicly accessed areas, dated 8/19/2013	3	As evidenced by review of lobby area where rights were conveniently posted and accessible.

#	ITEM	SCORE	COMMENTS
e	PRSN or agency brochure / information explaining available benefits. Measure- Available benefits information is made available.	3	As evidenced by review of inspection of lobby and foyer which adequate supply were clearly available to clients and families.
f	DSHS/ DBHR Benefits booklet available in the intake meeting rooms. Measure- DSHS Medicaid booklet is made available	3	As evidenced by review of inspection of lobby and foyer which adequate supply were clearly available to clients and families.
g	Request medical records to explain/ walk through process when an individual requests to review their own medical record. Reference PRSN policy 2.12 Measure- Staff explain process	3	As evidenced by review of policy and interview with medical records staff who articulated a very precise procedure and provided several clinical examples of efficiently providing access to records.
h	Confirm contractor maintains all necessary licenses, certifications and/or permits as required by law. Measure - Provider will produce current licenses/ certifications (Case Management, E&T, Boarding House) and other applicable documents as requested.	3	As evidenced by review of inspection of lobby where business license, E/T Treatment Program, DSHS, L/I certificates with current dates were clearly posted.
i	Posted Medicaid Fraud Control Unit (MFCU) HOTLINE Reporting flyer Measure- Posted MFCU Hotline flyer in common staff areas	3	As evidenced by review of inspection of lobby/foyer areas where ample supply of flyers were readily visible and available.
j	(KMHS, only) E&Ts walk- through for : <ul style="list-style-type: none"> • Posted Client Rights- OP and InPt • HIPAA Privacy Practices – private interview rooms, privacy screens, ect. • Ombuds Information – brochures or flyer posted • Security and Safety- review unit inpatient policy 		
8. Compliance			
a	Comply with PRSN Medicaid Fraud and Abuse Plan Measure- Review agency Plan for updates, such as PRSN Compliance Committee participation	3	As evidenced by review of agency Compliance Plan. QM Committee operates as Compliance Committee.
b	Reports of allegations of Medicaid Fraud or Abuse from agency/ staff in the past 12 months Measure- Review agency training, internal tracking/ investigation system and tracking log.		
c	Ensure Federal Exclusion website searches that are conducted upon hire, continue every month following (compliments #9b- verifying in a personnel record) Measure- Interview with agency Compliance officer; verify monthly staff lists are archived.	3	As evidenced by review of personnel files and monthly attestations.
d	Ensure monthly Federal Exclusion attestations are submitted in a timely manner. Measure- Confirm timeliness of submitted monthly attestation letter;	3	As evidenced by review of monthly attestations submitted to PRSN.
e	Agency maintained list of management staff that includes name, DOB, and SS number. (Reference PRSN PIHP contract, Exhibit E 1.5.6) Measure- Confirm agency maintained list of management staff with information.	3	As evidenced by review of list of BOD and management employee information located in each personnel file.

#	ITEM	SCORE	COMMENTS
f	Provider has a mechanism that if an employee or subcontractor is found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with Peninsula RSN/PIHP funded services.	3*	As evidenced by review of current practice. PRSN will research and provide clarification for ensuring past convictions. Recommendation: <ul style="list-style-type: none"> Develop written procedures that mimic current operations/ practices.
g	Evidence of agency Compliance Committee meetings and available trainings to staff Measure- Review agency Compliance Committee meeting notes and training logs	3*	As evidenced by review of QM Committee meeting notes and training provided (at staff meetings and policy review). QM meeting notes provided did not include Compliance issues, although there have been specific coding meeting with PRSN. Recommendation: <ul style="list-style-type: none"> Committee meeting notes need to reflect a more robust Compliance program.
9. Personnel: 3 personnel files reviewed (1 newly designated DMHP, 2 new OP direct service staff)			
a	Ensure number of qualified agency personnel, age appropriate, sufficient number, and access/ travel standards Measure- Review caseload numbers, availability to specialists, and travel standards	3	As evidenced by review of current specialists on staff and cab/ bus passes from Quilcene location due to office closure. Discussed DBHR licensing and WACs for ethnic and DDA specialists. PRSN will research and provide information to network.
b	Verify primary source verification for education and credentials (state licensure can substitute primary source documents) Measure- Random review of 10% of personnel files of recently hired staff for primary source verification check (see Personnel checklist)	3	As evidenced by review of 3 personnel files.
c	Random sample review of agency employee files for training and evaluation plans Measure- Random review of 10% of recently hired staff (see Personnel checklist)		
d	Signed statements are maintained on file acknowledging understanding and agreement to abide by HIPAA requirements. Measure – Random review of 10% of recently hired staff (see Personnel checklist)	3	As evidenced by review of 3 personnel files.
e	Agency staff have received annual HIPPA training. New staff receive training within 30 days of start date. Measure – Random review of 10% of recently hired staff (see Personnel checklist)	3	As evidenced by review of 3 personnel files.
f	Verify Medicaid fraud and abuse training. Measure – Random review of 10% of recently hired staff (see Personnel checklist)	3	As evidenced by review of 3 personnel files.
g	Verify Safety and Violence Prevention training occurs annually. Measure- Random review of 10% of recently hired staff & DMHPs (see Personnel checklist)	3	As evidenced by review of 3 personnel files.

#	ITEM	SCORE	COMMENTS
h	DMHPs only: Evidence of deputized date for recently hired (previous 12 months) DMHPs. Measure – 100% review of all recently hired DMHPs (see Personnel checklist)	3	As evidenced by review of 1 newly designated DMHP (since last review).
i	Verify no Physician Incentive Plan(s) Measure- Random review of Physician personnel records (FTE staff and contractors)	3	As evidenced by review of one contracted medical provider contract.
j	Random sample of Exit Interviews from recently departed staff (within the past 12 months) Measure- Random review Exit Interviews for trends	3	As evidenced by review of 3 Exit Interviews. No patterns noted.

Verify payors at time of service: The JMHS confirms all payors the day before a scheduled appointment, and prior to sending a reminder call to an individual (the day before an appointment).



PENINSULA RSN

ADVOCACY AND SUPPORT PROGRAMS POLICIES AND PROCEDURES

Policy Name: MENTAL HEALTH CARE PROFESSIONAL
ADVOCACY

Policy Number: 13.01

Reference: 42 CFR 438.102, 438.218; DSHS Contract

Effective Date: 2/2002

Revision Date(s): 12/2012

Reviewed Date: 11/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Grievance, Appeal and Fair Hearing General Requirements
- Policy: Corrective Action Plan

PURPOSE

The Peninsula Regional Support Network (PRSN) shall not restrict a health care professional from advising or advocating on behalf of an enrollee.

The PRSN strongly encourages the use of Peer Partners throughout the service provision available in the network.

PROCEDURE

The PRSN shall not prohibit in any way, nor allow PRSN contractors or subcontractors to prohibit health care professionals and/or a network agency from acting within the lawful scope of their practice from communicating, advising or advocating on behalf of an enrollee for any reason.

A community mental health agency, network provider, mental health care professional, or Peer Counselor acting on behalf of an individual and with their written consent, may:

- file an appeal on behalf of an enrollee
- file a grievance on behalf of an enrollee

- request a fair hearing on behalf of an enrollee
- act as the individual's authorized representative

MONITORING

This policy is a mandate by statute.

1. This policy will be monitored through use of PRSN:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Annual Provider Chart Reviews
 - Grievance Report and Tracking
 - Biennial Provider Quality Review Team On-site Review
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

Monitoring Report

Jefferson Mental Health Services

Revenue and Expenditures Report Reconciliation
Federal Block Grant Billing
Line Item Billings

Site Visit: December 10, 2014

On December 10, 2014, a Peninsula Regional Support Network (PRSN) review team made up of Mavis Beach and Anders Edgerton conducted an on-site monitoring visit at Jefferson Mental Health Services (JMHS). The monitoring visit covered the period October 1, 2013 to September 30, 2014. The visit had the objective of ensuring that expenses reported by the agency to the PRSN on Revenue and Expenditure reports could be accurately tracked back through the agency's accounting system, and to monitor the expenditure of Federal Block Grant and other specific budget proviso funding included in the agencies budget.

The State of Washington Department of Social and Health Services requires Regional Support Networks to submit quarterly Revenue and Expenditure reports to the DSHS Division of Behavioral Health and Recovery. Because the PRSN pays its provider network on a capitated basis, it must rely on the expenditure reports of our provider network to properly account for expenditures across programs and revenue streams. The complexity of the Revenue and Expenditure reporting system requires significant effort on the part of RSNs and provider agencies in order to properly allocate expenditures. The allocation of costs between programs and revenue streams must begin at the provider level in order for the overall regional report to accurately reflect program costs.

JMHS is a private not for profit agency which is licensed to provide mental health services in Washington State. The agency has contracted with the PRSN to provide public mental health services in eastern Jefferson County since 1990. The agency contracts with the PRSN for mental health services and has various other governmental grants for specific services. JMHS has a mental health budget of over \$2,000,000 per year and with an overall staffing of 35 individuals. The PRSN is the largest revenue source for the agency, comprising approximately 85% of total revenues.

JMHS uses Quickbooks for the agencies financial system. The agency hires an independent CPA firm to conduct a financial audit annually. The agency has a business manager who is responsible for managing the financial accounts of the agency.

JMHS has a chart of accounts which meets the needs of the agency. The accounts are set up to segregate costs to specific programs established by the agency. The agency continues to refine its cost allocation procedures for costs shared among programs.

The PRSN used a specific protocol to conduct this monitoring visit. The protocol was filled out by the agency prior to the arrival of the monitoring team. The team reviewed the agencies answers, asking for clarification and explanations when necessary.

REVENUE AND EXPENDITURE REPORT RECONCILIATION

The monitoring team examined the agencies August and September 2014 Revenue and Expenditure reports, and had the agency walk through the process of developing the report. Using agency accounting records as a starting point, the monitoring team was able to understand how agency data fit into the state reporting format. The agency has made great strides in moving towards a system that allows for the proper allocation of costs to specific programs. In reviewing the reports, it appears the agency needs to make a couple of adjustments in how administrative and program expenses are allocated to third party revenue streams. The PRSN is open to working with the agency as they define mechanisms to allocate these costs, or to reviewing the agency's proposed process.

Overall, the review team was pleased with the steps the agency has taken to adequately segregate expenses, and are very appreciative of the agency's efforts.

FEDERAL BLOCK GRANT

During this period, the agency received Federal Block Grant funding for Stabilization service, Housing Repairs and Non-Medicaid Services.

Service information was monitored while on site for Stabilization services, and these were found to be appropriately documented.

Non-Medicaid services were monitored remotely, utilizing a list of billed services for the months of August and September provided by the agency. One of the consumers billed for is actually Medicaid eligible during the service month, and the agency is in the process of defining alternative eligible services to substitute for these services.

JAIL SERVICES FUNDING

Jefferson Mental Health Services did not bill the PRSN for Jail Services since June of 2013, leaving over \$22,000 in potential revenue untapped. The agency is urged to review their practices with regards to serving individuals who are incarcerated, and bill Jail Services funding accordingly.

GENERAL

During the course of reviewing agency records for this review, the following issues were identified which need correction:

- The insurance certificate did not have the contractual combined auto required coverage, and the additional insureds listed were not in compliance with the contract.

- Fiscal policies state that records will be maintained for five years, while the contract requires records retention of 6 years from the end of the contract.
- Only half of reviewed time sheets were signed by supervisors – all time sheets should be reviewed by the direct supervisor.
- The agency continues to lack a written travel reimbursement policy.

Findings:

1. Correct insurance coverage and endorsements
2. Modify Fiscal policies
3. Ensure that all time sheets are reviewed by supervisors
4. Create a travel reimbursement policy
5. Develop a cost allocation procedure which allocates administrative costs to third party payors
6. Modify Federal Block Grant billing to ensure that FBG is not being used to reimburse for Medicaid eligible costs

The review team was very pleased with the strides the agency has made to ensure that accounting is in keeping with PRSN expectations and requirements, and very much appreciates the agencies efforts.

Peninsula RSN Monitoring Report for Kitsap Mental Health Services FY 2014

Items Monitored:

Local Medicaid Match
Revenue and Expenditures Report Reconciliation
Federal Block Grant
ECS Services
PACT Services (Team 1 and Team 2)
Jail Services
Crisis Services

Site Visit: July 9, 2015

On July 9, 2015, a Peninsula Regional Support Network (PRSN) review team made up of Mavis Beach and Richard VanCleave conducted an on-site monitoring visit at Kitsap Mental Health Services (KMHS). The monitoring visit covered the period October 1, 2014 to December 31, 2014. The visit had five objectives: 1) to verify that sufficient local funds eligible as match for the Medicaid program were available during the period covered by the monitoring visit to justify the Medicaid Match claimed by the agency, 2) to track expenses reported by the agency to the PRSN on Revenue and Expenditure reports back through the agency's accounting system, 3) monitor the agencies PACT project expenditures, 4) monitor contract compliance with legislative intent on the use of Jail Services funding 5) ensure that the use of Medicaid and state funds were accurately identified and billed for crisis services and 6) ensure that ECS funds were monitored and billed correctly.

The State of Washington Department of Social and Health Services requires Regional Support Networks to submit quarterly Revenue and Expenditure reports to the DSHS Mental Health Division. Because the PRSN pays its provider network on a capitated basis, it must rely on the expenditure reports of our provider network to properly account for expenditures across programs and revenue streams. The complexity of the Revenue and Expenditure reporting system requires significant effort on the part of RSNs and provider agencies in order to properly allocate expenditures. The allocation of costs between programs and revenue streams must begin at the provider level in order for the overall regional report to accurately reflect program costs.

KMHS is a private not for profit agency which is licensed to provide mental health services in Washington State. The agency has contracted with the PRSN to provide public mental health services in Kitsap County since 1990. KMHS is the largest mental health center the PRSN contracts with, with an overall agency budget of over 21,283,344 per year and with an overall staffing of 383 individuals. The PRSN is the largest revenue source for the agency, comprising approximately 83% of total revenues.

The agency contracts with the accounting firm of Ball and Treger to conduct an independent audit each year. The agency employs an experienced accountant as their finance manager. They have a full bookkeeping and accounting department within the agency, and the business manager has been with the agency for an extended period of time.

Kitsap Mental Health Services has a chart of accounts which meets the needs of the agency and its independent board of directors. The accounts are set up to segregate costs to specific program accounts established by the agency. The agency finance manager is experienced in accounting within the public mental health system, and well versed in creating allocation plans which are well founded and result in the accurate distribution of costs. The systems used to allocate costs also account for costs which are not reimbursable by certain funding streams such as Federal Block Grant and Medicaid.

The PRSN used a monitoring protocol for the site visit that was to be filled out by the agency prior to the arrival of the monitoring team. The agency did not fill out the form, but reported to the monitoring team that fiscal procedures had not changed from the year before.

MATCH

Kitsap Mental Health Services uses local school district revenues as a source of match for additional Federal Medicaid revenue. School districts contract with KMHS for access to the therapeutic day treatment program operated by KMHS. Each of the school contracts includes the statement that the funds being used for this contract are not federal funds. No donations are used for local match. Accounting records were reviewed for the period covered by this review, and the agency records demonstrated revenue sufficient to support the additional match requested by KMHS.

FEDERAL BLOCK GRANT

During the review period, Kitsap Mental Health Services used Federal Block Grant funds to pay for a variety of activities, including protective payee services, rent subsidies, property damage repair, and screening, brief intervention and referral to treatment (SBIRT) services. The review team examined records for two months of expense claims. The agency accounting records were able to fully support the reimbursement requests made by the agency. There was clear documentation indicating how rent subsidies were awarded, records of payment for rent, and invoices for repair costs. Payee costs were demonstrated by showing employee costs assigned to that program.

The agency has been using some FBG funds for SBIRT services. These screening services were provided to individuals calling the agency to request information, services, and/or referral to other resources. A recent clarification of use of FBG funds indicated that monies from this grant could no longer be used for screening services. As a result, KMHS will not use FBG for SBIRT in this coming fiscal year.

REVENUE AND EXPENDITURE REPORT RECONCILIATION

The monitoring team examined the agency's October through December 2015 Revenue and Expenditure report. The finance manager provided a significant amount of back up documentation that supported the numbers found in the R&E report. During the review, we were able to track the numbers from the supporting documentation up to the figures on the report. One significant change from previous years was that the agency now uses actual costs in developing

the R&E report. Previously, KMHS used revenue as a starting point and allocated "costs" within each department. The finance manager reported that the new, more accurate method of reporting actual costs was easier to develop. At the same time, the RSN appreciates being able to see the agencies actual operating costs.

PACT EXPENDITURES

The monitoring team reviewed the agency's revenues and expenditures associated with both PACT teams. Program expenditures were reviewed to ensure that sufficient expenditures were incurred to justify the program billings to the PRSN. The PACT reports showed line items for actual employee and other business costs. The report also demonstrated reconciliation of Medicaid and non-Medicaid billing for the period. The review revealed that sufficient expenditures existed and billings were accurate.

JAIL SERVICES

Funding is provided by the Washington State Legislature to fund necessary mental health services in local jails, assistance with the application for benefits, and transitional services for mentally ill individuals returning to local communities from jails. There are two approaches to funding jail services in PRSN. Juvenile jail services at KMHS are funded by staff allocation. Fiscal staff at KMHS were able to walk the review team through the process for determining which employee costs (% of employee time) were allocated to the juvenile jail services.

The adult jail services are funding on a fee-for-service approach. The jail services fiscal report and supporting documentation indicated which jail services were billed to the RSN. The PRSN allows agencies to bill for other "pay points" in addition to services in the jail (e.g. successfully helping an individual obtain Medicaid). The agency indicated that they had not taken advantage of these pay points.

ECS SERVICES

The agency is provided funding for ECS services. The goal of this funding is to provide increased services in order to prevent individuals from returning to the state hospital. The agency is currently funded for four ECS consumers. KMHS fiscal staff was able to provide documentation indicating how they ensure that the minimum number of contract days of service are met before billing the RSN for ECS funds.

CRISIS SERVICES

The focus of the crisis services review was to ensure that the percentage of crisis services billed to Medicaid and non-Medicaid was accurate. The crisis services budget report supported the cost allocation indicated on the R&E report. KMHS provided documentation showing how they determined the correct allocation of Medicaid and non-Medicaid funding for crisis services. The agency verifies funding for each individual identified in the Medicaid eligibility download file from the state, then makes corrections to eligibility records in their own system. The documentation included print-outs showing which consumers were identified as misidentified in the Medicaid eligibility download.

FINDINGS

There were no findings associated with this review.



Peninsula Regional Support Network (PRSN)

Encounter Data Validation Deliverable

Contract Year 2013-2014

Prepared by
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Prepared for
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State of Washington

Date: Sept 2014

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Study Approaches and Methods

Request for record and review process

Clinical entries and narratives in Profiler, the electronic medical record (EMR) used by all PRSN Network Agencies, were compared to data that had been submitted to the Provider One system and then transferred to The Department of Behavioral Health's Consumer Information System (CIS). This exercise allows us to validate that the data submitted to the state's system and returned to the RSN remains accurate and in tact during the transmission process.

PRSN staff attended a pre review meeting to go over instructions and staff each completed a series of identical entries to ensure there was an inter rater reliability agreement system in place. Staff also attended a post review meetings to answer questions and discuss trends and/or anomalies. Further the review was scheduled on a day that all PRSN staff could work on it simultaneously so that staff could have discussions regarding scoring in real time, thereby supporting efforts toward increased inter-rater reliability. All clinical entries and narratives were accessed through the Pro-Filer EMR.

Staff Involved

Reviews were accomplished by the following PRSN staff:

- Richard VanCleave, MA, LMHC - Clinical Manager
- Stacey Smith, M. Ed, LMHC, CMHS - Resource Manager and Compliance Officer
- Toby Bingham, M. Ed, LMHC, CMHS - Children's Manager
- Michelle Alger, MA, LMHC, NCC - Quality Assurance Manager and HIPAA Officer

Study Time Frame

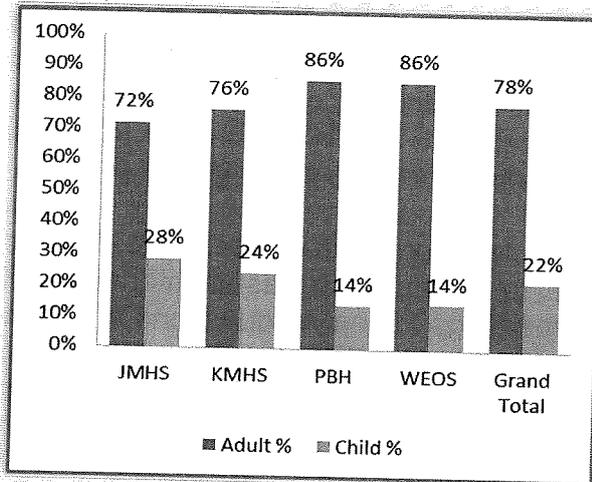
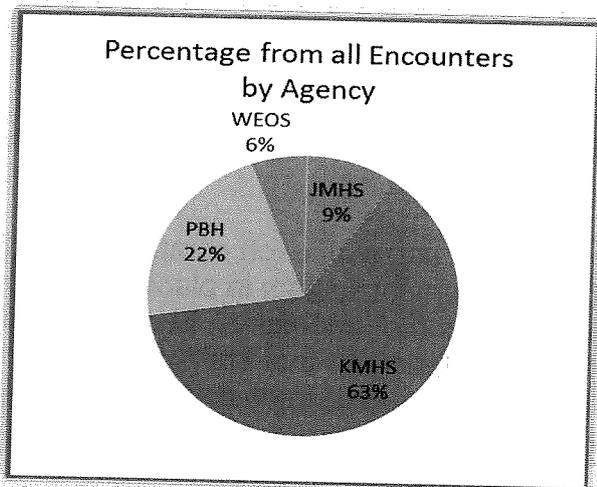
Reviews were completed September 23, 2014. The reviews included encounters that were submitted in the Federal fiscal year of October 1, 2013 and September 30, 2014. The specific months that reviewed encounters occurred are described in Table 1: Stratification by Numbers of Encounters and Client Records per Network Agency.

Sampling Methodology, Data source, and Stratification

The sample exceeded 411 of all encounters submitted between February 2014 and May 2014 for each PRSN Network Provider. A random sample of clients for whom encounters were submitted during the contract year was selected. The data source for the sampling selection was a data extract generated from The Department's CIS data system. The report included an accounting of encounters and associated data elements that have been submitted to The Department, processed and returned to the RSN. The random sampling methodology included the following:

- A pivot table with the count of each client ID was created in Excel from the encounters which occurred during the timeframe of the review.
- A column was then added to the Excel sheet with a random number generator formula (RAND()) executed so that each client was assigned a random number generated by Excel.
- The client ID's gathered from the pivot table were then sorted by the randomly assigned number. Five encounters per consumer became the sample for review.
- If there were more than the desired number of encounters for a client only the first 5 were accepted.
- This method was done for both adults and children in the specified time frame.
- The Excel worksheets were frozen, except for drop down boxes answering data validation questions, to prevent accidental changes to the data.

The data for the time period in question was reviewed and stratified to select both percentages that were representative of the number of clients served per agency as well as by age.



Age Group	JMHS	KMHS	PBH	WEOS	Grand Total
Adult	13017	90331	35298	9402	148048
Child	5117	28361	5760	1586	40824
Grand Total	18134	118692	41058	10988	188872
Adult %	72%	76%	86%	86%	78%
Child %	28%	24%	14%	14%	22%

Table 1: Stratification by Numbers of Encounters and Client Records per Network Agency

Service Time period:	KMHS		PBH		JMHS		WEOS		Region Total	
	Client Records	Encounters								
February – May 2014	268	313	82	96	48	58	25	33	423	500
Percentage of Reviewed Encounters	62.8%		21.7%		9.6%		5.8%		100%	
Number of applicable encounters submitted between 02/1/2014-05/30/2014	37558		12138		5402		3311		58409	
Percentage of overall encounters	62.6%		19.2%		11.6%		6.6%			

Scoring Methods, Record Review Tool, and Audit Guide

In accordance with the State and PIHP contracts, the following elements were reviewed to determine whether the accounting of encounters from the PRSN IS matched the information documented in the EMR:

- Date
- Code
- Modifier
- Provider Name
- Service Provider Type
- Service Location
- Duration
- Service Code Agrees with Treatment Described

The review of the Code and Modifier had two parts: 1) A review of whether the code in the EMR matched the code on the report (accuracy), and 2) an assessment of the clinical narrative documented for each coded service to determine whether the use of the code was valid and appropriate (validity). The validity portion of the review included looking for evidence that the service reported actually occurred, and judging whether the service description demonstrated medical necessity. Medical necessity was met if the use of the code was generally consistent with the Service Encounter Reporting Instructions (SERI), and there were sufficient descriptions of clinical content of the service, such as the interventions and mental health-related issues the service addressed.

Scoring Standards

Based on the standards defined in the State and PIHP contracts the data elements were all reviewed and scored using the following standards:

Match: The information on the report matches the information in the record

Erroneous: There is a record representing the encounter, but the information does not match

Unsubstantiated: The encounter on the report cannot be verified (i.e. it is completely absent in the electronic record, or it is duplicated)

Missing: Any encounter in the record that was not represented by an encounter on the report

The following standards were used for part two (2) of the code/modifier review which focused on the validity and appropriateness of code use:

Match: The clinical documentation in Profiler is consistent with the service description in the SERI, and demonstrates medical necessity.

Erroneous- Inappropriate code used: Based on the clinical documentation, a different code should have been used. Reviewers provided a short narrative explaining the reason for concluding the incorrect code was used.

Unsubstantiated-

Not Encounterable: The documentation of the service indicates that the event did not meet criteria for any allowable service code in the SERI. Reviewers provided a short narrative explaining the reason for concluding the code use was invalid.

Duplicate Service: The documentation of the service indicates the service was reported more than once or occurred at the same time as another service.

Missing: Clinical record contains evidence of a service but is not represented by the clinical record.

Record Review Tool and Audit Guide

The record review tool was a spreadsheet that included the following information for each encounter:

- Contractor
- RUID / Agency,
- Profiler Client ID,
- Claim ID
- CID
- Service Date,
- Service Location
- CPT Code
- Service Minutes,
- Payor Source
- Service Provider Type
- Modifier

And the following questions that correspond with the audit guide (see below)

- Does the date match?
- Does the service code agree with treatment described?
- Comments (regarding service provided and treatment note):
- Does the place of service match?
- Does the duration match?
- Does the code on report match?
- Does the modifier match?
- Does the provider match?
- Does the provider type match?
- Comments:

Data Analysis Results

Aggregated results for each data element per contract by Region

The following table includes the aggregate results of the 4000 data elements reviewed, by error types. The data elements summarized include:

- **Date of Service**
- **Name of service provider**
- **Service location**
- **Treatment matches code**
- **Procedure Code & Modifiers:** Includes scores of part 2 (Code Use Validity) of the code/modifier review.
- **Number of Minutes**
- **Provider Type**

Table 2: Aggregate Results of Data Match per Data Element for Region with *Duration element removed*

		PIHP		State		Grand Total		Comments
Match		3005	99.4%	473	99.4%	3478	99.4%	Previous year's score: 99.7%
No Match	Missing	0	0.0%	0	0.0%	0	0.0%	Previous year's score: 0.0%
	Erroneous	15	0.5%	3	0.6%	18	0.5%	Previous year's score: 0.2%
	Unsubstantiated	4	0.1%	0	0.0%	4	0.1%	Previous year's score: 0.08%
Total "No Match"		19	0.6%	3	0.6%	22	0.6%	Previous year's score: 0.3%
Grand Total of Data Elements Reviewed:		3024		476		3500		

*These results exclude all data duration element due to a known 'duration match' issue.

Summary of results of error type by encounter

The following table includes the results by error types, per encounter reviewed. If any one of data elements listed below was not a match, the entire encounter was counted in the "no match" category. If any data element was considered unsubstantiated, the entire encounter was counted in the "unsubstantiated" sub- category of "no match". The following data elements were included in this analysis:

- Date of Service
- Name of service provider
- Service location
- Procedure Code/Modifier: Includes scores of part 2 (Code Use Validity) of the code/modifier review.
- Number of Minutes (duration)
- Provider Type

Table 3: Summary of Results per Encounter for Region *each encounters may have discrepancies counted in more than one category.

		PIHP		State		Grand Total		Comments
Match		313	72.5%	41	60.3%	354	70.8%	Previous Year Score: 97.1%
No Match	Missing	11	2.5%	3	4.4%	14	2.8%	Previous Year Score: 0.0%
	Erroneous	94	21.8%	24	35.3%	118	23.6%	Previous Year Score: 2.2%
	Unsubstantiated	4	0.9%	1	1.5%	5	0.1%	Previous Year Score: 0.72%
Total "No Match"		119	27.5%	27	39.7%	146	29.2%	Previous Year Score: 3.0%
Grand Total of Encounters Reviewed:		432		68		500		

This year's encounter data validation revealed a much higher number of errors than in previous years. An in depth review of the data demonstrated that the majority of the errors were in the element of duration (minute/unit) match. A conversation with The Department of Behavioral Health and Recovery's Target System Manager revealed that there is a known issue with the state's contracted reporting data system. It is further documented as a problem with the state's contracted ProviderOne reporting system in Acumentra Health's External Quality Review Report dated July 2014. This report reviews the 2011-2012 encounter data validation and on page three of this report it states, "Due to a known issue with ProviderOne processing of service minutes and units, service duration matched in only 77.1% of encounters." PRSN staff has been an active participant in both Data Quality and Performance Indicator Work Group in working with state to identify and rectify this issue.

This is an existing state system issue and we are unable to effect change or impact these issues from our processes or system. Due to these constraints and upon the advice of both Acumentra and The Department, we will be removing all duration errors from the data compilation summaries; however we will be reporting these findings to the external quality review organization in the next review. Table 4 below is a summary of results per encounter with the 136 questionable duration inaccuracies removed from the total.

Table 4: Summary of Results per Encounter for Region with Duration Errors Removed

		PIHP		State		Grand Total		Comments
Match		313	97.2%	41	97.6%	354	97.3%	Previous Year Score: 97.1%
No Match	Missing	0	0.0%	0	0.0%	0	0.0%	Previous Year Score: 0.0%
	Erroneous	7	2.2%	1	2.4%	8	2.2%	Previous Year Score: 2.2%
	Unsubstantiated	2	0.6%	0	0.0%	2	0.5%	Previous Year Score: 0.72%
Total "No Match"		9	2.8%	1	2.4%	10	2.7%	Previous Year Score: 3.0%
Grand Total of Encounters Reviewed:		322		42		364		

Based on the aggregated results of the required data elements calculated according to the formula presented in the PIHP and State Contracts, it appears that the data integrity of PRSN is within the acceptable range. When the review results are summarized per encounter as opposed to per data element, the code validity portion of the review carries more weight, yet PRSN encounter data is still well within the acceptable range of 95% for matching, and within the 2% standard for unsubstantiated.

The following data tables summarize the results for each data element and describe findings:

Table 4: Review of Data Accuracy per Data Element for Region

		PIHP		State		Grand Total		Comments
Date								
Match	432	100%	68	100%	500	100%		
Erroneous	0	0.0%	0	0.0%	0	0.0%		
Unsubstantiated	0	0.0%	0	0.0%	0	0.0%		
Missing	0	0.0%	0	0.0%	0	0.0%		
Grand Total	432		68		500			
Code:								
Match	432	100%	68	100%	500	100%		
Erroneous	0	0.0%	0	0.0%	0	0.0%		
Unsubstantiated	0	0.0%	0	0.0%	0	0.0%		
Missing	0	0.0%	0	0.0%	0	0.0%		
Grand Total	432		68		500			
Modifier:								
Match/n/a	432	100%	68	100%	500	100%		

	PIHP		State		Grand Total	
Erroneous	0	0.0%	0	0.0%	0	0.0%
Unsubstantiated	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%
Grand Total	432		68		500	
Provider:						
Match	432	100%	68	100%	500	100%
Erroneous	0	0.0%	0	0.0%	0	0.0%
Unsubstantiated	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%
Grand Total	432		68		500	
Provider Type:						
Match	420	97.2%	67	99.0%	487	97.4%
Erroneous	12	2.8%	1	1.5%	13	2.6%
Unsubstantiated	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%
Grand Total	432		68		500	
Location:						
Match	431	99.8%	68	100%	499	99.8%
Erroneous	1	0.2%	0	0.0%	1	0.2%
Unsubstantiated	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	0	0.0%
Grand Total	432		68		500	
*Duration:						
Match	322	0.0%	42	0.0%	364	100.0%
Erroneous	0	0.0%	0	0.0%	110	0.0%
Unsubstantiated	0	0.0%	0	0.0%	0	0.0%
Missing	0	0.0%	0	0.0%	26	0.0%
Grand Total	322		42		364	

*This summary of the duration element excludes the known data issues from the state system.

Table 5: Summary of Review of Code Validity (Part 2 of Code/Modifier Review)

Review of Code Use Validity							
	PIHP		State		Total		Comments:
1. Match	427	98.8%	67	98.5%	494	98.8%	Previous year's score: 98.4%
2. Erroneous	1	0.2%	0	0.0%	1	0.2%	Previous year's score: 1.1%
3. Unsubstantiated	4	0.9%	1	1.5%	5	1.0%	Previous year's score: 0.8%
4. Missing	0	0.0%	0	0.0%	0	0.0%	Previous year's score: 0.0%
Grand Total	432		68		500		

The following tables provide a summary of the code use portion of the review, broken down by code:

Table 6: Review of Code Validity by Code: Match

1. Match							
Match is defined as: The service description for code used was generally consistent with the Service Encounter Reporting Instructions (SERI), and there were adequate descriptions of clinical content of the service, interventions, and mental health-related issue the service addressed. Consistency of services with treatment plans are a basic component of a valid service, and this was not explicitly reviewed this time due to the onerous process of locating the treatment plan in two electronic medical systems.							
	PIHP		State		Total		Comments:
90832	2	0.5%	0	0.0%	2	0.4%	
90834	2	0.5%	0	0.0%	2	0.4%	
90837	26	6.0%	4	0.0%	30	6.0%	
90846	1	0.2%	0	0.0%	1	0.2%	
90847	17	4.0%	0	0.0%	17	3.4%	
90853	3	0.7%	1	0.0%	4	0.8%	
90889	1	0.2%	0	0.0%	1	0.2%	
96372	1	0.2%	0	0.0%	1	0.2%	
99213	4	0.9%	0	0.0%	4	0.2%	
99214	20	4.6%	1	1.5%	21	4.2%	
99215	0	0.0%	1	1.5%	1	0.2%	
H0019	35	8.1%	3	4.5%	38	7.6%	
H0023	15	3.5%	1	1.5%	16	3.2%	
H0031	12	2.8%	0	0.0%	12	2.4%	
H0033	14	3.2%	3	4.5%	17	3.4%	
H0036	125	29%	16	23.9%	141	28.2%	
H0038	7	1.6%	2	3.0%	9	1.8%	
H0046	17	3.9%	3	4.5%	20	4.0%	
H2011	11	2.5%	9	13.4%	20	4.0%	

1. Match

Match is defined as: The service description for code used was generally consistent with the Service Encounter Reporting Instructions (SERI), and there were adequate descriptions of clinical content of the service, interventions, and mental health-related issue the service addressed. Consistency of services with treatment plans are a basic component of a valid service, and this was not explicitly reviewed this time due to the onerous process of locating the treatment plan in two electronic medical systems.

	PIHP		State		Total		Comments:
H2012	42	9.7%	16	23.8%	58	11.6%	
H2015	41	9.5%	1	1.5%	42	8.4%	
S9446	10	2.3%	4	6.0%	14	2.8%	
T1001	20	4.6	2	3.0%	22	4.4%	
Grand Total	427/432	99.8%	67/68	98.5%	494/500	98.8%	

Table 7: Review of Code Use Validity by Code: Erroneous

2. Erroneous

Inappropriate Code Used is defined as: Description of Service indicated that the service was valid, but was more consistent with a different code.

	PIHP		State		Total		Comments:
H2011	1	0.2%	0	0.0%	1	0.2%	Coded as crisis intervention service, per 15 minutes but note clearly states the service was an intake and should have been encountered as intake.
Grand Total	1		0		1	0.2%	

Table 8: Review of Code Use Validity by Code: Unsubstantiated

3. Unsubstantiated

Justification is Questionable or Unclear is defined as: Description of service provided an unclear justification as to whether it fully met requirements for a valid reimbursable service.

	PIHP		State		Total		Comments:
S9446	1	0.2%	0	0.0%	1	0.2%	Note stated "active participant". There is not adequate clinical content to verify service. 1- Note states this was an email, which is not encounter-able. 2- Note states a phone call with no answer. This is not billable.
H2015	2	0.5%	0	0.0%	2	0.4%	Note states call to client to 'see if she is up for the visit.' Appears this was a reminder call as no clinical content was noted.
H0046	1	0.2%	0	0.0%	1	0.2%	Note states client no-showed for appointment. Appears no service
90853	0	0.0%	1	1.5%	1	0.2%	Note states client no-showed for appointment. Appears no service
Grand Total	4		1		5	1.0%	

* There were no errors in review of code use validity for the category of Missing.

Aggregated results for each data element per contract by CMHA

The following table includes the aggregate results of the 4932 data elements reviewed, by error types. The data elements summarized include:

- **Date of Service**
- **Name of service provider**
- **Service location**
- **Procedure Code/Modifier:** Includes scores of part 2 (Code Use Validity) of the code/modifier review.
- **Number of Minutes**
- **Provider**
- **Provider Type**

Table 9: Aggregate Overall Match and Rate Error Type by CMHA

CMHAs	Match		No Match					
			Erroneous		Missing		Unsubstantiated	
	#	%	#	%	#	%	#	%
KMHS	2409/2425	99.3%	14	5.8%	0	0.0%	2	.08%
PBH	732/733	99.9%	0	0.0%	0	0.0%	1	1.4%
JMHS	443/445	99.6%	1	0.2%	0	0.0%	1	0.2%
WEOS	260/261	99.6%	0	0.0%	0	0.0%	1	0.4%

*This summary of the duration element excludes the known data issues from the state system from both the numerator and denominator.

From the table of aggregated matches by agency we can see that all agencies were well above the accepted standard required by contract.

Table 10: Results of Data Match per Data Element by CMHA

Encounter Data Element CMHA	KMHS		PBH		JMHS		WEOS	
	#	%	#	%	#	%	#	%
Date of Service	313/313	100.0%	96/96	100.0%	58/58	100.0%	33/33	100.0%
Service Location	313/313	100.0%	96/96	100.0%	57/58	98.3%	33/33	100.0%
Procedure Code	313/313	100.0%	96/96	100.0%	58/58	100.0%	33/33	100.0%
Procedure Modifier	313/313	100.0%	96/96	100.0%	58/58	100.0%	33/33	100.0%
Service Unit / Duration*	234/234	100.0%	61/61	100.0%	39/39	100.0%	30/30	100.0%
Provider	313/313	100.0%	96/96	100.0%	58/58	100.0%	33/33	100.0%
Provider Type	300/313	95.8%	96/96	100.0%	58/58	100.0%	33/33	100.0%
Service Code agree with Treatment described	310/313	99.0%	95/96	99.0%	57/58	98.3%	32/33	96.7

*This summary of the duration element excludes the known data issues from the state system from both numerator and denominator.

Conclusions and Recommendations

Limitations and Opportunities for Improvement

Limitations and opportunities for improvement revealed by this study primarily include the study design prescribed in the contract.

In the 2014 External Quality Review Report the recommendations were made to:

- 1) Implement an inter-rater reliability system to ensure consistency.
- 2) Provide break out scoring for each agency
- 3) Use The Department's data in this data matching exercise.

PRSN has embraced the recommendations from Aumentra's External Quality Review Report and responded to these recommendations by:

- 1) Continuing to utilize an inter-rater reliability system. This practice has been implemented in previous years and continues to be used currently. The practice (described at the top of page 2 in this report) includes:
 - Scheduling the exercise when all PRSN staff that participate in the exercise are available and working simultaneously to allow for real time discussion and collaboration;
 - A pre review meeting to go over instructions, scoring guidelines and answer questions as a team;
 - As per the Aumentra training on Encounter Data Validation Exercise of June 2013, all participating staff completed practice chart review to ensure the tool works properly and to work through any answer questions on the process;
 - A post review meeting to discuss finding.
- 2) Including agency specific scoring in this report. In previous years PRSN had provided each agency with an individualized version of this report that addresses their particulars in detail. This year we have included all agency findings in one report.
- 3) Use The Department's data. For the first time PRSN has utilized The Department's data for this exercise. We used the OP_Svc_v4, which is a data extract from the DBHR CIS data system. There were multiple challenges in utilizing this data including:
 - Extracting the data for the specific time period from the large data file;
 - Cross-walking all codes (Contractor code, RUID code, Location code, CPT code and Provider Type code) into a useable format for comparison.
 - Working through known system issues, such as the errors in the duration (minutes/units) data element.

Summary of Findings and Corrective Action Plans/Activities

Generally the agencies that contract with PRSN had a high degree of accuracy and validity in their encounters. All providers were well above the 95% standard for no match errors and had less than the 2% allowed unsubstantiated errors. Most elements reviewed had no errors noted in data elements, including date of service, provider, duration, procedure code and procedure modifier and only slight errors noted in remaining 3 elements. There were no significant themes noted in the code use validity from this review. Items noted as being coded invalidly were small in comparison to the overall numbers.

The only element that showed any trend was within the provider type element. There were 2 trends noted within this element.

- 1) It was found that 10 of 13 errors noted were coded in The Department's data as "not applicable" while the clinical chart showed a staff credential. These were marked as erroneous in this report.
- 2) There were also 3 encounter records noted that The Department data listed as a credential that did not match our own data and were marked erroneous in this report.

Both of these items were addressed with our IT subcontractor, Kitsap Mental Health Services. While neither issue rose to the level of requiring a corrective action, both have already investigated and corrected.

The review of all data elements (with the exception of duration) scored very well and any errors found were not significant enough to warrant a corrective action. These errors were reported to their respective agencies for their review and action.

The results of this year's review are very consistent with the findings from the previous year. A comparison between years showed less than 1 percent difference in any category. PRSN will continue to monitor for sustainability of this high level of accuracy in data reporting.

APPENDIX

PRSN Data Validation Audit Guide

MATCH	ERRONEOUS	UNSUBSTANTIATED
M = The information on the report matches the information in Profiler	E = There is an electronic record representing this encounter but the information does not match	U = The encounter on the report cannot be verified (i.e. it is completely absent in the electronic record, or there is no evidence that an "encounter-able" service occurred, or it is duplicated on the report
Svc Date	Match: The date on the report matches the date in Profiler Erroneous: There is an electronic record representing this encounter but the date does not match. Unsubstantiated: The encounter on the report cannot be verified in Profiler (it's absent), or is duplicated on the report.	
Code on report	Match: The code on the report matches the date in Profiler Erroneous: There is an electronic record representing this encounter but the code does not match. Unsubstantiated: The encounter on the report cannot be verified in Profiler (it's absent) or is duplicated on the report.	
Mod 1 and 2 on report	Match: The code on the report matches the date in Profiler Erroneous: There is an electronic record representing this encounter but the code does not match. Unsubstantiated: The encounter on the report cannot be verified in Profiler (it's absent) or is duplicated on the report.	
Does Procedure Code match content of note	Match: The clinical documentation in Profiler is consistent with the service description in the SERI, and demonstrates medical necessity Inappropriate code used: Based on the clinical documentation, a different code should have been used: (describe the code that should have been used in the comments section). Unsubstantiated: The documentation of the service indicates that the service is not encounter-able: (describe the justification for this in the comments section). See Comments: Unsure of whether note is consistent with the service description in SERI, whether a different code should have been used, or whether the note was encounter-able (describe issue in the comments section).	
Comments	Comment on any issues regarding whether the procedure code and content of the note match.	
Provider	Match: The provider name on the report matches the provider name in Profiler Erroneous: There is an electronic record representing this encounter but the provider name does not match. Unsubstantiated: The encounter on the report cannot be verified in Profiler (it's absent), or is duplicated on the report.	
Provider Type	Match: The provider type on the report matches the provider type in Profiler Erroneous: There is an electronic record representing this encounter but the provider name does not match. Unsubstantiated: The encounter on the report cannot be verified in Profiler (it's absent), or is duplicated on the report.	
Location	Match: The location on the report matches the location in Profiler Erroneous: There is an electronic record representing this encounter but the location does not match. Unsubstantiated: The encounter on the report cannot be verified in Profiler (it's absent), or is duplicated on the report.	
Duration	Match: The duration on the report matches the duration in Profiler Erroneous: There is an electronic record representing this encounter but the duration does not match. Unsubstantiated: The encounter on the report cannot be verified in Profiler (it's absent), or is duplicated on the report.	
Funding	PIHP: The payor for an RSN funded Service is Medicaid/Title 19 STATE: The payor for an RSN funded service is not Medicaid/Title 19 If there is an encounter that is unsubstantiated, choose the payor for the other encounters that are substantiated for that month.	
Comments	For any errors or unsubstantiated findings, describe the issue here. If there are any encounters in Profiler that are not on the report (missing) record the service description, code, date, and duration here.	



Salish BHO

INPATIENT POLICIES AND PROCEDURES

Policy Name: ADMISSION and DISCHARGE
COORDINATION of INPATIENT CARE

Policy Number: 12.06

Reference: WAC 388-865-0229, -0320, -0425, -0510;
DSHS Contract

Effective Date: 10/2005

Revision Date(s): 2/2013

Reviewed Date: 8/2015

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that effective service coordination takes place between inpatient and community care services. Coordination efforts are designed to ensure that an individual's care is coordinated between the two (2) levels of care, that discharge planning is appropriate, and that appropriate community services are provided upon discharge.

PROCEDURE

Inpatient Services

1. The SBHO maintains formal policies and agreements with inpatient service providers that clearly define processes for providing:
 - a. Culturally competent services
 - b. Voluntary treatment
 - c. Referrals
 - d. Admissions
 - e. Discharges

- f. Discharge Treatment Plans
 - g. Involuntary evaluation and treatment
2. The SBHO maintains agreements with sufficient numbers of certified involuntary evaluation and treatment facilities to ensure that consumers eligible for regional support network services have access to involuntary inpatient care. The agreements and contracts with our contracted network providers address regional support network responsibility for discharge planning.
 3. The SBHO ensures that all service providers that provide evaluation and treatment services are currently certified by the Department and licensed by the Department of Health.
 4. The SBHO conducts periodic reviews of the evaluation and treatment service facilities consistent with SBHO procedures and notifies the appropriate authorities if a facility is not in compliance with applicable statutes, rules and regulations.
 5. The SBHO, through the Administrative Service Organization (ASO) subcontracted to conduct the authorization functions, authorizes admissions, transfers and discharges into and out of inpatient evaluation and treatment services for eligible consumers including:
 - a. Community hospitals providing inpatient psychiatric services
 - b. Residential inpatient evaluation and treatment facilities licensed by the department of health as adult residential rehabilitation centers
 - c. Discharges from inpatient settings with transfers to State psychiatric hospitals
 - d. Discharges from inpatient settings with transfers to Children's long-term inpatient program
 6. The SBHO will receive prior approval from the Department in the form of a single bed certification for services to be provided to consumers on a ninety (90) or one hundred eighty (180) day involuntary commitment order in a community inpatient facility consistent with the exception criteria in WAC 388-865-0502; and will identify in the agreement with the Department and any of these duties is has delegated to a subcontractor.

Community Care Services

1. The SBHO maintains formal contracts with Community Mental Health Agencies (CMHA) that clearly define processes for providing:
 - a. Emergency crisis intervention services
 - b. Case management services
 - c. Psychiatric treatment including medication supervision
 - d. Counseling and psychotherapy services

- e. Day treatment services as defined in RCW 71.24.300(5) and 71.24.035(7)
 - f. Consumer employment services as defined in RCW 71.24.035 (5)(e)
 - g. Peer support services
- 2. The SBHO contracts with a sufficient number and variety of culturally competent and age appropriate licensed and/or certified providers to ensure that eligible consumers have access to services
 - 3. The SBHO conducts prescreening determinations for providing community support services for persons with mental illness who are being considered for placement in nursing homes (RCW 71.24.025(7) and 71.24.025(9))
 - 4. The SBHO completes screenings for persons with mental illness who are being considered for admission to residential services funded by the regional support network (RCW 71.24.025 and 71.24.025(9))

Discharge Planning and Coordination of Care

- 1. All individuals authorized for inpatient care are assigned to a responsible CMHA upon admission.
 - a. The responsible CMHA must contact the inpatient program within three (3) days of admission to coordinate discharge planning and shall provide to the inpatient unit:
 - i. Any available information regarding the Enrollee's treatment history at the time of admission.
 - ii. All available information related to payment resources and coverage
 - iii. A provisional placement plan for the enrollee to return to the community that can be implemented when the enrollee is determined to be ready for discharge by the hospital and the Contractor.
 - iv. If the provisional placement plan for an enrollee cannot be implemented when an enrollee is determined to be ready for discharge, the provider's liaison must convene a meeting of the inpatient treatment team and other discharge plan participants to review action taken to implement the plan, barriers and proposed modifications to the plan. Such meetings shall occur every 30 days until the enrollee has been placed.
 - v. In the event the agency liaison is aware that the enrollee is a Tribal member or receiving mental health services from a Tribe and the enrollee consents, efforts must be made to notify the Tribe to assist in discharge and transition planning.

- b. Contact shall be maintained throughout the inpatient stay.
 - c. CMHA staff shall participate in treatment planning to facilitate timely discharge.
 - d. For Medicaid individuals an appointment with the assigned CMHA shall be offered to the hospitalized individual within seven (7) days of discharge, with a follow-up appointment scheduled within thirty (30) days.
 - The offered seven (7) day follow-up appointment date (and reason for no appointment offered, if applicable) shall be recorded in the Profiler Hospital Authorization screen located in the End User Assessments.
 - e. The provider shall use best efforts to secure an appointment, within 30 days of release from the facility, for medication, evaluation and prescription re-fills for Enrollees discharged from inpatient care, to ensure there is no lapse in prescribed medication.
2. Individuals discharging from inpatient care in community hospitals, Western State Hospital, or a Children Long Term InPatient (CLIP) facility and returning to community based outpatient care, will receive discharge planning from the network provider in the individual's community within contract requirements. The Discharge Treatment Plan is:
- a. Developed by the consumer, social worker, treatment team, and provider staff.
 - b. Indicates all follow-up concerns and plans related to the consumer's post discharge activities.
 - c. Provided to the responsible CMHA's crisis team, case managers, prescribers, or other providers as necessary.
 - d. Given to the consumer, along with all relevant contact materials.

MONITORING

1. This policy is a mandate by contract. This policy will be monitored through use of SBHO:
 - Annual SBHO Provider and Subcontractor Administrative Review
 - Annual Provider Chart Reviews. Charts of individuals receiving inpatient care will be examined to determine if care coordination occurred according to this policy.

- Monthly analysis of 7 Day Follow-up Reports reviewed at SBHO UM meetings
 - Quarterly Provider Performance Reports. The time between discharge and first offered service will be tracked for all individuals receiving inpatient services
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations
 - Average length of stay, overall bed day utilization and per capita utilization will be tracked to determine over or under utilization of inpatient services and effectiveness of discharge coordination.
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval. Reference SBHO Corrective Action Plan Policy.



PENINSULA RSN

INPATIENT POLICIES AND PROCEDURES

Policy Name: VOLUNTARY INPATIENT GATEKEEPING **Policy Number:** 12.02

Reference: WAC 388-865-0229

Effective Date: 2/2002

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Notice of Action Requirements
- Policy: DSHS Inpatient Billing Instructions

PURPOSE

This policy applies to the Peninsula Regional Support Network (PRSN) authorization/certification of voluntary hospitalizations for individuals within the PRSN.

VOLUNTARY ADMISSION CRITERIA

For voluntary admission to an inpatient facility, the following criteria must be met:

1. Determine if the individual has Medicaid or non-Medicaid funding, research third party options.
2. Meets the PRSN Level of Care Criteria for Inpatient Services.
3. All diversion options have been attempted/ reviewed and were not appropriate.
4. **For children only**, there is a consultation by a child mental health specialist that supports the decision to request inpatient hospitalization.

PROCEDURE

1. **Certification Provided at the time of hospital admission:** Certification for Voluntary Hospitalization must be authorized according to the DSHS Inpatient Instructions and PRSN LOC.
 - The PRSN network provider crisis team conducts the initial two (2) hour response and triages a voluntary hospital admission request. The crisis team must request authorization/ certification from the PRSN utilization management subcontractor “CommCare”, prior to the hospital admission.
 - If the request for voluntary hospitalization is from outside the catchment area, CommCare is the first point of contact. CommCare gathers all the clinical and administrative information, makes an initial determination, and contacts the local network agency (DMHP) to consult prior to providing the determination to the hospital.
2. **Length of stay extension authorizations:** Authorization for length of stay extensions provided by following the DSHS Inpatient Instructions and PRSN LOC.
 - For voluntary extension requests for children/ youth at the Youth Inpatient Unit only: All extension requests must be reviewed by the PRSN Children’s Services Manager. Upon review, the PRSN will forward the extension request to the ASO for authorization.
3. **Retroactive certifications authorized in specific circumstances:** If a person is found eligible for Medicaid following admission or following the inpatient stay, these time lines for securing retroactive certification apply per PRSN LOC:
 - a. The network crisis team designated to the individual’s catchment area must receive notification of Medicaid eligibility and request for retro-authorization/ certification within 30 (thirty) days of the determination of Medicaid eligibility, unless the delay was as a result of third party (insurance) claims determination.

*According to the DSHS memo # 0108 (dated 10/17/2008):
“hospitals are allowed to seek retrospective certification of an inpatient stay beyond 30 days after discharge if the delay in seeking authorization resulted from attempts to pursue Medicare or other third party coverage. Prior Authorization must be sought whenever possible.”*

Hospitals continue to risk denial of authorization if medical necessity is not present.
 - When retro-authorization requests are beyond the 30 (thirty) days timeline for cases *not* involving a third party payor, the requests will be on a case by case basis (such as community hospitals lag information on Medicaid eligibility or requesting regional support network certification).

- The designated crisis team forwards the request for retro-authorization to the PRSN utilization management subcontractor "CommCare" for a determination.

4. ITA to Voluntary Legal Status authorization: Authorizations for individual's legal status changing from involuntary to voluntary must be provided/ authorized according to the DSHS Inpatient Instructions and PRSN LOC.

MONITORING

1. This policy is a contract and statute mandate. The PRSN will be monitor this policy through use of the:
 - Annual PRSN Provider and Subcontractor Administrative Review
 - Annual Provider Chart Reviews
 - PRSN Grievance Tracking Reports
 - Quarterly Provider Performance Reports
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations
 - NOA tracking and 100% review of all appeal requests
2. If a network provider or subcontractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

Quality Improvement Committee Agenda

The mission of the QUIC is to support recovery and foster excellence in the provision of regional mental health care through the application of quality initiatives that produce effective, measurable outcomes.

July 8, 2015

Location: West End Outreach Services
551 Bogachiel Way Forks, WA 98368

- | | |
|----------|--|
| 10:30 AM | Introductions
Add any additional agenda items and/or concerns |
| 10:35 AM | Announcements and updates |
| 10:45 AM | Projects <ul style="list-style-type: none">• Evidence Based Practices• Transitional Age Youth- discharge from service studies• Missing Demographics• 2015 Consumer Survey results |
| 11:30 AM | Review of Regional Performance Measures <ul style="list-style-type: none">• Peer Measures• NEW 7 day measure• Readmission Project |
| 12:15 PM | LUNCH |
| 1:15 PM | Children and Youth PIP update
Tobacco Cessation PIP update |
| 2:00 PM | Ombuds update |
| 2:15 PM | Questions or concerns |
| 2:30 PM | Wrap up and next meeting |

Quality Improvement Committee Meeting Notes

The mission of the QUIC is to support recovery and foster excellence in the provision of regional mental health care through the application of quality initiatives that produce effective, measurable outcomes.

July 8, 2015

Location: West End Outreach Services ~ 551 Bogachiel Way, Forks, WA

Attended by: Michelle Alger, Tina Mitchell, Dani Repp (PRSN), LaVonne Fachner, Richelle Jordan (KMHS), Connie Irving (PBH), Tanya McNeil (WEOS), Karla Zabel (Ombuds), Sally O'Callaghan, Lois Hoell (Board Member)

<p>Announcements and Updates</p>	<p><u>KMHS</u>- Introduced Richelle Jordan as the new performance improvement specialist to assist LaVonne. Also stated the new IS person will be starting July 16th and they still have many position openings.</p> <p><u>JMHS</u>- did not attend.</p> <p><u>PBH</u>- Still working to hire for open positions. Also stated they have begun using MyStrength app with consumers and continuing looking at EMR's.</p> <p><u>WEOS</u>- Continue looking for a new child mental health specialist.</p> <p><u>Ombuds</u>- Will probably be hiring part time person in the future.</p> <p><u>PRSN</u>- Recently hired Dani Repp as our IS Manager. EQRO will be reviewing PRSN next week.</p>	<p>Action: none</p>
<p>Performance Measure Updates</p>	<p>Reviewed the two MH measures that will be included in the upcoming contract. DBHR has stated these will be: MH Penetration and the Readmission rate. Discussed briefly how the state is looking to measure these and how all future measures are changing so they will not be able to be duplicated or validated at the regional level. Also discussed topics of focus by the state for 2018.</p>	<p>Action: none</p>
<p>Projects</p>	<p><u>Evidence Based Practices:</u> We reviewed the EBPs offered in our region and agencies agreed it appeared accurate. We also discussed the ever changing list in SERI and the need to keep ProFiler up to date with these changes.</p> <p><u>Transitional Youth Population:</u> We reviewed the sample report on discharge reasons by age population. The group was unable to reach a consensus on what area of this population we wanted to measure. Agencies requested to take the question back to their clinical staff and get their input.</p> <p><u>Missing Demographics:</u> Reviewed the missing demo report in ProFiler and requested that agencies work to fix any missing demographics.</p>	<p>Action: <u>EBP:</u> Michelle will check to see if the Profiler list is updated.</p> <p><u>Transitional Youth:</u> Michelle verified that in this report we have defined the TA ages as 16 through 20. Agencies will submit the following to Michelle before the next QUIC:</p> <ol style="list-style-type: none"> 1) An idea what percentage the TA population is out of their overall population. 2) Suggestions for the measure. <p><u>Surveys:</u> Providers will keep the</p>

	<p><u>Surveys:</u> Reviewed the updated MHSIP surveys for 2014. These results were imported into our regional historic graphs and also compared to our regional survey results.</p>	<p>same questions for 2015 and send data to PRSN when their surveys are complete.</p>
<p>Regional Performance Measures</p>	<ul style="list-style-type: none"> • Reviewed peer services report and discussed the fact that it was requested we also measure by modality to determine how our peers are being utilized. A report was created to pull all encounters submitted by a peer. This was reviewed and discussed at the meeting. It was determined that this need was primarily requested by KMHS and they have since changed their reporting practice to be more in line with the current indicator. The modality report will not become a regular measure at this time. • Child and Family Team meetings were reviewed and low numbers discussed. It was again mentioned that documenting this service was a challenge for providers, as one member of the team must remember to use the HT modifier. • The access measure shows a decline in overall penetration rates, although there is an increase in intakes the rate of increase is not keeping up with the growth in the Medicaid expansion numbers. This may need a closer look to help identify why penetration rates are not growing. • 7 day- discussed that this measure would be coming off contract and we could change the measure to make it more meaningful. We reviewed both the offered and accepted report and a lengthy discussion ensued regarding what type of inpt/outpt coordination report would be useful to providers. Options include measuring: 3 day from admission, 3 day post discharge follow up, and 7 day from discharge to first routine appt. Agencies asked that they have time to discuss this topic with direct service staff for their input. 	<p><u>Action:</u> Agencies will discuss with their staff and provide feedback on how they would like to see inpt-outpt coordination measured.</p>
<p>Readmission Project</p>	<p>The need to identify barriers to successful discharges and items that increase our readmission</p>	<p><u>Action:</u> Michelle will send out poll to determine dates of conference calls.</p>

	<p>rates were discussed. A subcommittee was formed that will help develop the tool we will use to capture data elements for further review.</p> <p>Volunteers for the subcommittee were: LaVonne, Richelle, Connie and Lois</p>	
<p>Children's PIP</p>	<p>Tina updated the group on the Children's PIP progress. We reviewed the intervention tracking and noted the continued expected increase in CIS authorizations since the expansion of the criteria. We discussed some data issues, noting that there are some authorizations that do not have expiration dates filled in, and that in July and August, these will have been authorized for 6 months. The providers were asked to ensure that expiration dates are filled in so that it is clear whether the client is still authorized for the CIS level of care. We reviewed the measurement periods, noting that an additional measurement period was added as the final step to this PIP to ensure that the improvement is sustained. The PIP will complete its last measurement cycle by December 2016.</p> <p>Also discussed were next steps for this population now that the accurate identification of the population appears to be in place. We discussed best ways to measure utilization, as well as other outcomes. Some initial data on utilization and outcomes for the CIS population was shared with the group. Feedback was sought on what utilization patterns would be expected for this population and how they might compare to children who are not authorized for the CIS level of care. The following suggestions from providers were made:</p> <ul style="list-style-type: none"> • Measure number of services per client per month in CIS, compared to number of services per client (possibly at 30 day and 6 month mark) for all other children authorized for services (both level 1 and 2 should be included). CIS authorized services should be higher. • Also compare number of services per client per month in CIS, to number of services per client per month for the same clients once they are no longer in CIS, theoretically they would have fewer services when they are no longer in the program. • Measure number of CFT meetings per month for children in CIS. Providers indicated this measure would be low, and is something they are working on improving. • Providers would expect that hospitalizations 	<p>Action: Providers will ensure that clinicians are trained to fill in expiration dates, and check the "Met" box if the client meets the criteria for the CIS authorization.</p> <p>Tina will explore some of the utilization and outcome measures discussed in the meeting.</p>

	<p>would decrease over time once authorized, and that ITA investigations would decrease over time. Measuring standard crisis services however may not be a useful outcome because often receiving standard crisis services is not necessarily an indication of a poor treatment outcome.</p> <ul style="list-style-type: none"> • It is not useful to compare measures counting location of services because location of most services for all clients are out of office, and are not acuity based. • It would be useful to explore where the majority of services lie. 	
<p>Tobacco Cessation PIP</p>	<p>We reviewed the baseline and first 2 months of tracking data for all 7 measures of the tobacco PIP, demonstrating that the intervention is occurring as planned, and an improvement so far, is detected. We discussed that there were a small amount of data entry problems in that a couple clinicians in the region are entering the assessment data in a text field with non-standardized categories instead of using the drop down fields. It was noted that the each agency was informed individually of the details and asked to ensure proper training of the individuals making the error.</p> <p>We also reviewed an age breakdown of data including the indicator and outcomes for the whole region for the baseline time period.</p> <p>We reviewed the timeline for the tobacco use project noted that the “ask and record” phase is scheduled to be completed by the end of February 2016, and that the next phase, focusing on expanding the intervention should be in place by March of 2016, with planning beginning in August, according to the timeline. Planning for this next phase includes 1) determining what interventions will be offered at each agency 2) creating a workflow/procedure for providing and documenting the interventions, and 3) providing training for the interventions and their documentation in Profiler. It was noted that KMHS already has a workflow and procedure in place for providing interventions and that more information would need to be gathered to determine whether or not it would be useful for KMHS to be involved in this phase of the PIP.</p> <p>Tina asked for a representative from each agency to be on the sub-committee for planning this phase of the PIP.</p>	<p>Action: Each agency will e-mail Tina with the name of their staff who will participate on the sub-committee.</p> <p>Each agency will explore what types of resources their agency can commit to tobacco cessation intervention programs</p> <p>Tina will talk with KMHS’s Health Living Program Developer to learn more about how KMHS has developed their program, and what resources might be available for the region.</p> <p>Tina will plan the first Tobacco intervention sub-committee meeting in August.</p>

Ombuds	Karla reviewed the trends from the overall number of grievances reported. The dignity and respect subcategory remains our main topic for issues. Also of note was that the subcategory that was the most dominate ('lack of compassion, courtesy and kindness') now also includes 'lack of personal respect.'	Action: none
Scheduling Next Meeting	We tentatively set the next few meetings: Oct 14 th - PBH	Action: Next meeting is Oct 14th at PBH.

Michelle Alger

From: Tracy Thompson <tracy@kmhs.org>
Sent: Thursday, January 22, 2015 2:15 PM
To: Michelle Alger
Subject: RE: demo errors
Attachments: image001.png@01D0364D.66C850D0; image002.png@01D0364D.66C850D0; image003.png@01D0364D.66C850D0

Follow Up Flag: Follow up
Flag Status: Flagged

This is anyone who has/had the RSN payor (Crisis, Standard, PACT, Inpatient) – that is what queues the demo to send (the opening of the payor). ALL RSN clients must have the basic demographic and the agencies agreed that really, ALL clients (RSN or not) should have this data because they can get RSN Crisis at any time.

If the client cannot be reached/data not known, EVERY required field has Unknown/Not Reported available. The demo record will not send if there is no demographics at all OR there is missing information in the record (one of the fields is blank).

We have ALWAYS required the minimum data – even if it is Unknown/Not reported!

Hope that helps....

Tracy Thompson
IS Director - Kitsap Mental Health Services
5455 Almira Drive NE - Bremerton, WA 98311
tracy@kmhs.org
360.415.5813 (office)
360.478.0951 (fax)
360.271.9879 (cell)

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From: Michelle Alger [mailto:malger@co.kitsap.wa.us]
Sent: Thursday, January 22, 2015 12:52 PM
To: Tracy Thompson
Subject: RE: demo errors

This is perfect!

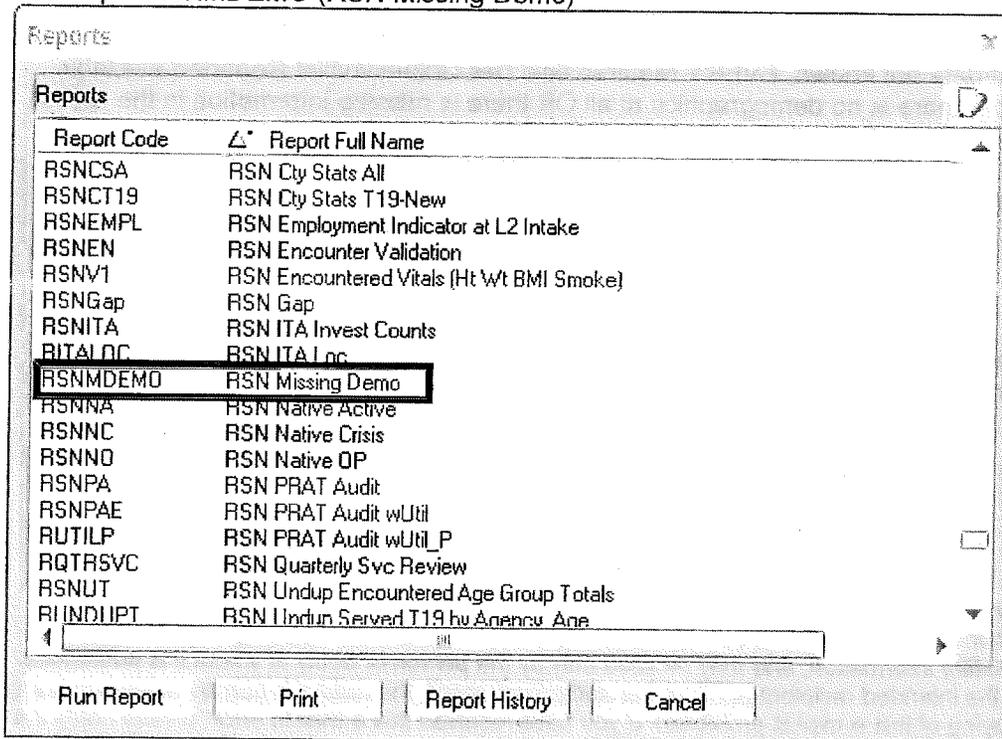
I know this question will come up so..... does this include those clients who were only seen as crisis? And if someone came in for an intake and never came back is there a way to close them off the report since the data isn't available?
Thanks!

Michelle Alger, MA, LMHC, NCC
Quality Assurance Manager
Peninsula Regional Support Network
614 Division St, MS- 23
Port Orchard, WA 98366
☎: (360) 307-4274 (direct)
FAX (360) 337-5721

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From: Tracy Thompson [mailto:tracy@kmhs.org]
Sent: Thursday, January 22, 2015 12:39 PM
To: Michelle Alger
Subject: RE: demo errors

Yes- you can save it out as Excel as it is now. Again, I didn't do a full QA on it but it is available on your My Desktop – RSNMDEMO (RSN Missing Demo)



Tracy Thompson
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From: Michelle Alger [mailto:malger@co.kitsap.wa.us]
Sent: Thursday, January 22, 2015 11:25 AM
To: Tracy Thompson
Subject: RE: demo errors

Hi,
I was wondering if you'd had a chance to make any progress on this?
We talked about pulling by all agencies and also making it more excel friendly....
Thanks

Michelle Alger, MA, LMHC, NCC
Quality Assurance Manager
Peninsula Regional Support Network
614 Division St, MS- 23
Port Orchard, WA 98366
☎: (360) 307-4274 (direct)
FAX (360) 337-5721

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From: Tracy Thompson [mailto:tracy@kmhs.org]
Sent: Monday, January 12, 2015 4:13 PM
To: Michelle Alger
Subject: RE: demo errors

Hi –there is a report for providers to see what client records have no or incomplete Demographic records.

We don't give them the Services w/out Encounters report because the system has a hard time with the Crisis Only (they don't require all the items), however if the agencies run this one for missing demo they should never have an encounter without a demo! We do run it on occasion and provide the information as needed.

The agencies are supposed to routinely run and correct client demo information from the MSGDEMO Missing Demo Data report from My Desktop.



My Desktop

Reports	
Report Code	Report Full Name
MSGDEMO	Missing Demo Data
MCAN	Missing Crisis KILL
MODC	Modality Review

Example of report

KMHS

IF CLIENT HAS MULTIPLE RSN PAYORS, DEMOGRAPHIC DATA SHOULD SATISFY THE REQUIREMENT FOR ALL RSN PAYOR TYPES.

<u>Client Name</u>	<u>Client ID</u>	<u>RSN Payors</u>
		RSN Crisis Svcs
		<u>RSN Crisis Svcs</u> Ethnicity Demographic Required Race Demographic Required Sexual Orientation Demographic Required Language Demographic Required
		RSN Crisis Svcs
		<u>RSN Crisis Svcs</u> Ethnicity Demographic Required Race Demographic Required Sexual Orientation Demographic Required Language Demographic Required

Tracy Thompson
 IS Director - Kitsap Mental Health Services
 5455 Almira Drive NE - Bremerton, WA 98311
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From: Michelle Alger [<mailto:malger@co.kitsap.wa.us>]
Sent: Monday, January 12, 2015 8:26 AM
To: Tracy Thompson
Subject: demo errors

Hi Tracy,

Is there any report on Profiler that shows agency RSN demographic data errors and how long they have been hanging out there?

Michelle Alger, MA, LMHC, NCC
Quality Assurance Manager
Peninsula Regional Support Network
614 Division St, MS- 23
Port Orchard, WA 98366
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Tracy Thompson
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Current List of EBP options:

Drop List Choices (enter one choice per line)
001 Aggression Replacement Training
016 CBT for Children in Schools
022 CBT for Depressed Adolescents
028 CBP Plus
037 Dialectic Behavior Therapy
076 Incredible Years Parent Train/Child Train
109 Parent-Child Interaction Therapy
136 Trauma Focused CBT for Children
139 Triple P

→ removed

remove entry to correct

Jan 5, 2015 list will be updated – moving 028 CBT Plus to read OBS 028 CBT Plus and adding 020 CBT for Anxious Children.

Example list:

- 001 Aggression Replacement Training
- 016 CBT for Children in Schools
- 020 CBT for Anxious Children
- 022 CBT for Depressed Adolescents
- 037 Dialectic Behavior Therapy
- 076 Incredible Years Parent Train/Child Train
- 109 Parent-Child Interaction Therapy
- 136 Trauma Focused CBT for Children
- 139 Triple P

Remove entry to correct

OBS 028 CBT Plus (Do not use)

EVIDENCE BASED PRACTICE – CHILDREN’S MENTAL HEALTH

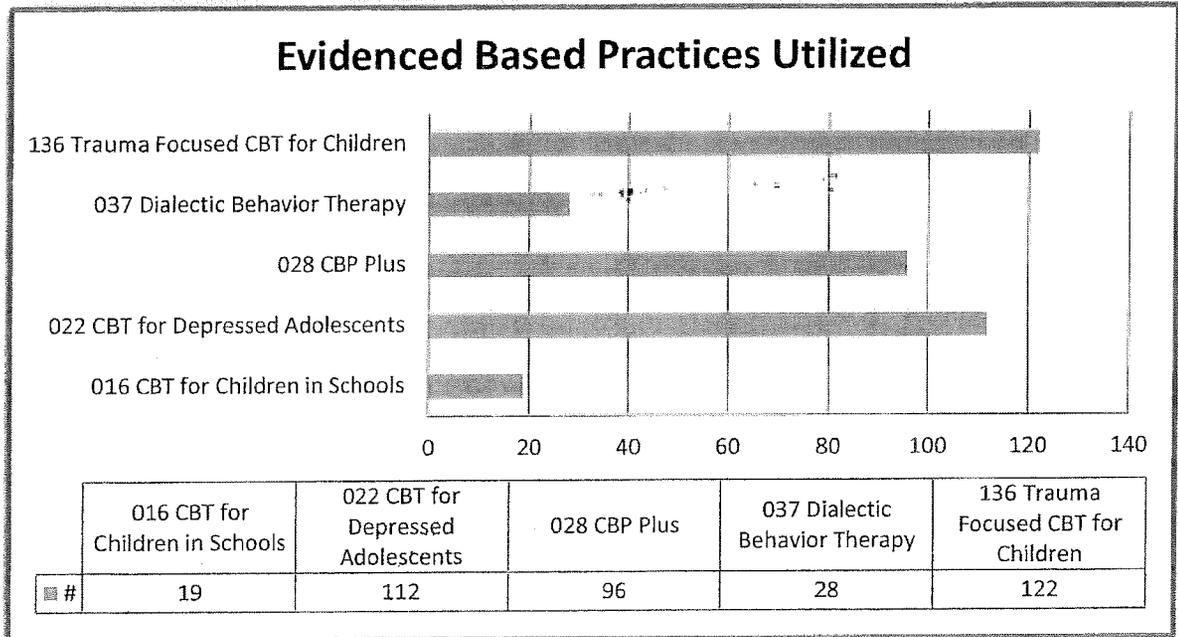
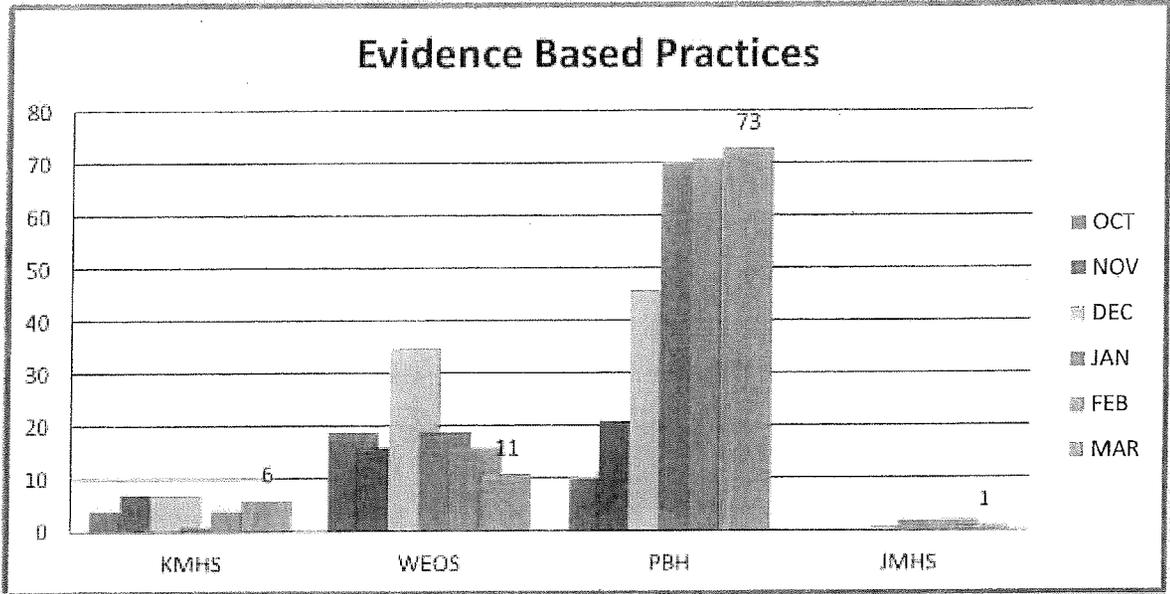
Programs	ADSA/DBHR Code
Adolescent Assertive Continuing Care	002
Barkley Model	003
Behavioral Parent Training (BPT) for Children with ADHD	004
Adolescent Community Reinforcement Approach	005
Behavioral Parent Training (BPT) for Children with Disruptive Behavior Disorder	007
Brief Strategic Family Therapy (BSFT)	010
Child-Parent Psychotherapy	011
Classroom Based Intervention for war-exposed children	013
Cognitive Behavioral Intervention for Trauma in Schools	016
Cognitive Behavioral Therapy (CBT)-Based Models for Child Trauma	019
Cognitive Behavioral Therapy (CBT) for Anxious Children (group, individual, or remote)	020
Cognitive Behavioral Therapy (CBT) for Depressed Adolescents	022
Cool Kids	032
Coping Cat	035
Coping Cat/Koala	036
Coping with Depression – Adolescents	038
Enhancing Resiliency Among Students Experiencing Stress (ERASE-Stress)	040
Eye Movement Desensitization and Reprocessing (EMDR) for Child Trauma	043
Families And Schools Together (FAST)	046
Full Fidelity Wraparound for youth with Serious Emotional Disturbance (SED)	061
Incredible Years Parent Training	073
Incredible Years Parent Training + Child Training	076
KID-NET Narrative Exposure Therapy for Children	079
Life Skills Training	082
Modular Approaches to Treatment of Anxiety, Depression and Behavior (MATCH)	085

Programs	ADSA/DBHR Code
Multimodal Therapy (MMT) for Children with ADHD	091
Multisystemic Therapy (MST) for youth with Serious Emotional Disturbances (SED)	094
New Forest Parenting Programme	095
Multidimensional Family therapy for substance abusing juvenile offenders	096
Other Behavioral Parent Training	098
Other Cognitive Behavioral Therapy (CBT) for Depressed Adolescents	099
Other Cognitive Behavioral Therapy (CBT) - Based Models for Child Trauma	100
Multisystemic Therapy (MST) for substance-abusing juvenile offenders	101
Parent-Child Interaction Therapy (PCIT)	109
Parent Child Interaction Therapy (PCIT) for Children with Disruptive Behavior Problems	112
Parent Cognitive Behavioral Therapy (CBT) for Anxious Children	113
Project ALERT	117
Project STAR	118
Teen Marijuana Check-Up	134
Therapeutic communities for substance abusing juvenile offenders	135
Trauma Focused CBT for Children	136
Trauma Grief Component Therapy	137
Triple-P Level 4, Group	139
Triple-P Level 4, Individual	140

<u>MARCH - SEPT 2015 EVIDENCE BASED PRACTICE/RESEARCH BASED PRACTICE</u>	<u>JMHS</u>	<u>KMHS</u>	<u>PBH</u>	<u>WEOS</u>
Trauma Focused Cognitive Behavioral Therapy (TC-CBT) - 136	X	X	X	X
Parent Child Interaction Therapy (PCIT) - 109		X		
Triple P - 140				X
Cognitive Behavioral Therapy for Depressed Adolescents - 022		X	X	
Cognitive Behavioral Therapy for Anxiety - 020		X		
Cognitive Behavioral Therapy for Child Trauma			X	

EVIDENCE BASED PRACTICES PRSN SUMMARY

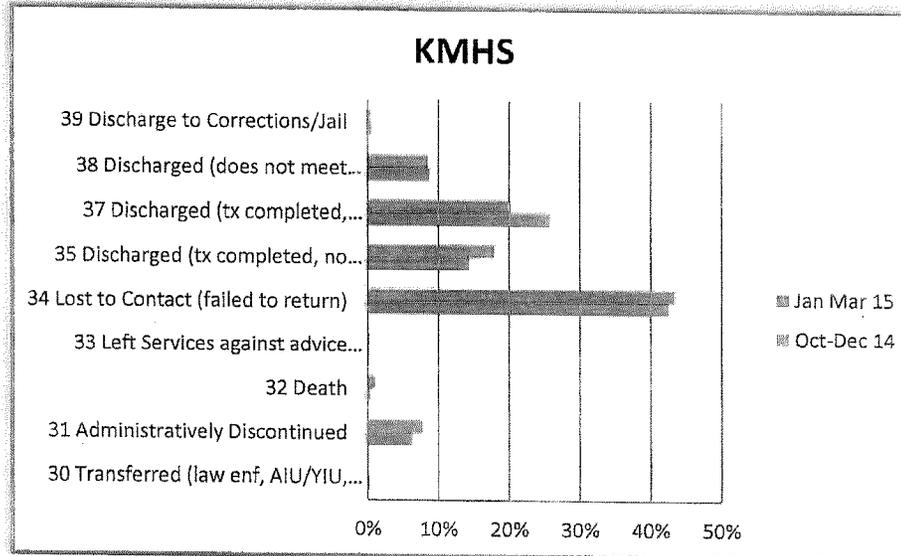
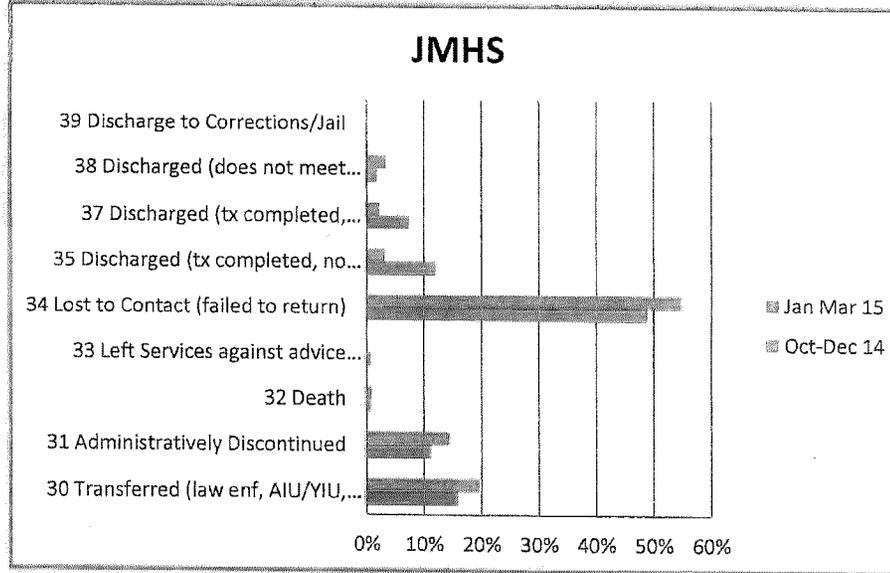
Updated 6/9/2015



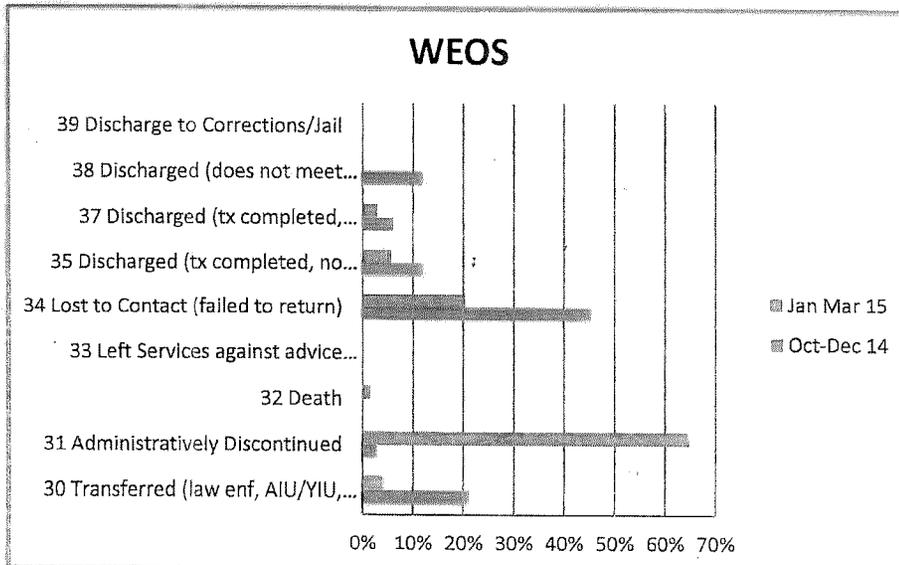
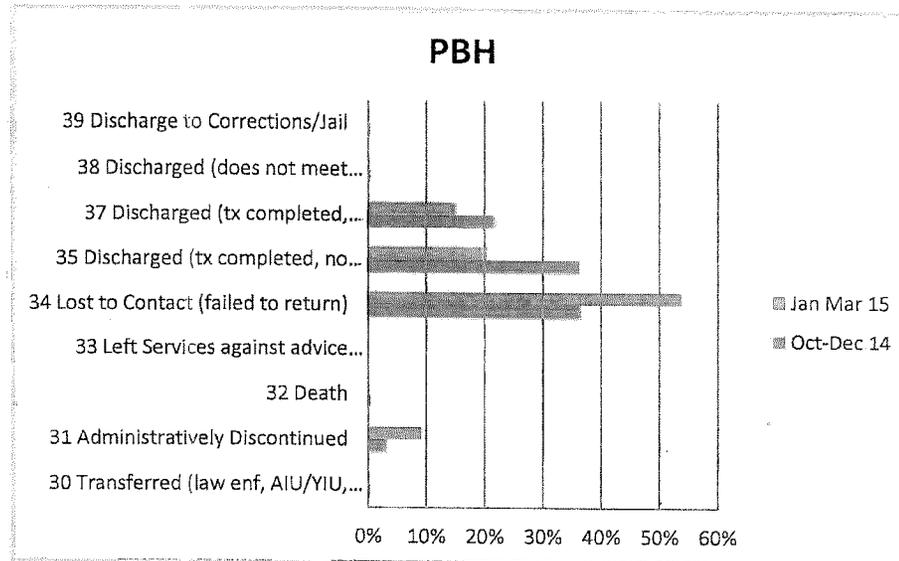
Discharge Review Historic View

JMHS	Oct-Dec 14	Jan Mar 15
30 Transferred (law enf, AIU/YIU, internal svcs)	16%	20%
31 Administratively Discontinued	11%	15%
32 Death	1%	1%
33 Left Services against advice (AMA AWOL)	1%	0%
34 Lost to Contact (failed to return)	49%	55%
35 Discharged (tx completed, no referral)	12%	3%
37 Discharged (tx completed, referral made)	8%	2%
38 Discharged (does not meet access to care standard)	2%	3%
39 Discharge to Corrections/Jail	0%	0%

KMHS	Oct-Dec 14	Jan Mar 15
30 Transferred (law enf, AIU/YIU, internal svcs)	0%	0%
31 Administratively Discontinued	6%	8%
32 Death	1%	1%
33 Left Services against advice (AMA AWOL)	0%	0%
34 Lost to Contact (failed to return)	43%	43%
35 Discharged (tx completed, no referral)	14%	18%
37 Discharged (tx completed, referral made)	26%	20%
38 Discharged (does not meet access to care standard)	9%	9%
39 Discharge to Corrections/Jail	1%	0%

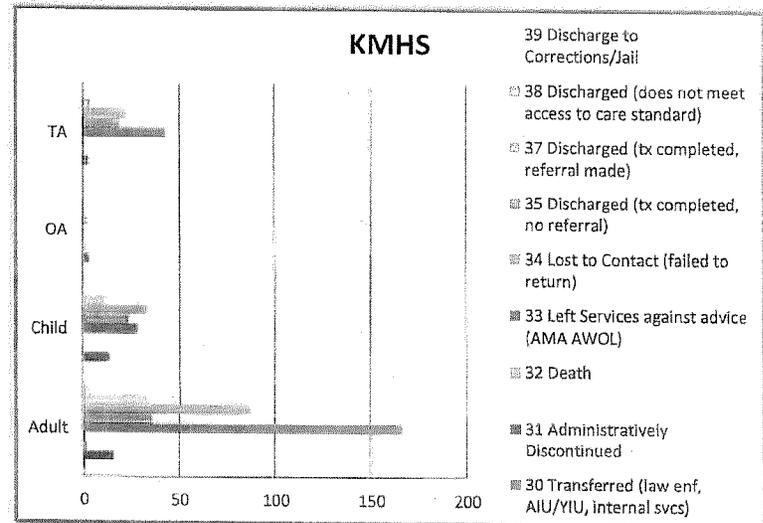
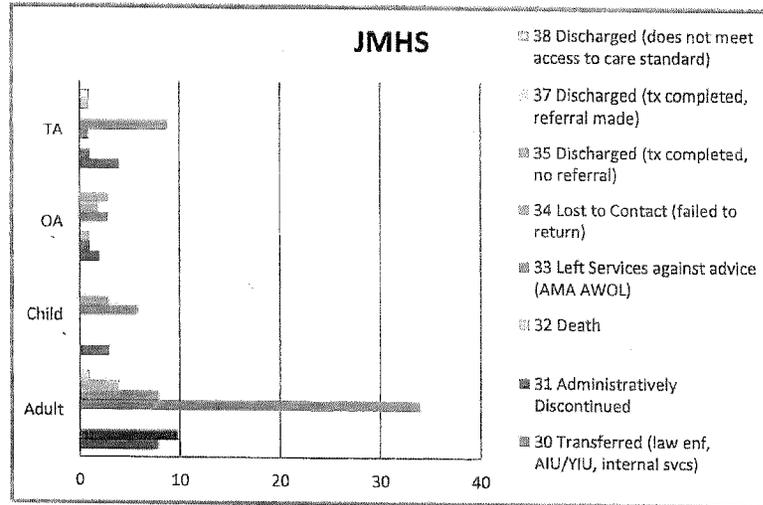


PBH	Oct-Dec 14	Jan Mar 15
30 Transferred (law enf, AIU/YIU, internal svcs)	0%	0%
31 Administratively Discontinued	3%	9%
32 Death	1%	0%
33 Left Services against advice (AMA AWOL)	0%	0%
34 Lost to Contact (failed to return)	37%	54%
35 Discharged (tx completed, no referral)	36%	20%
37 Discharged (tx completed, referral made)	22%	15%
38 Discharged (does not meet access to care standard)	0%	0%
39 Discharge to Corrections/Jail	1%	0%
WEOS	Oct-Dec 14	Jan Mar 15
30 Transferred (law enf, AIU/YIU, internal svcs)	21%	4%
31 Administratively Discontinued	3%	65%
32 Death	0%	1%
33 Left Services against advice (AMA AWOL)	0%	0%
34 Lost to Contact (failed to return)	45%	21%
35 Discharged (tx completed, no referral)	12%	6%
37 Discharged (tx completed, referral made)	6%	3%
38 Discharged (does not meet access to care standard)	12%	0%
39 Discharge to Corrections/Jail	0%	0%

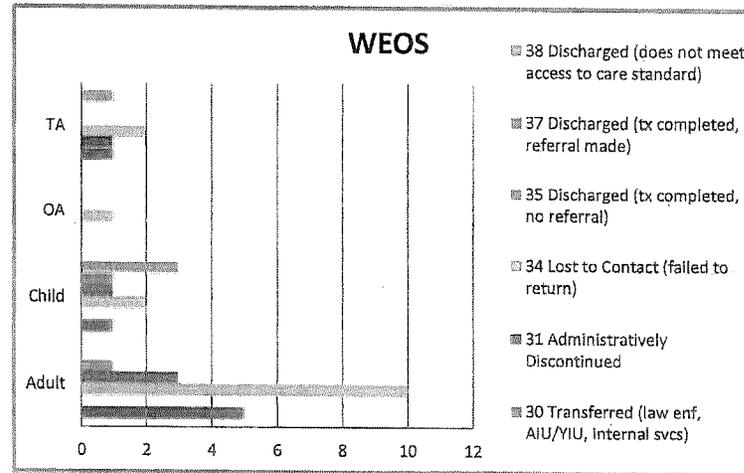
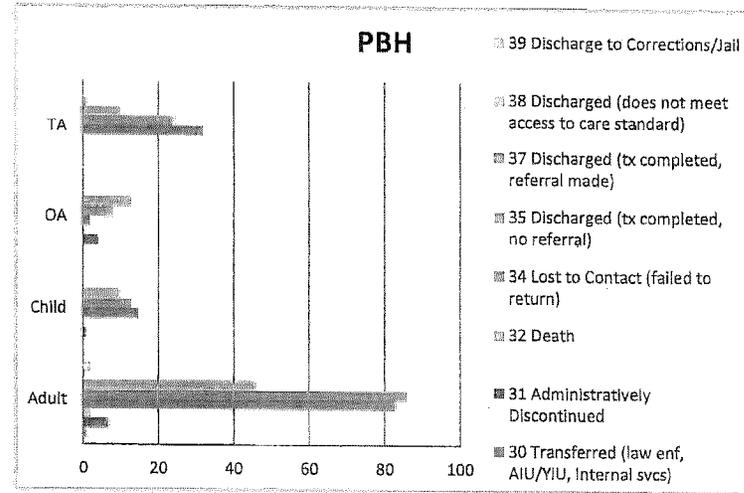


Discharge Review Oct- Dec 2014

JMHS (9 OBS entries)	Adult	Child	OA	TA	Grand Total	Percentage
30 Transferred (law enf, AIU/YIU, internal svcs)	8	3	2	4	17	16%
31 Administratively Discontinued	10		1	1	12	11%
32 Death			1		1	1%
33 Left Services against advice (AMA AWOL)				1	1	1%
34 Lost to Contact (failed to return)	34	6	3	9	52	49%
35 Discharged (tx completed, no referral)	8	3	2		13	12%
37 Discharged (tx completed, referral made)	4		3	1	8	8%
38 Discharged (does not meet access to care standard)	1			1	2	2%
Grand Total	65	12	12	17	106	
Percentage	61%	11%	11%	16%		
KMHS (5 OBS entries)	Adult	Child	OA	TA	Grand Total	Percentage
30 Transferred (law enf, AIU/YIU, internal svcs)	1				1	0%
31 Administratively Discontinued	16	14	3	3	36	6%
32 Death	2		1		3	1%
33 Left Services against advice (AMA AWOL)	1				1	0%
34 Lost to Contact (failed to return)	167	29		43	239	43%
35 Discharged (tx completed, no referral)	36	24	2	19	81	14%
37 Discharged (tx completed, referral made)	87	34	1	23	145	26%
38 Discharged (does not meet access to care standard)	34	12		4	50	9%
39 Discharge to Corrections/Jail	4				4	1%
Grand Total	348	113	7	92	560	
Percentage	62%	20%	1%	16%		

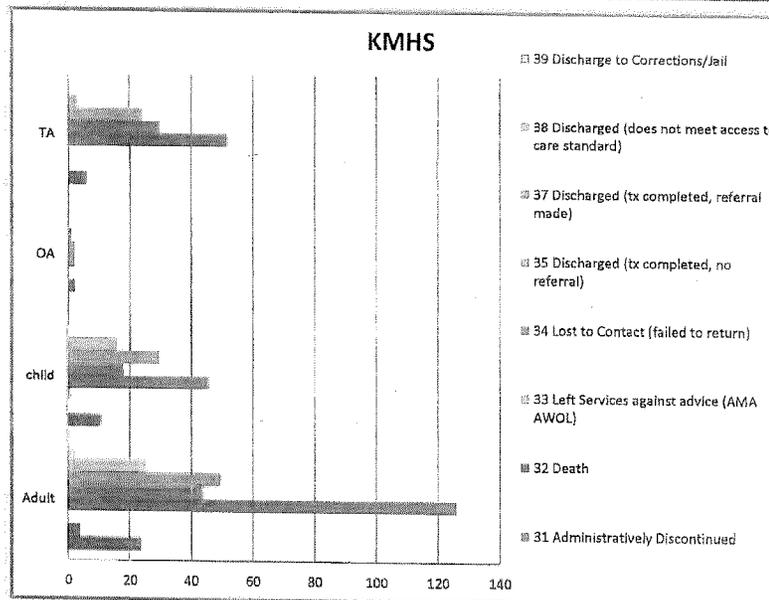
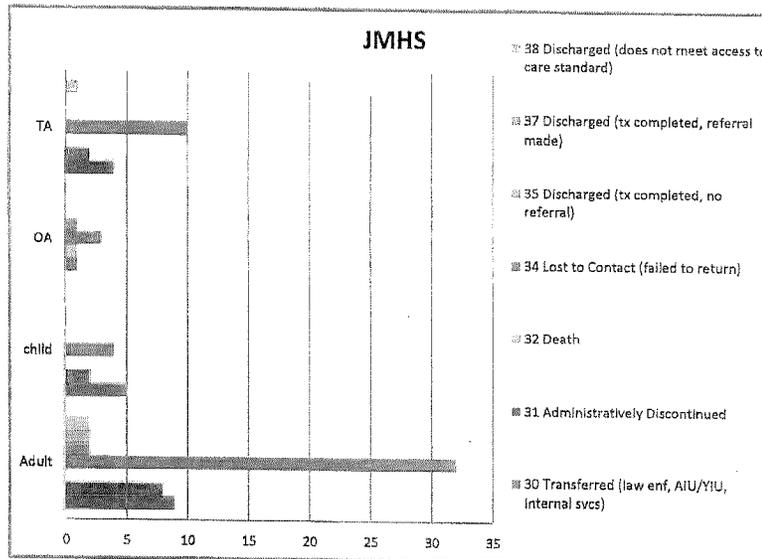


PBH (7 OBS entries)	Adult	Child	OA	TA	Grand Total	Percentage
30 Transferred (law enf, AIU/YIU, internal svcs)	1				1	0%
31 Administratively Discontinued	7	1	4		12	3%
32 Death	2				2	1%
34 Lost to Contact (failed to return)	83	15	2	32	132	37%
35 Discharged (tx completed, no referral)	86	13	8	24	131	36%
37 Discharged (tx completed, referral made)	46	10	13	10	79	22%
38 Discharged (does not meet access to care standard)				1	1	0%
39 Discharge to Corrections/Jail	2				2	1%
Grand Total	227	39	27	67	360	
Percentage	63%	11%	8%	19%		
WEOS (3 OBS entries)	Adult	Child	OA	TA	Grand Total	Percentage
30 Transferred (law enf, AIU/YIU, internal svcs)	5	1		1	7	21%
31 Administratively Discontinued				1	1	3%
34 Lost to Contact (failed to return)	10	2	1	2	15	45%
35 Discharged (tx completed, no referral)	3	1			4	12%
37 Discharged (tx completed, referral made)	1	1			2	6%
38 Discharged (does not meet access to care standard)		3		1	4	12%
Grand Total	19	8	1	5	33	
Percentage	58%	24%	3%	15%		

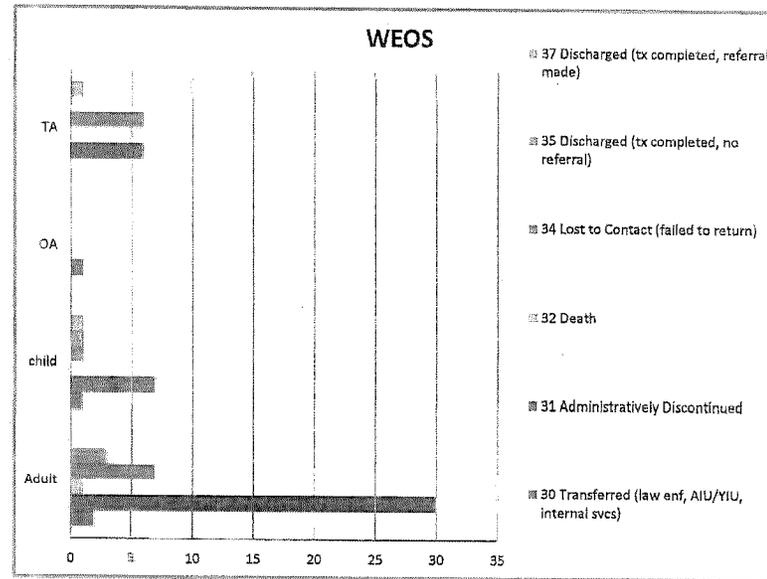
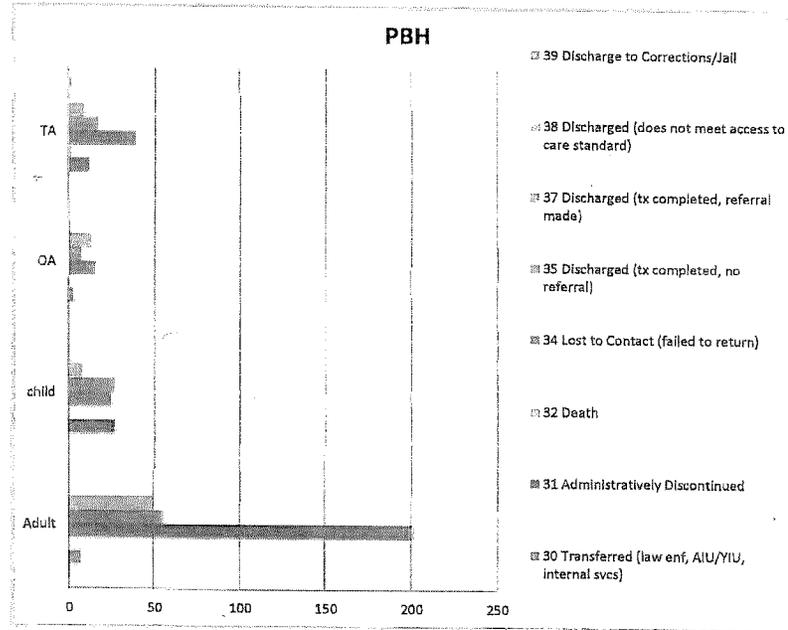


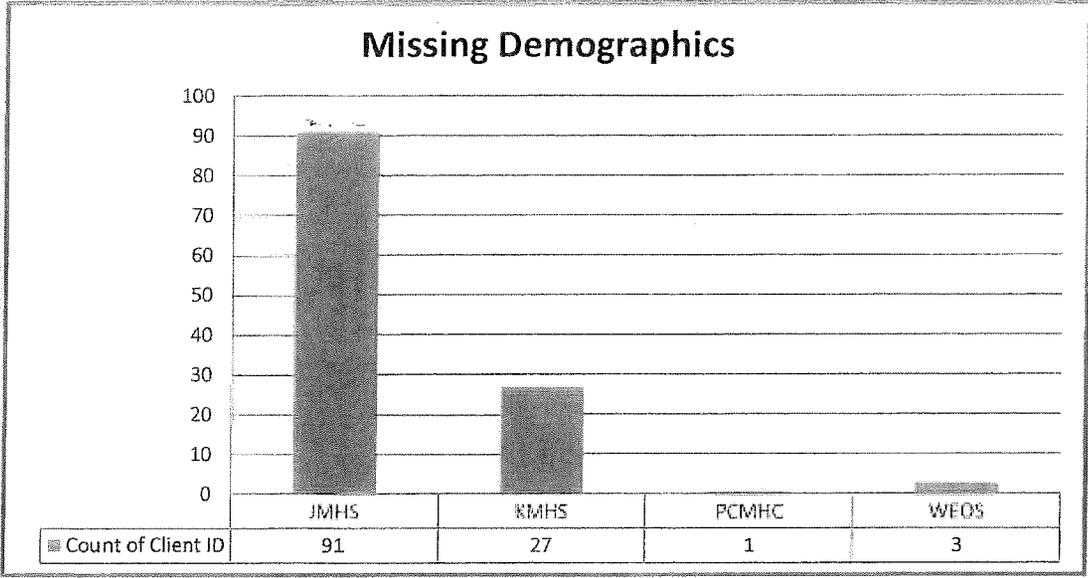
Discharge Review Jan-Mar 2015

JMHS (5 OBS entries)	Adult	child	OA	TA	Grand Total	Percentage
30 Transferred (law enf, AIU/YIU, internal svcs)	9	5		4	18	20%
31 Administratively Discontinued	8	2	1	2	13	15%
32 Death			1		1	1%
34 Lost to Contact (failed to return)	32	4	3	10	49	55%
35 Discharged (tx completed, no referral)	2		1		3	3%
37 Discharged (tx completed, referral made)	2				2	2%
38 Discharged (does not meet access to care standard)	2			1	3	3%
Grand Total	55	11	6	17	89	
Percentage	62%	12%	7%	19%		
KMHS (8 OBS entries)	Adult	child	OA	TA	Grand Total	Percentage
31 Administratively Discontinued	24	11		6	41	8%
32 Death	4		2		6	1%
33 Left Services against advice (AMA AWOL)		1			1	0%
34 Lost to Contact (failed to return)	126	46	2	52	226	43%
35 Discharged (tx completed, no referral)	44	18	2	30	94	18%
37 Discharged (tx completed, referral made)	50	30	1	24	105	20%
38 Discharged (does not meet access to care standard)	26	16		3	45	9%
39 Discharge to Corrections/Jail	2				2	0%
Grand Total	276	122	7	115	520	
Percentage	53%	23%	1%	22%		



PBH (7 OBS entries)	Adult	child	OA	TA	Grand Total	Percentage
30 Transferred (law enf, AIU/YIU, internal svcs)	1				1	0%
31 Administratively Discontinued	7	27	3	12	49	9%
32 Death				1	1	0%
34 Lost to Contact (failed to return)	201	25	15	39	280	54%
35 Discharged (tx completed, no referral)	55	27	7	17	106	20%
37 Discharged (tx completed, referral made)	49	8	13	9	79	15%
38 Discharged (does not meet access to care standard)		1			1	0%
39 Discharge to Corrections/jail				1	1	0%
Grand Total	313	88	38	79	518	
Percentage	60%	17%	7%	15%		
WEOS (50 OBS entries)	Adult	child	OA	TA	Grand Total	Percentage
30 Transferred (law enf, AIU/YIU, internal svcs)	2	1			3	4%
31 Administratively Discontinued	30	7	1	6	44	65%
32 Death	1				1	1%
34 Lost to Contact (failed to return)	7	1		6	14	21%
35 Discharged (tx completed, no referral)	3	1			4	6%
37 Discharged (tx completed, referral made)		1		1	2	3%
Grand Total	43	11	1	13	68	
Percentage	63%	16%	1%	19%		

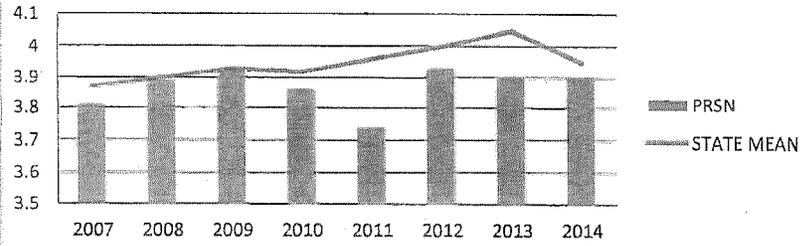




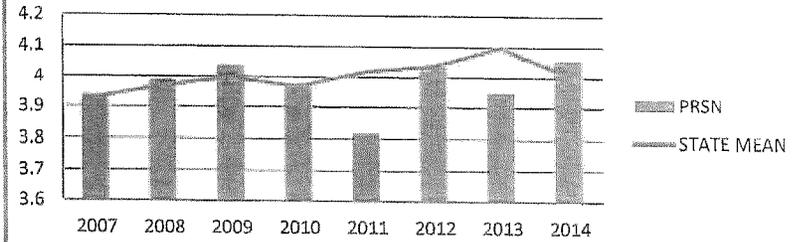
Profiler report: RSN Missing Demo pulling client with RSN payor, in agency outpt cost center. They will show up if a mandory field is missing such as ethnicity, sexual orientation, race, living situation, language, employment, education.

Historic View- Adults 2007-2014

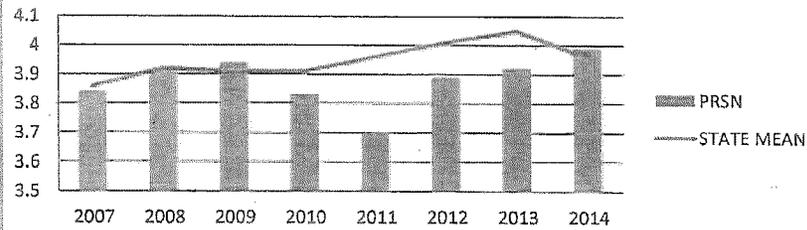
Satisfaction with Services



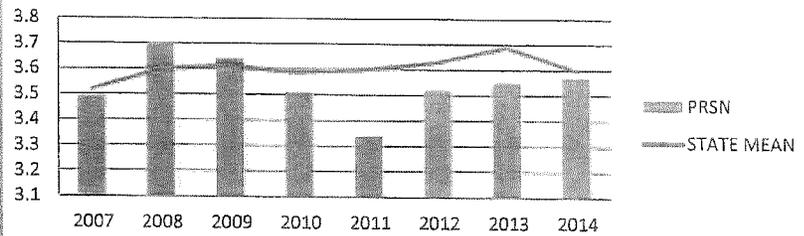
Appropriateness and Quality of Services



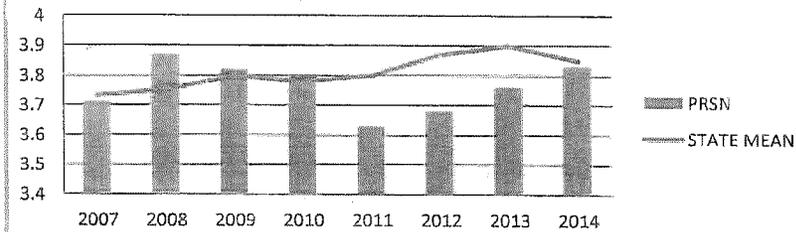
Participation in Treatment Goals



Perceived Outcome of Services

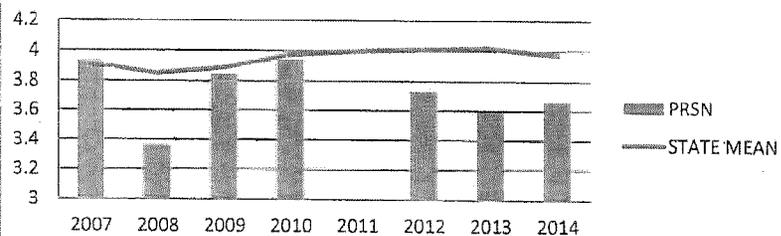


Perception of Access to Services

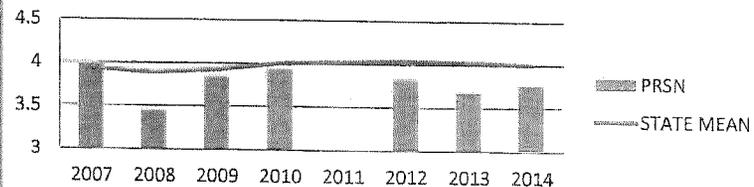


Historic Views- Youth 2007-2014

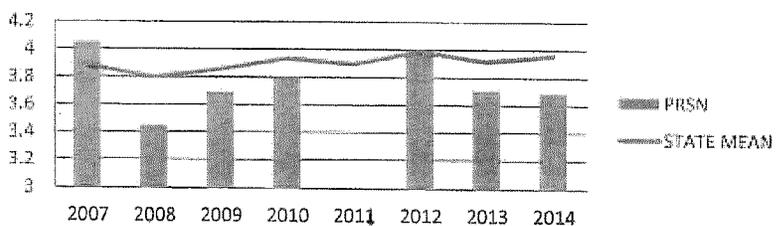
Satisfaction with Services



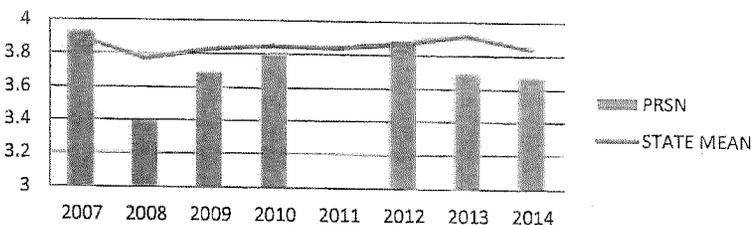
Appropriateness and Quality of Services



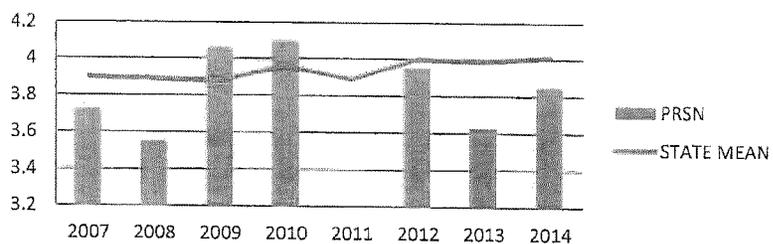
Participation in Treatment Goals



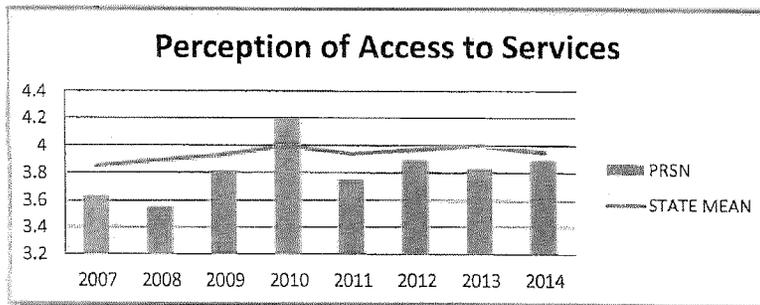
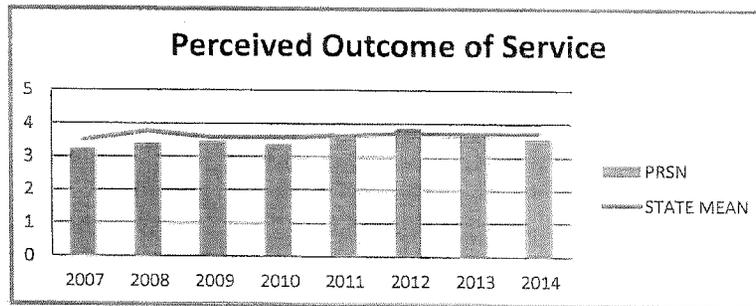
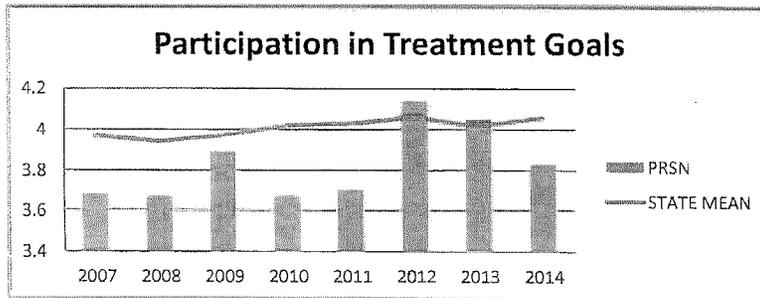
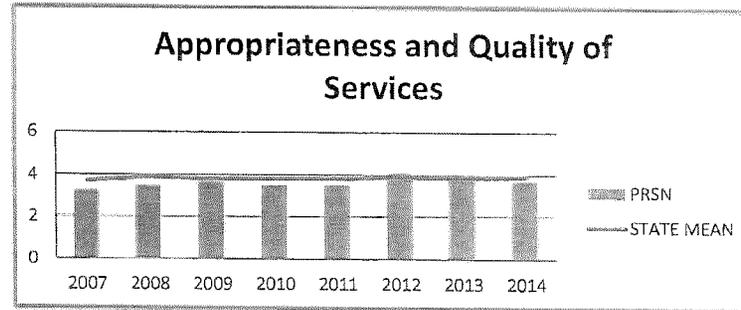
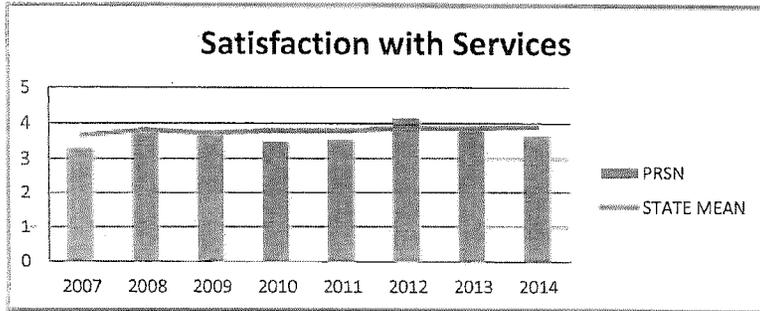
Perceived Outcome of Service

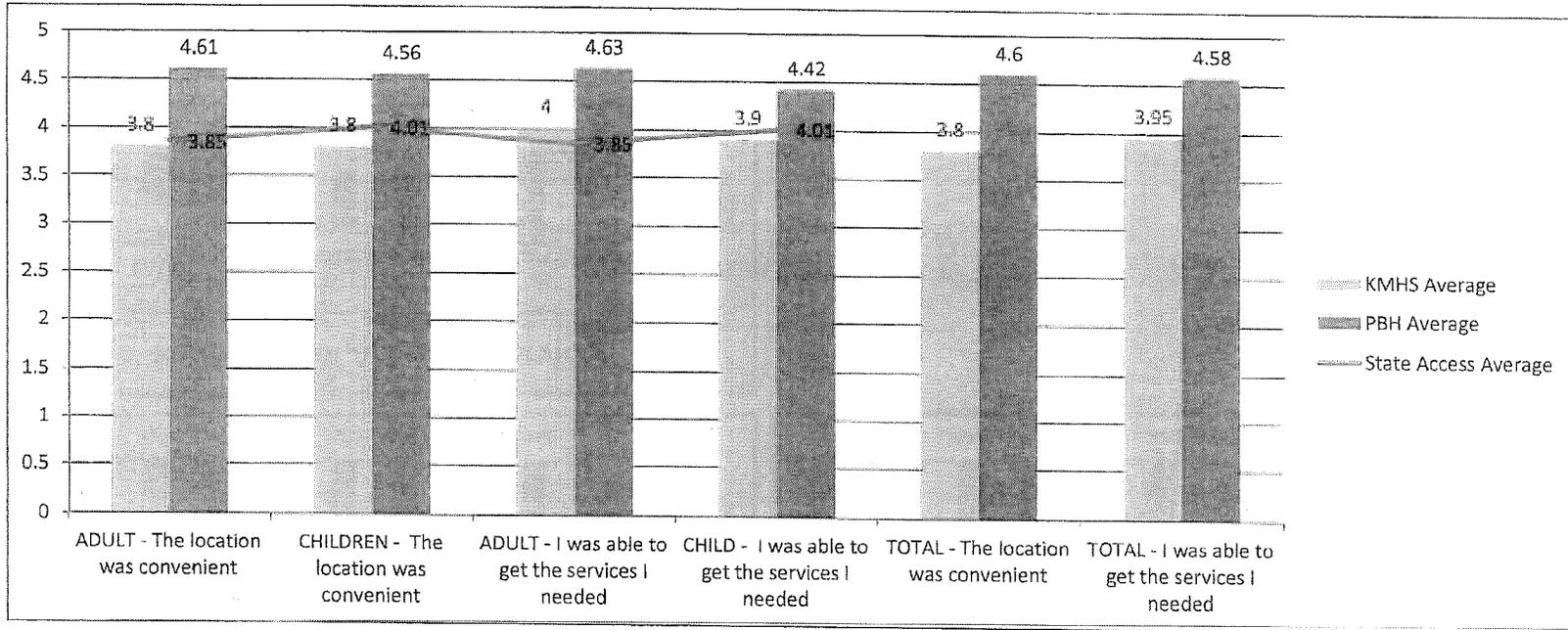


Perception of Access to Services



Historic Views- Family 2007-2014





	KMHS		PBH	
	Sample	Average	Sample	Average
ADULT - The location was convenient	159	3.8	402	4.61
CHILDREN - The location was convenient	62	3.8	127	4.56
ADULT - I was able to get the services I needed	155	4	402	4.63
CHILD - I was able to get the services I needed	60	3.9	127	4.42
TOTAL - The location was convenient	155	3.8	529	4.6
TOTAL - I was able to get the services I needed	215	3.95	529	4.58

PENINSULA REGIONAL SUPPORT NETWORK: QUALITY INDICATORS FY 15

* Core performance measures required and measured by The Department in 09-11 contract years

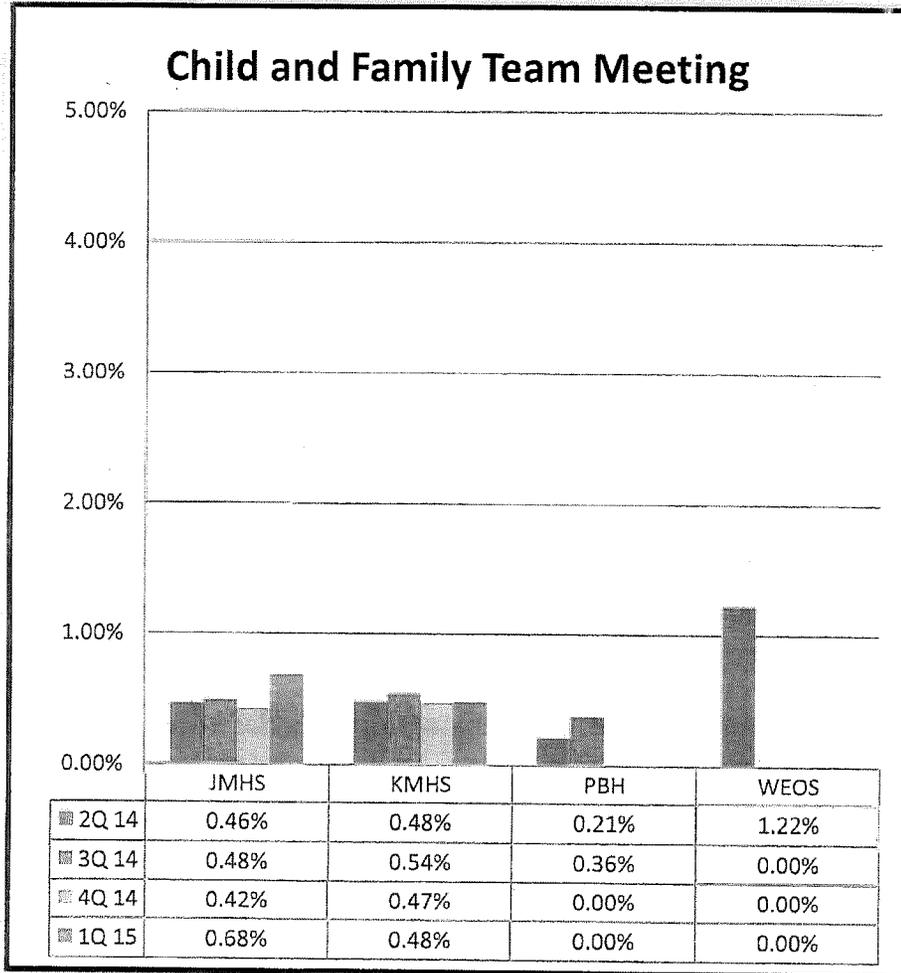
** Submitted to The Department as Regional Performance Measures

Definition of Indicator and Measurement Standard	Measurements																																																																															
<p>1. Peer Services</p> <p>Peer service hours encountered for Medicaid funded individuals by each agency for the specified time frame.</p> <p>Data source: Profiler, T19 county stats report</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p style="text-align: center;">Peer Service Percentage of Goal</p> <table border="1" style="display: none;"> <caption>Peer Service Percentage of Goal Data</caption> <thead> <tr> <th>Agency</th> <th>1Q % of Goal</th> <th>2Q % of Goal</th> <th>3Q % of Goal</th> <th>4Q % of Goal</th> </tr> </thead> <tbody> <tr> <td>JMHS</td> <td>~120%</td> <td>~50%</td> <td>~50%</td> <td>~70%</td> </tr> <tr> <td>KMHS</td> <td>~150%</td> <td>~280%</td> <td>~620%</td> <td>~250%</td> </tr> <tr> <td>PBH</td> <td>~140%</td> <td>~100%</td> <td>~60%</td> <td>~90%</td> </tr> <tr> <td>WEOS</td> <td>~70%</td> <td>~70%</td> <td>~70%</td> <td>~70%</td> </tr> </tbody> </table> </div>	Agency	1Q % of Goal	2Q % of Goal	3Q % of Goal	4Q % of Goal	JMHS	~120%	~50%	~50%	~70%	KMHS	~150%	~280%	~620%	~250%	PBH	~140%	~100%	~60%	~90%	WEOS	~70%	~70%	~70%	~70%	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Region</th> <th>JMHS</th> <th>KMHS</th> <th>PBH</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Quarterly GOAL</td> <td>1384.85</td> <td>15</td> <td>42.3</td> <td>1311.72</td> <td>15</td> </tr> <tr> <td>4th FY 2013 measure</td> <td>1191.71</td> <td>13.75</td> <td>37.33</td> <td>1140.63</td> <td>0.0</td> </tr> <tr> <td>1Q 2014</td> <td>1987.6</td> <td>18.8</td> <td>63.8</td> <td>1905</td> <td>0.0</td> </tr> <tr> <td>2Q 2014</td> <td>1514.9</td> <td>8.3</td> <td>121.0</td> <td>1385.7</td> <td>0.0</td> </tr> <tr> <td>3Q 2014</td> <td>1014.5</td> <td>8</td> <td>163.8</td> <td>843.7</td> <td>0.0</td> </tr> <tr> <td>4Q 2014</td> <td>1354.7</td> <td>8.3</td> <td>160</td> <td>1186.4</td> <td>0.0</td> </tr> <tr> <td>1Q 2015</td> <td>1118</td> <td>12</td> <td>106.3</td> <td>999.6</td> <td>0*</td> </tr> <tr> <td>Notes:</td> <td colspan="5"></td> </tr> </tbody> </table> <p>Target: 15% increase from baseline</p>		Region	JMHS	KMHS	PBH	WEOS	Quarterly GOAL	1384.85	15	42.3	1311.72	15	4 th FY 2013 measure	1191.71	13.75	37.33	1140.63	0.0	1Q 2014	1987.6	18.8	63.8	1905	0.0	2Q 2014	1514.9	8.3	121.0	1385.7	0.0	3Q 2014	1014.5	8	163.8	843.7	0.0	4Q 2014	1354.7	8.3	160	1186.4	0.0	1Q 2015	1118	12	106.3	999.6	0*	Notes:					
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2. Child and Family Team Meetings

Child and family team meetings encountered using the HT modifier by each agency and by number of children and youth services encountered for the time frame.

Data source: Profiler, RSN Encounter Data Validation report



	Region	JMHS	KMHS	PBH	WEOS
SFY					
1Q 2014	0.23% 27/9027	0.52% 5/965	0.27% 18/6657	0.0% 0/1111	1.4% 4/294
2Q 2014	0.46% (47/10116)	0.46% (6/1307)	0.48% (34/7022)	0.21% (3/1458)	1.22% (4/329)
3Q 2014	.49% 44/8955	.48% 5/1032	.54% 34/6340	.36% 5/1374	0.0% 0/209
4Q 2014	.39% 44/11399	.42% 5/1182	.47% 39/8320	0.00% 0/1444	0.00% 0/453
1Q 2015	.41% 30/7321	.68% 4/586	.48% 26/5407	0.00% 0/1154	0.00% 0/174
Notes:					

Numerator: Number of child and family team meetings (using the HT modifier) that are recorded for children and youth under the age of 21 in the time range.

Denominator: Total number children and youth services (under the age of 21) encountered in the time range.

Current Target:

3. Inpatient Utilization (readmission rate)

Readmission rate to inpatient services

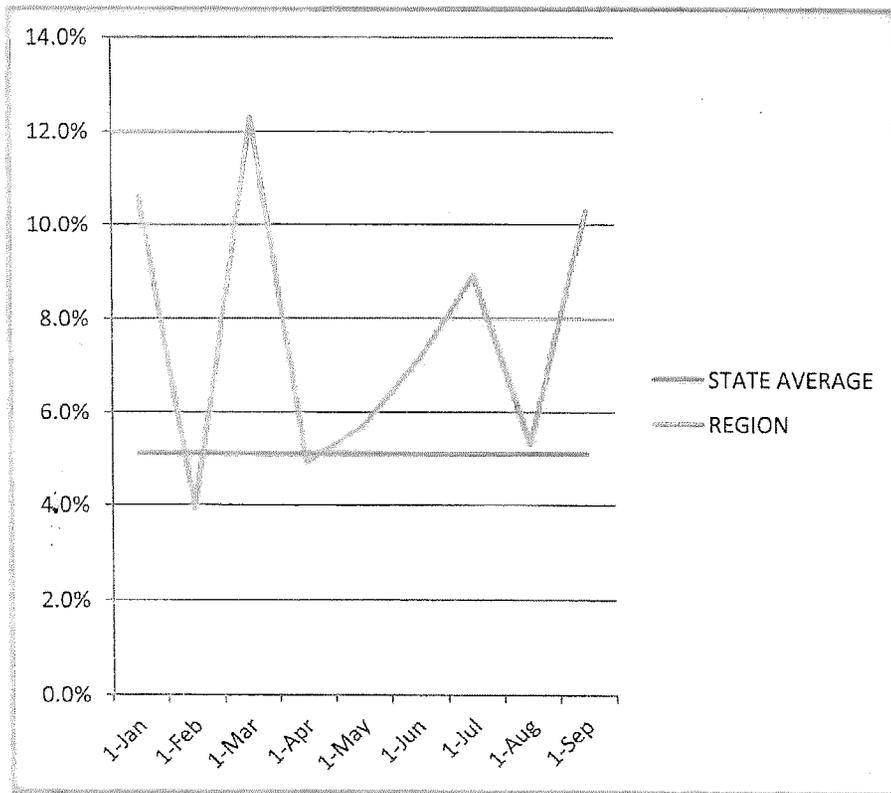
Data source:

Numerator: Number re-admitted to inpatient services within 30 days from discharge.

Denominator: Number of individuals discharged from inpatient services during the reporting period

Minimum Performance Standard= Within 2 points of the State's average for previous fiscal year

State's Average for FY14= 5.7%, FY13= 5.5%, FY12= 6.1%, FY11=6.3 FY10= 6.9, FY09 = 6.9, and FY08= 7.4



	Region	KMHS	FBH	JMHS	WMEOS
FY					
11 TOTAL	9.8% 63/643	10.6% 55/518	6.3% 4/63	5.9% 3/51	9.1% 1/11
12 TOTAL	5.5% 34/620	6.4% 30/466	1.3% 1/77	5.5% 3/55	0.0% 0/12
13 TOTAL	5.8% 50/864	6.4% 38/597	4.7% 7/144	5.4% 5/93	0.0% 0/18
CY14					
JAN	10.6% 9/85	7.5% 5/67	18% 2/11	50% 2/4	0.0% 0/3
FEB	3.9% 3/77	5.7% 3/53	0.0% 0/9	0.0% 0/12	0.0% 0/3
MAR	12.3% 8/65	12.2% 5/41	0.0% 0/9	23.1% 3/13	0.0% 0/2
APR	4.9% 3/61	4.5% 2/44	0.0% 0/12	33.3% 1/3	0.0% 0/2
MAY	5.7% 4/70	7.7% 4/52	0.0% 0/9	0.0% 0/6	0.0% 0/3
JUNE	7.1% 5/70	9.0% 4/44	7.0% 1/14	0.0% 0/11	0.0% 0/1
JULY	8.9% 6/67	9.0% 3/33	4.8% 1/21	18.2% 2/11	0.0% 0/2
AUG	5.3% 4/76	4.0% 2/50	10.5% 2/19	0.0% 0/5	0.0% 0/2
SEPT	10.3% 8/78	10.9% 6/55	9.5%* 2/21	0.0% 0/2	NA 0/0

Data notes:

- Discharges were only counted if there were more than 7 days between discharge and previous admit
- For Medicaid only, discharges were only counted if the client had Medicaid during the month of discharge.
- In 2014 we moved from SFY to CY monthly monitoring and also switched data sources from Pro-Fler and Community Hospital Billings to CommCare.
- 9/2014 included 8 readmission from 6 clients. 2 clients had 2 readmissions in 30 days

4. Access (Outpatient Penetration Rates)

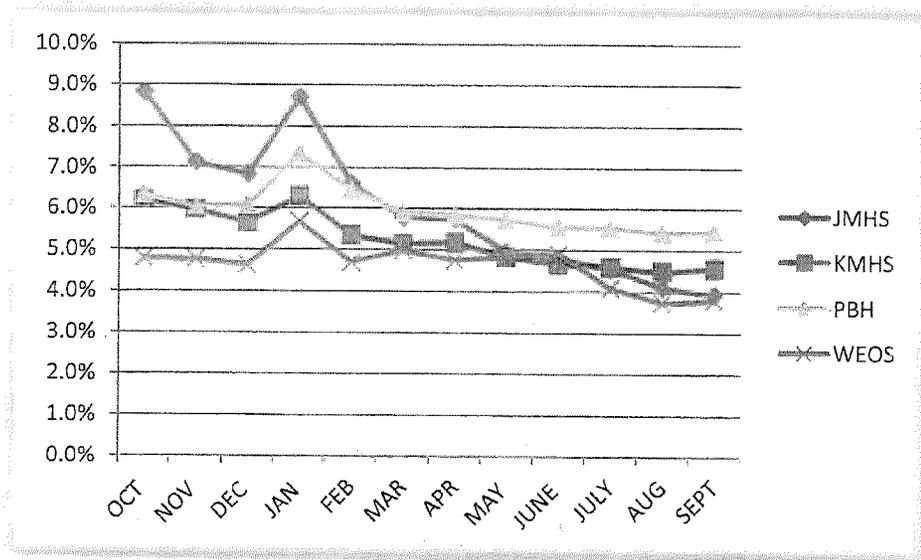
The study measures the penetration rates of each agency in providing services to their overall Medicaid population.

Data source: Medicaid eligible population, Pro-filer report for RSN Unduplicated T19 Serviced by Agency and Age group report.

Numerator: All Medicaid consumers served for the given time frame whose services are funded by Medicaid.

Denominator: Total Medicaid population

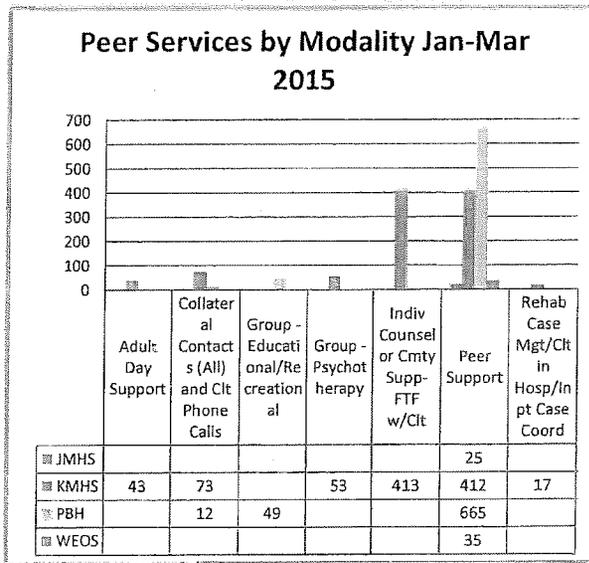
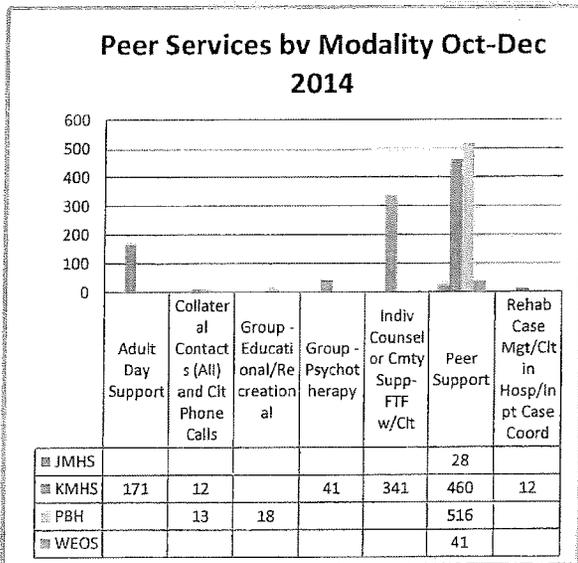
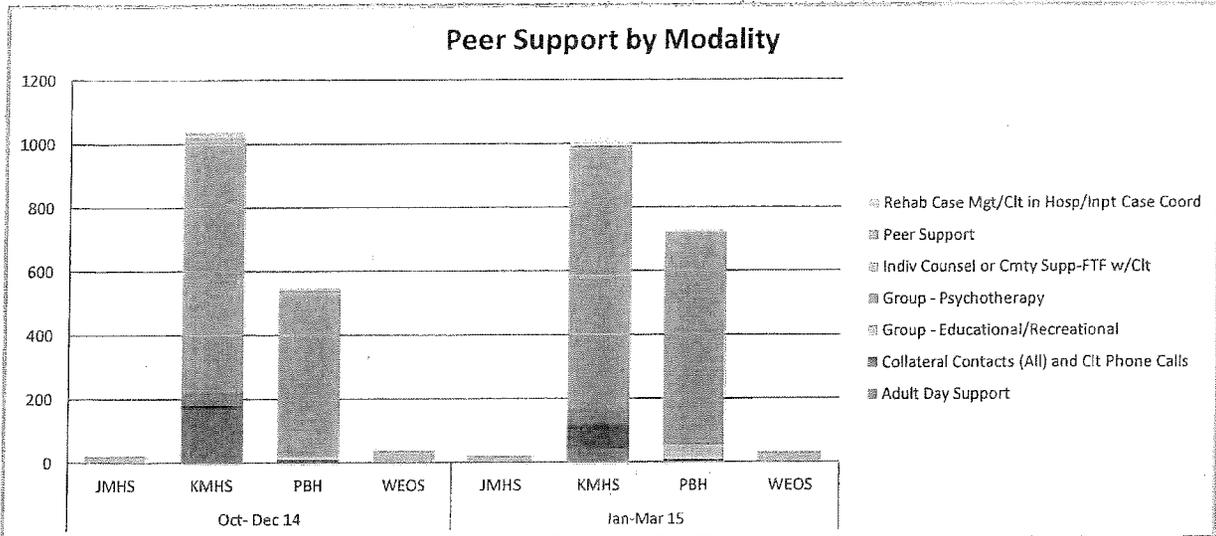
Minimum Performance Standard for Region =



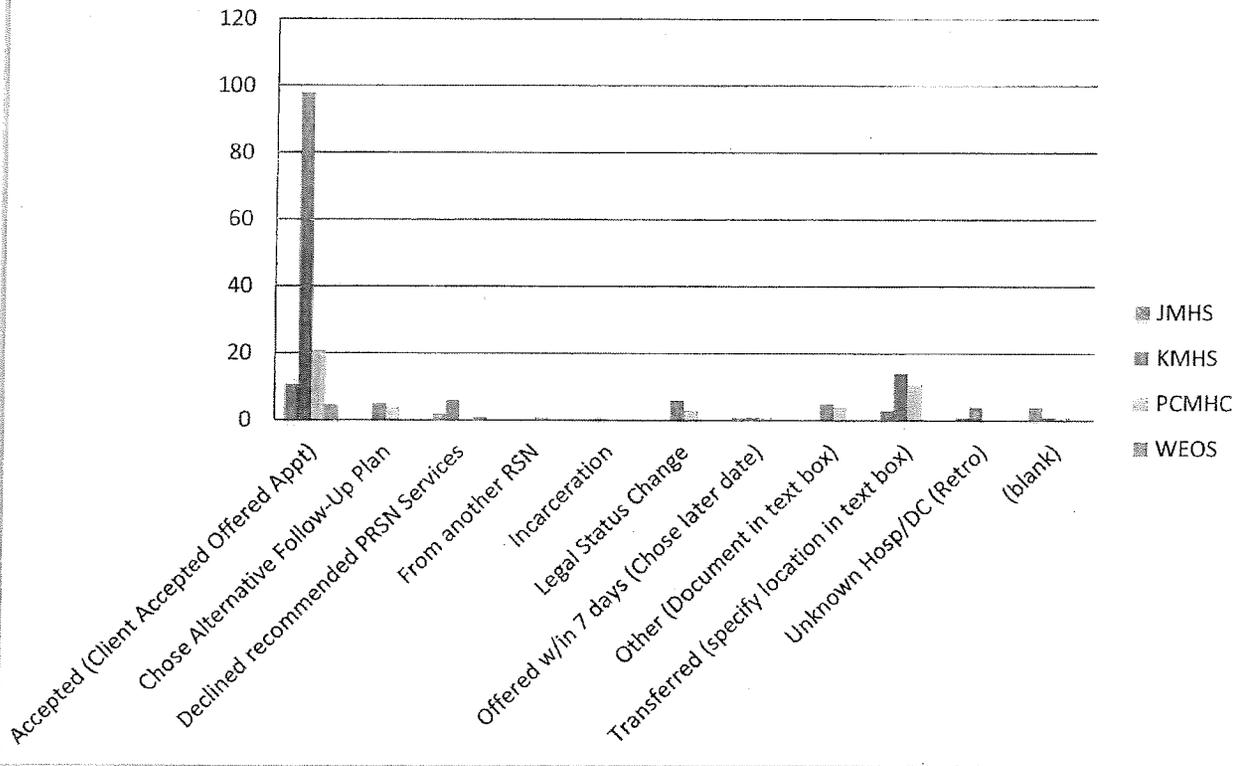
	Region	JMHS	KMHS	PBH	WEOS
OCT 13	6.3%	8.8%	6.2%	6.3%	4.8%
NOV 13	6.0%	7.1%	5.9%	6.0%	4.7%
DEC 13	5.8%	6.8%	5.6%	6.1%	4.6%
JAN 14	6.6%	8.7%	5.4%	6.1%	5.1%
FEB 14	5.6%	6.6%	5.3%	6.4%	4.7%
MAR 14	5.3%	5.8%	5.1%	5.9%	5.0%
APR 14	5.3%	5.7%	5.1%	5.8%	4.7%
MAY 14	5.0%	4.9%	4.8%	5.7%	4.8%
JUNE 14	4.8%	4.8%	4.6%	5.5%	4.9%
JULY 14	4.7%	4.5%	4.6%	5.5%	4.1%
AUG 14	4.6%	4.1%	4.5%	5.4%	3.7%
SEPT 14	4.6%	3.9%	4.5%	5.4%	3.8%

*This measure will be changing to include specific Medicaid funding (MAGI vs. Classic) when the data reports can support this query.

Peer Services

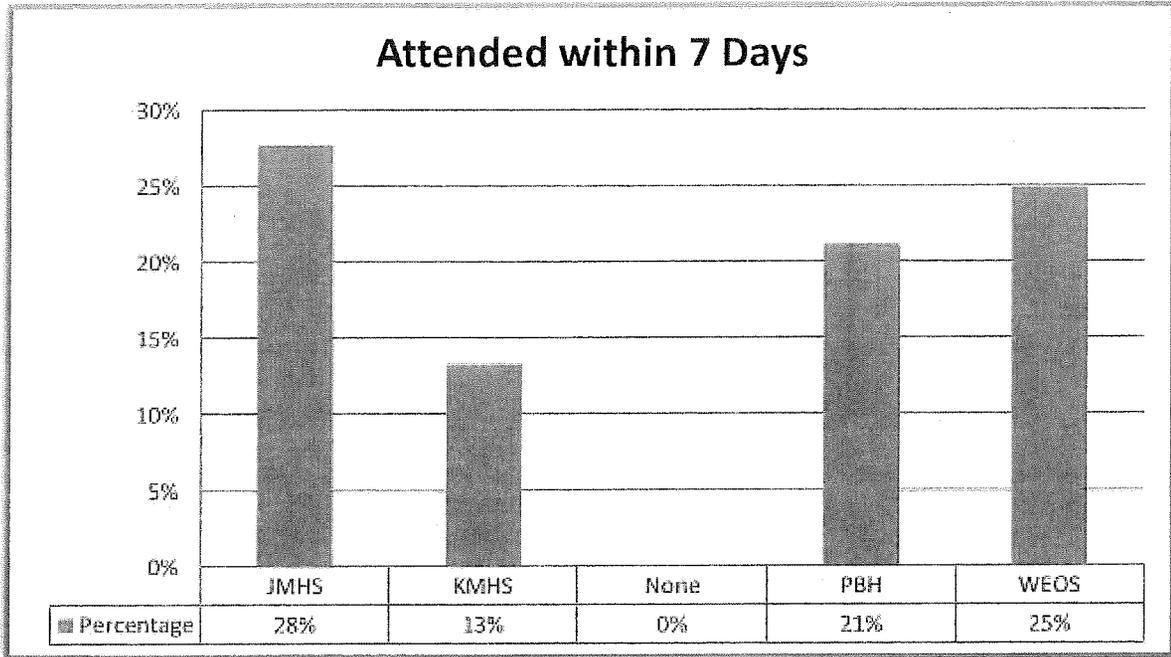


Appt offered within 7 days



<u>Offered 7 Day Codes</u>	<u>JMHS</u>	<u>KMHS</u>	<u>PCMHC</u>	<u>WEOS</u>	<u>Grand Total</u>
Accepted (Client Accepted Offered Appt)	11	98	21	5	135
Chose Alternative Follow-Up Plan		5	4		9
Declined recommended PRSN Services	2	6		1	9
From another RSN			1		1
Incarceration		1			1
Legal Status Change		6	3		9
Offered w/in 7 days (Chose later date)	1	1	1		3
Other (Document in text box)		5	4		9
Transferred (specify location in text box)	3	14	11		28
Unknown Hosp/DC (Retro)	1	4			5
(blank)	4	1	1		6
Grand Total	22	141	46	6	215
percentage of Accepted	50%	70%	46%	83%	63%

Attended within 7 Days



Hospital 7 day table only using criteria code #37 - Discharged, treatment completed no referral made and 'NONE'. Request for service entries are not included in this measure as a first service.

30 - Transferred (law enforcement, AIU/YIU, Internal Services)

35 - Discharged (treatment completed, no referral made)

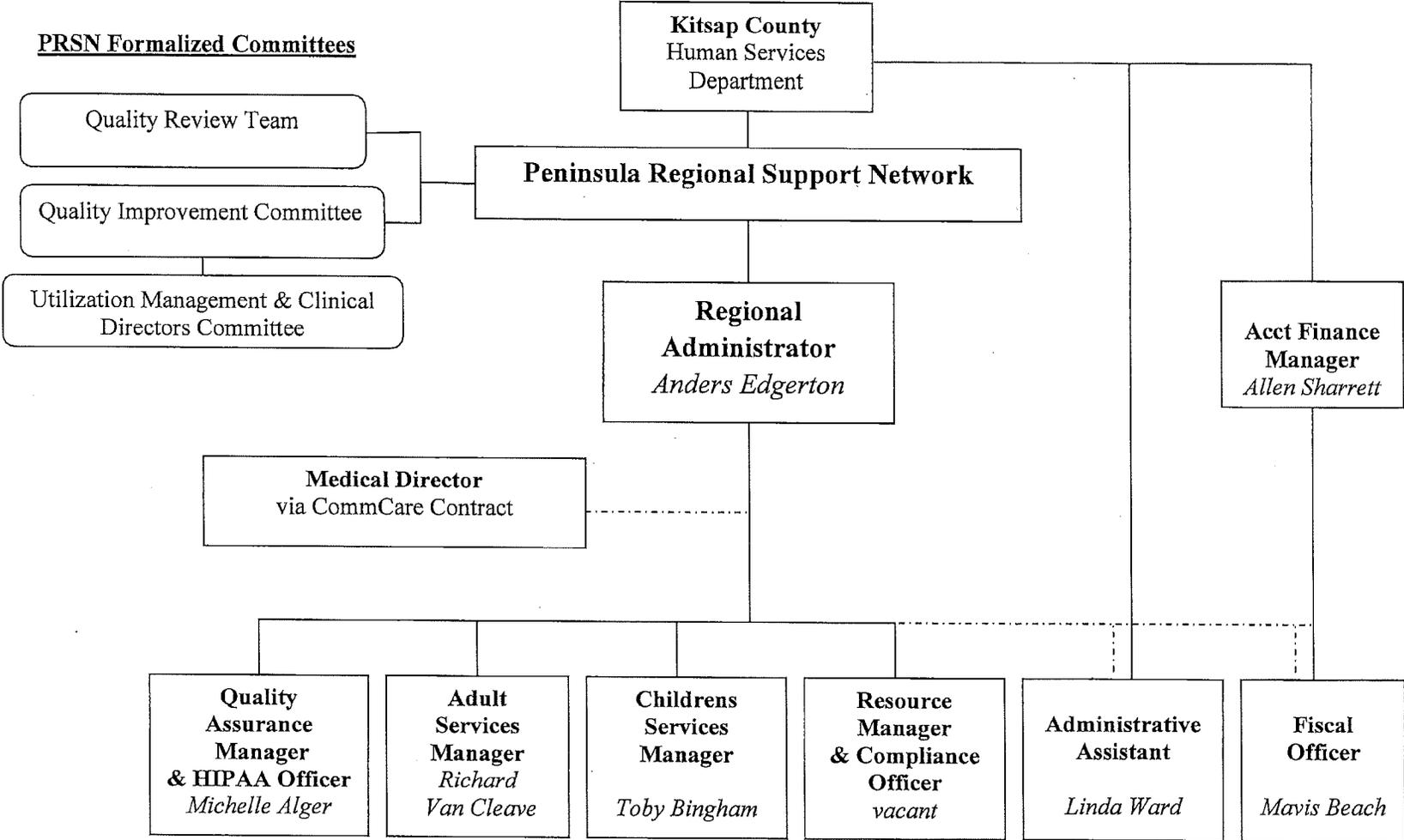
37 - Discharged (treatment completed, referral made)

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
Client Name	Cl't ID	Agency	Enrolled?	Funding	Age	Primary DX	Facility	LOS	Initial Discharge Date	Re-admit Date	Days between ReAdmit?	Planned Readmit? Y/N	Has Cl't been hospitalized in the past? Y/N	Does Cl't have hx of COD? Y/N	Does Cl't have hx of problems with treatment and/or medication adherence? Y/N	Discharge plan is clear, written and shared with cl't. Y/N	Follow up appt was within 7 days of discharge? Y/N	Cl't received 72 hr F/U call? Y/N	Cl't has housing? Y/N	COMMENTS
1																				

LaVonne
 Lois
 Richelle
 Connie
 Dani

PENINSULA REGIONAL SUPPORT NETWORK
* Staffing Organizational Chart

PRSN Formalized Committees





PENINSULA RSN

INPATIENT POLICIES AND PROCEDURES

Policy Name: CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP) COORDINATION

Policy Number: 12.09

Reference: WAC 388-865-0229

Effective Date: 2/2002

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Level Of Care
- Policy: Corrective Action Plan

PURPOSE

The Peninsula Regional Support Network (PRSN) has established a non-financial Working Agreement with the Childrens Long Term InPatient (CLIP) administration to ensure a consistent and effective partnership when coordinating services for children/youth.

PROCEDURE

The PRSN has established standardized criteria for children/youth seeking voluntary placement in the statewide CLIP program(s). Reference PRSN Level of Care for Voluntary CLIP.

The PRSN uses three (3) mechanisms to provide resource management, case coordination/ case management, community education, and CLIP gatekeeping for children and youth residing within Kitsap, Jefferson, and Clallam Counties.

PRSN Mechanisms:

1. The PRSN provides direct resource management, utilization management, and case management oversight of the CLIP program for children and youth

designated/ from the PRSN. The PRSN Childrens Services Manager is responsible for the individual transitional and discharge planning to/ from the community for children/ youth from Jefferson and Clallam Counties.

2. The PRSN CLIP Coordinator is a delegated case management position that is responsible for community education, referral inquiries, sending out and gathering completed applications, coordinating the local community gatekeeping committee(s) located in each county, and communicating the committee recommendations for approval or alternative options to CLIP. The CLIP Coordinator is also responsible for the individual transitional and discharge planning to/from the community for children/ youth from Kitsap County.
3. The local community gatekeeping committees (CLIP Community Resource Committees) are a group of volunteers from formal and informal child serving system within the community, as well as the child/ youth's family members and direct service team. The PRSN Childrens Services Manager participates on the committee as a community team member. The committee is responsible for recommending the approval/ authorization decisions of voluntary CLIP applications for voluntary children and youth from their community.

Admission Criteria:

1. The following admission criteria apply for children admitted on a voluntary basis:
 - a. Child must have severe psychiatric impairment which warrants the intensity and restrictions of the treatment provided in the long-term inpatient programs. A child will be considered to have such impairment if he/she has a severe emotional disturbance, corroborated by a clear psychiatric diagnosis based on the presence of signs and symptoms delineated in one or more of the following three categories:
 - 1) Signs and symptoms explicitly associated with marked, severe and/or chronic thought disorders, as defined in the DSM, including bizarre behavior, delusions, hallucinations, disturbed thought processes (e.g. loosened associations, illogical thinking, poverty of content or speech), blunt, flat or inappropriate affect, or grossly disorganized behavior.
 - 2) Signs and symptoms explicitly associated with marked severe, or chronic affective disorders, as defined in the DSM, including mania, depression, vegetative signs, suicide attempts, or self-destructive behaviors.
 - 3) Chronic or grossly maladaptive behaviors associated with incipient forms or components of 1) or 2) above, or symptomatic of other diagnosed severe psychiatric impairment. The presence of such symptoms should be clearly identified as resulting from a mental disorder and not be solely attributable to other factors (e.g. alcohol or drug abuse, antisocial behavior, sexual deviancy, mental retardation). Children who have been diagnosed as having a severe psychiatric illness and who demonstrate a repetitive pattern of antisocial behavior (e.g. sexual aggression) are considered eligible for admission if their needs can reasonably and appropriately be met in a long-

- term program. All other community based least restrictive alternatives must have been attempted.
- b. Children whose intellectual functioning is below the normal range as defined in the DSM are considered for admission if it has been determined that they meet the above criteria of having a severe psychiatric disorder, and their needs can reasonably and appropriately be met in a long-term program.
2. The following admission criteria apply for adolescent (over 12 years of age) admitted on an involuntary basis:
 - a. Adolescents committed for 180 days of restrictive care under the provisions of Chapter 71.34 RCW are thereby certified as eligible for admission to the program.
 - b. Hospitals and Evaluation and Treatment facilities must inform the CLIP administration when they place an adolescent on a 180 day hold.
 - c. The PRSN network providers may work in cooperation with the hospital/ Evaluation and Treatment Center and determine to the adolescent can be served on a 180 day Least Restrictive Court Order (LRA), instead of admitted to CLIP.
 - When this occurs, the CLIP Administration must be notified.
 - The adolescent may continue to stay on the CLIP waiting list while on a LRA, until the date of the 180 day expiration.
 3. All children served, whether on a voluntary or involuntary basis, shall be admitted and discharged in accordance with Chapter 388-865-0500 through 0565.
 4. The PRSN will utilize the established Working Agreement to promote rapid and successful integration of children/ youth to the community from a CLIP program. The PRSN provides oversight and direct case coordination to monitor these activities and target quality improvement processes.
 5. In the case of an admission directly from a Tribe, the PRSN and assigned network provider will work with the tribe during discharge planning as necessary to provide appropriate services to the child/youth.

MONITORING

1. The PRSN monitors this policy through:
 - Frequent consultation with the CLIP Administration and CLIP facilities
 - Monthly analysis of CLIP utilization management reports (as available)
 - Weekly oversight from PRSN Childrens Services Manager discussing children /youth awaiting CLIP, in CLIP, and recently discharged from CLIP
 - PRSN staff participation on the Community Resource (gatekeeping)Team

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

Children's Long-Term Inpatient Program Requirements (2007 MHD InPt Instructions Per Diem)

The Children's Long-Term Inpatient Program (CLIP) is provided under contract with the MHD. For more information, go to <http://www.clipadministration.org/>

The following requirements apply to hospitals and Evaluation and Treatment (E&T) facilities:

- **Referral to CLIP:** When the court determines that a 180-day commitment to inpatient care in a state-funded facility is necessary for a juvenile, the committing hospital or E&T facility must notify CLIP Administration of the court's decision *by the end of the next working day following the court hearing.* (RCW 71.34.) Once the Committee is notified, authorization for additional care can be issued by the appropriate MHD designee (see MHD designee flow chart at the end of this document.)

When a hospital or E&T receives a consumer for CLIP, they are expected to supply information as specified in the information requirements in the children's long-term inpatient care referral packet.

HRSA will not reimburse for services provided in a juvenile detention facility.

- ✓ **Initial Notification:** The committing hospital or E&T must notify the CLIP Administration by the end of the next working day of the 180-day court commitment to state-funded long-term inpatient care.

The following information is expected:

- Referring staff, organization and telephone number.
 - Consumer's first name and date of birth.
 - Beginning date of 180-day commitment and initial detention date.
 - Consumer's county of residence.
- ✓ **Discharge Summary and Review of Admissions:** Within two weeks of transfer from the hospital or E&T to a CLIP facility, a copy of the completed discharge summary must be submitted to the CLIP Administration and to the facility where the child is receiving treatment. *All referral materials* should be sent to the CLIP Administration at the following address:

CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP)
2142 10TH AVENUE W
SEATTLE WA 98119
(206) 298-9654

Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the MHD designee access to review the care of any minor (regardless of source of payment) who has been admitted upon application of his/her parent or legal guardian. For the purposes of the Review of Admissions, all information requested must be made available to the MHD designee. The MHD designee must document in writing any subsequent determination of continued need for care. A copy of the determination must be in the minor's hospital record.

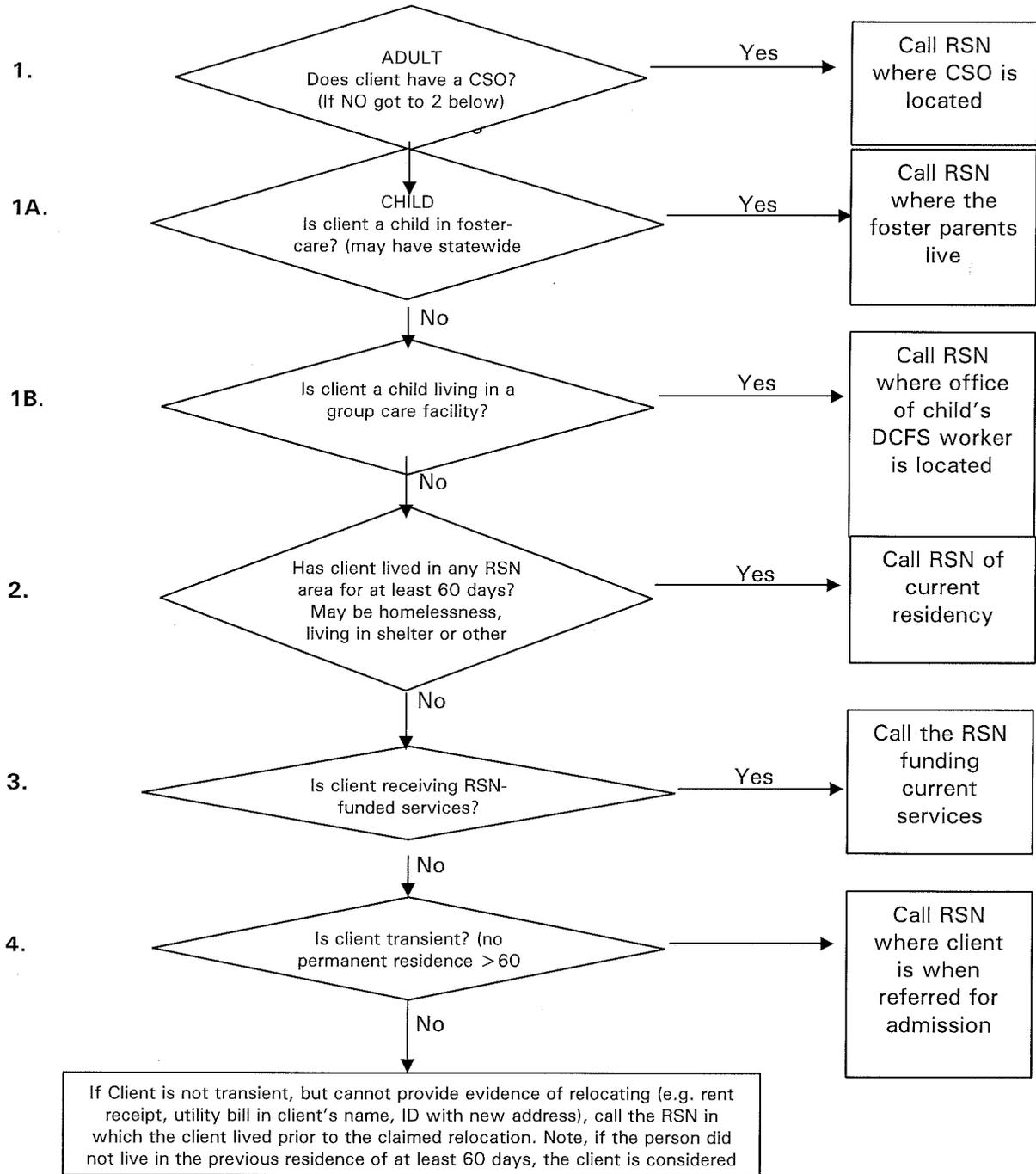
- ✓ **Referral Packet:** A referral packet concerning the ITA committed youth must be submitted to the CLIP Administration within five (5) working days of telephone notification for the 180-day commitment. If the child is transferred to another facility for an interim placement until CLIP care is available, the referral packet must accompany the child. The following items are required components of the referral packet:
 - A certified copy of the court order: 180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist.
 - A diagnosis by a Psychiatrist including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
 - An admission evaluation including:
 - ✓ Medical evaluation
 - ✓ Psychosocial evaluation
 - The hospital or E&T record face sheet
 - Other information about medical status including:
 - ✓ Laboratory work
 - ✓ Medication records
 - ✓ Consultation reports
 - Outline of entire treatment history
 - All transfer summaries from other hospitals or E&Ts where the child has been admitted during current commitment as well as all discharge summaries from any prior hospitalization or E&T.
 - A brief summary of youth's progress in treatment to date including inpatient course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment.
- ✓ **Submitting Other Background Information for CLIP referrals:**

During the 20 days following the 180-day commitment hearing, the committing hospital or E&T must arrange to have the following background information submitted to the CLIP Administration. This information should be submitted prior to admission to the CLIP program.

- Written formulation/recommendation of the local intersystem team responsible for the adolescent's long-term treatment plan should include family's involvement, and detail of treatment history, as well as less restrictive options being considered.
 - DSHS case records, including placement history form, ISPs, court orders, etc. Include legal history regarding juvenile arrests, convictions, probation/parole status
 - Complete records from all hospitalizations or other inpatient care, including admission and discharge summaries, treatment plans, social history evaluations, consultations, and all other assessments (do not include daily progress notes.)
 - Treatment summaries and evaluations from all foster or residential placements and all day treatment and outpatient treatment summaries.
 - If not contained in other documents, a comprehensive social history, including developmental and family history.
 - School records, including special services assessments, transcripts, psychological evaluations, current IEP, current level of functioning.
 - Immunization record, copy of social security card and birth certificate.
- ✓ **Inter-facility Transfer Reports**

When an youth who has been involuntarily detained is transferred from one facility to another, an inter-facility or hospital transfer report detailing the adolescent's current medical, psychiatric, and legal status (in terms of both ITA commitment and custody) must accompany that child as well as a certified copy of the court order.

MHD Designee Flow Chart –



To access CLIP services the following procedures apply.

1. Voluntary Admissions Process

Action By	Action
PRSN CLIP Coordinator (360-479-4994)	Receives the CLIP application, supporting documentation, and schedules a meeting of the local Community Resource Team, made up of members of the child serving system and families. Provides the application material for review by the Community Resource Team.
Community Resource Team	Reviews the application and explores less restrictive alternatives available in the community, in making the determination for CLIP approval. Recommendations are provided to the CLIP Coordinator to communicate to the child/youth family. <ul style="list-style-type: none"> • If the CLIP application is approved, the coordinator submits the application to the state CLIP Administration for consideration. • If the CLIP application is denied, the coordinator provides a written notice with an explanation, recommendations, and timeframes for another review.
CLIP Administration State Committee	Approves or denies the PRSN CLIP application, forwards their decision to the PRSN CLIP Coordinator for transitional case management.
PRSN CLIP Coordinator	Coordinates the CLIP placement, liaisons with the family, and oversees continued certification while the child/youth is on the waiting list (prior to admission). Addresses any local issues the CLIP Administration identifies.

2. Involuntary Admissions Process

Action By	Action
DMHP	Detains an adolescent under the Involuntary Treatment Act for 72 hours to an acute psychiatric facility.
Inpatient Facility and the Court	Determines the continued medical necessity for inpatient care, and if warranted orders a 14-day detention
Inpatient Facility and the Court	Following the 14-day hold, determines if 180-day inpatient care is warranted and petitions for a 180-day hold. Notifies the CLIP Administration of the 180-day order and the local PRSN CLIP Coordinator. <ul style="list-style-type: none"> • If the adolescent is discharged on 180-day LRA, the inpatient facility or PRSN CLIP Coordinator will notify the CLIP Administration Coordinator.
PRSN CLIP Coordinator	Coordinates the CLIP placement, liaisons with the family, and oversees the ITA documentation (i.e. the 5 day packet) child/youth is on the waiting list (prior to admission). Addresses any local issues the CLIP Administration identifies.

Working Agreement
Between

Peninsula Regional Support Network
Kitsap Mental Health Services
And

Kitsap County Jail and Kitsap County Juvenile Department

Parties:

This Agreement is made and entered into by the Peninsula Regional Support Network (PRSN), Kitsap Mental Health Services (KMHS), the Kitsap County Jail (hereinafter referred to as the "Jail") and the Kitsap County Juvenile Department (hereinafter referred to as KCJD).

Intent:

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

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

Purpose:

The purpose of this Agreement is to create a structure that promotes a productive working relationship between public mental health services, the Jail, and KCJD. It is understood that, for mutually served clients, the Jail and KCJD are responsible to provide a safe and secure environment for inmates. KMHS is responsible to provide the mental health services needed by mutually served clients who qualify for public mental health services, including transitional services.

It is not the responsibility of KMHS to provide services to inmates who do not meet State access to care guidelines.

Subcontractor (KMHS) Responsibilities:

1. Coordinate with local law enforcement and Jail/KCJD personnel in the contractors' service area to facilitate a referral process for individuals with mental illness who are incarcerated and meet state access to care criteria (see attached).
2. Provide transition services to individuals with mental illness who meet state access to care criteria to expedite, facilitate, and coordinate their return to the community.
3. Identify and accept referrals for intake of individuals who are not enrolled in community mental health services but who meet priority populations as defined in 71.24. KMHS shall conduct mental health intake assessments for these individuals and provide transition services prior to their release from Jail/KCJD.
4. Coordinate with local community service offices toward the facilitation of expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. KMHS shall assist individuals with mental illness who meet State access to care criteria in completing and submitting applications for medical assistance to the local CSO prior to release from Jail/KCJD.
5. Provide a quarterly report to the Jail/KCJD and PRSN on services provided with this funding in accordance with the Report Schedule listed below:

Jail Services Program Report Schedule

Service Period	Due Date

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

1. Daily cross-reference between new bookings and the PRSN data base to identify newly booked persons known to the PRSN.
2. Development of individual alternative service plans (alternative to the Jail/KCJD) for submission to the courts – if receptive.
3. Pre-release transition planning (e.g. assessments, mental health services, co-occurring services, and housing).

4. Intensive post-release outreach to ensure individuals follow up with CSO and appointments for mental health and other services (e.g. substance abuse).
5. Inter-local agreements with juvenile detention facilities.
6. Training to local law enforcement and jail services personnel.
7. Provision of some direct mental health services to individuals who are in small jails which have no mental health staff.

Jail/KCJD Responsibilities:

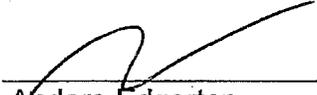
1. Identify those individuals who may meet priority populations as defined in RCW 71.24 and make timely referrals to KMHS.
2. Provide a referral with pertinent information and appropriate releases (if applicable) to KMHS designated staff.
3. Appropriate Jail/KCJD staff will participate in the mental health assessment and treatment as needed or requested by KMHS.
4. Upon request of either party, Jail/KCJD staff will participate in interagency staffing for mutually shared inmates. This will allow for updating treatment planning, sharing of information, and collaborative problem-solving.
5. For inmates served by both the Jail/KCJD and KMHS, service planning will be collaborative and focused on transitional outcomes.

REVIEW AND AMENDMENTS:

1. For each county served by the PRSN, a description of the specific implementation of the Agreement will be attached to Working Agreement. (See attachment.)
2. The parties will review the Agreement and its attachments at least every two years. The agreement will remain in effect until a new agreement is signed or funding ceases.
3. If at any time the Agreement becomes a barrier to good practice, or inhibits positive innovations in service delivery, the parties will meet to eliminate the barriers to services. The Agreement may be reviewed at any time at the request of one of the parties.
4. Either party may submit to the other party an amendment to this Agreement. The amendments shall be accepted with both parties sign the amended Agreement.

5. The PRSN contact person regarding this Agreement is the Administrator. The KMHS contact person regarding this Agreement pertaining to the Kitsap County Jail is Kathryn Felix. The KMHS contact person regarding this Agreement pertaining to the KCJD is Beth Friedman-Darner. The Jail contract person regarding this Agreement is Ned Newlin. The contract person regarding this agreement for KCJD is Michael Merringer.
6. KMHS and the Jail/KCJD agree to abide by the following process in resolving disputes, including disputes related to services or cost responsibility:
 - a. Each party agrees to begin a dispute resolution process. The initial attempts to resolve the dispute will occur between the local Jail/KCJD staff and the KMHS staff.
 - b. If the resolution efforts fail at that level, the issue shall be referred to the KMHS contact person and the Jail/KCJD supervisor within three working days. Both the mental health provider and the Jail/KCJD supervisor will be given the opportunity to provide information, preferably through a conference call or, if this is not possible, in writing to the PRSN Administrator.
 - c. If the KMHS contact person and the Jail/KCJD supervisor are not able to resolve difference, the matter will be referred to the PRSN Administrator.
 - d. If the resolution cannot be reached through the above process, the matter may be referred by either party to DSHS Headquarters.
 - e. This process does not interfere with the right of the PRSN to involve the Ombudsman for the mental health system.

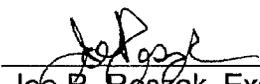
For the Peninsula Regional Support
Network:


Date 8-2-13
Anders Edgerton,
Regional Administrator
Peninsula Regional Support Network

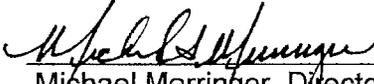
For the Kitsap County Jail:


Date 6/25/13
Ned Newlin, Chief of Corrections
Kitsap County Sheriff's Office

For Kitsap Mental Health Services:


Date 06/18/2013
Joe R. Roszak, Executive Director
Kitsap Mental Health Services

For the Kitsap County Juvenile
Department:


Date 6-27-13
Michael Merringer, Director
Kitsap County Juvenile Department

KMHS Jail Services

Mental Health Professional (.5)

20 hours/week

- Screening
- Matching list of new inmates with client list at KMHS
- Engagement into outpatient mental health services
- Intake assessment
- Coordination with Benefit Specialist
- Collaboration with Defense Attorney/Probation Officer as needed
- Service referrals
- Brief interventions as needed
- Transition planning/coordination with mental health provider
- Assign clinician upon release of inmate until Medicaid benefits kick in
- Follow-up to ensure that all eligible inmates are enrolled into services upon release

Benefits Specialist

As needed

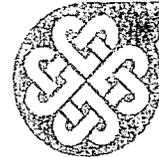
- Assist inmates with benefit applications
- Submit applications to CSO upon release

KMHS Juvenile Services

Mental Health Professional

6 hours/week

- Meets with all youth who are on Documented Watch and Undocumented Watch per Kitsap County Juvenile Detention Center protocols. Make assessment of risk and provide recommendations. Communicate with detention staff, probation officer, therapist, case managers and family members about needs/risk.
- Provides follow-up support to the DMHP's who may have evaluated youth and are looking for a Less Restrictive Alternative or having youth contract for safety with the knowledge they will have another Mental Health Professional meet with them the following day.
- As time allows meets with all youth who have expressed, upon intake, a need/desire to meet with a counselor while they are detained.



**KITSAP
MENTAL
HEALTH
SERVICES**

July 3, 2013

Anders Edgerton
Kitsap County Department of Personnel
and Human Services
614 Division Street, MS-23
Port Orchard, WA 98366-4676

Re: Working Agreement Between PRSN, KMHS, KC Jail, KC Juvenile
Department

Dear Mr. Edgerton:

Attached please find two originals of the Working Agreement Between Peninsula Regional Support Network, Kitsap Mental Health Services, Kitsap County Jail, and Kitsap County Juvenile Department. The Agreement has been signed by Ned Newlin, Michael Merringer, and Joe Roszak. If it meets with your approval, would you kindly sign the agreement where it is indicated and return one fully executed agreement to me for our records. You may retain the other for your files. I will send copies of the fully executed Working Agreement to Mr. Newlin and Mr. Merringer for their records upon my receipt.

If you have questions or concerns, please do not hesitate to contact me at 360-415-5802 or via e-mail at andy@kmhs.org.

Thank you.

Jody Doty
Jody Doty
Executive Assistant
Kitsap Mental Health Services

Encs.

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Joe Roszak
Executive Director

The mission of Kitsap
Mental Health Services
is to improve the lives of our
mental health through
care of the science
services delivered
community partnerships
and advocacy.

PH: (360) 372-5031
TDD: (360) 372-5031
Fax: (360) 372-4158

5555 Amity Drive NE
Bremerton, WA 98311-8311

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United Way

KMHS does not discriminate against
any person on the basis of race, color,
national origin, sex, disability, marital
status, religion, ancestry, age, veteran
status, or other protected status under
applicable laws in its programs and
activities.



**KITSAP
MENTAL
HEALTH
SERVICES**

August 14, 2014

Anders Edgerton
PRSN Regional Administrator
Kitsap County Department of Personnel
And Human Services
614 Division Street, MS-23
Port Orchard, WA 98366-4676

Re: Amendment to Agreement – KMHS Juvenile Detention Services

Dear Mr. Edgerton:

Enclosed please find three (3) originals of the Amendment to Agreement – KMHS Juvenile Detention Services signed by Kitsap Mental Health Services Chief Executive Officer Joe Roszak and Michael Merringer, Director KCJDC.

After review and signature, please return it to me for our records. Thank you for your assistance. If you have questions or concerns, please feel free to contact me at 360-415-5802 or via e-mail to jody@kmhs.org.

Sincerely,

10-13-14
To —

Jody Doty
Executive Assistant
Kitsap Mental Health Services

cc: Michael Merringer
Enc.

Returned per instructions - signed amendments. lw

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- Joe Roszak
Chief Executive Officer

The mission of Kitsap Mental Health Services is to shape the future of mental health through state-of-the-science service delivery, community partnerships, and advocacy.

PH: (360) 373-5031
TDD: (360) 478-2715
Fax: (360) 377-0458
5455 Almera Drive NE
Bremerton, WA 98311-8331
www.kitsapmentalhealth.org



KMHS does not discriminate against any person on the basis of race, color, national origin, sex, disability, marital status, religion, ancestry, age, veteran status, or other protected status under applicable laws in its programs and activities.

WORKING AGREEMENT
between

PENINSULA REGIONAL SUPPORT NETWORK,
JEFFERSON MENTAL HEALTH SERVICES (JMHS)
and
JEFFERSON COUNTY JAIL (JCJ)

Parties:

This Agreement, is made and entered into by the Peninsula Regional Support Network (PRSN), Jefferson Mental Health Services (JMHS) and the Jefferson County Jail (JCJ) hereinafter referred to as the "Jail".

Intent:

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

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

Purpose:

The purpose of this Agreement is to create a structure that promotes a productive working relationship between public mental health services and the Jail. It is understood that, for mutually served clients, the Jail is responsible to provide a safe and secure environment for inmates. Jefferson Mental Health Services (JMHS) is responsible to provide the mental health services needed by mutually served clients who qualify for public mental health services, including transitional services.

It is not the responsibility of Jefferson Mental Health Services (JMHS) to provide services to inmates who do not meet the State established access to services guidelines.

Subcontractor Jefferson Mental Health Services (JMHS) Responsibilities:

- 1) Coordinate with local law enforcement and jail personnel in the contractors' service area to facilitate a referral process for individuals with mental illness who are incarcerated and need mental health services.
- 2) Provide transition services to individuals with mental illness to expedite, facilitate, and coordinate their return to the community.

- 3) Identify and accept referrals for intake of individuals who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. Jefferson Mental Health Services (JMHS) shall conduct mental health intake assessments for these individuals and provide transition services prior to their release from jail.
- 4) Coordinate with local community service offices toward the facilitation of expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. Jefferson Mental Health Services (JMHS) shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.
- 5) Provide a quarterly report to the Jail and PRSN on services provided with this contract.

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

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

Jefferson County Sheriff's Office (JCSO) Jail Responsibilities:

1. Identify those individuals who may meet priority populations as defined in RCW 71.24 and make timely referrals to Jefferson Mental Health Services (JMHS).
2. Provide a referral packet containing pertinent information and appropriate releases to Jefferson Mental Health Services (JMHS) designated staff.
3. Appropriate Jail staff will participate in the mental health assessment and treatment as needed or requested by Jefferson Mental Health Services (JMHS).
4. Upon request of either party, Jail staff will participate in interagency staffing for mutually shared inmates. This will allow for updating treatment planning, sharing of information and collaborative problem-solving.
5. For inmates served by both the Jail and Jefferson Mental Health Services (JMHS), service planning will be collaborative and focused on transitional outcomes.

REVIEW AND AMENDMENTS:

The parties will review the Agreement at least every two years. The Agreement will remain in effect until a new agreement is signed or funding ceases.

If at any time the Agreement becomes a barrier to good practice, or inhibits positive innovations in service delivery, the parties will meet to eliminate the barriers to services. The Agreement may be reviewed at any time at the request of one of the parties.

Either party may submit to the other party an amendment to this Agreement. The amendments shall be accepted when both parties sign the amended Agreement.

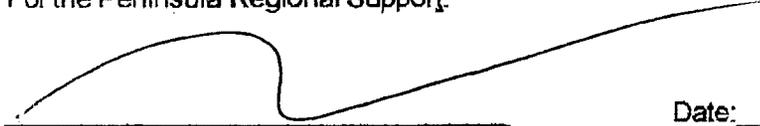
The PRSN contact person regarding this Agreement is the Administrator. The Jefferson Mental Health Services (JMHS) contact person regarding this Agreement is Adam Marquis, Executive Director,

The Jail contact person regarding this Agreement is Steven Richmond, Jefferson County Jail Superintendent.

A. Jefferson Mental Health Services (JMHS) and the Jail agree to abide by the following process in resolving disputes, including disputes related to services or cost responsibility:

1. Each party agrees to begin dispute resolution as close to direct client care as possible. The initial attempts to resolve the dispute will occur between the local Jail leadership staff to include but no limited to the Sheriff, Undersheriff and Superintendent, and the Jefferson Mental Health Services (JMHS) leadership staff.
2. If resolution efforts fail at that level, the issue shall be referred to the Jefferson Mental Health Services (JMHS) contact person and the Jail Supervisor within three working days. Both the mental health provider and Jail supervisor will be given the opportunity to provide information, preferably through a conference call or, if this is not possible, in writing, to both the PRSN Administrator.
3. If the Jefferson Mental Health Services (JMHS) contact person and the Jail supervisor are not able to resolve differences, the matter will be referred to the PRSN Administrator.
4. If resolution cannot be reached through the above process, the matter may be referred by either party to DSHS Headquarters.
5. This process does not interfere with the right of PRSN to involve the Ombudsman for the mental health system.

For the Peninsula Regional Support:



 Anders Edgerton, Regional Administrator

Date: 10-1-15

For Jefferson Mental Health Services (JMHS):



 Adam Marquis, Executive Director

Date: 10/1/2015

For the Jefferson County Jail (JCJ):



 David Stanko, Sheriff

Date: 9/20/2015



 STEVE RICHMOND, JAIL SUPERINTENDENT

Date: 9/30/15

Memorandum of Understanding (MOU)
Between
Port Angeles Service Office (CSO)
Clallam County Correctional Facility (CCCF)
And
Peninsula Community Mental Health Center (PCMHC)

This MOU is made and entered into between the Port Angeles CSO, CCCF, and PCMHC. This agreement is effective from **September 1, 2010** through **August 31, 2011**. Termination of any, or all, processes of this MOU may be made by either party with thirty (30) days written notice.

Intent:

The intent of this MOU is to coordinate with local law enforcement and jail personnel in order to detail a referral process for individuals with mental illness who are incarcerated and need mental health services.

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

While primary responsibility for direct mental health services and medications for individuals in the jail is the responsibility of the county, given that the CCCF does not have any mental health providers on staff, PCMHC shall provide required services. These services include medications or other treatments as necessary to meet clinical needs, and prepare the individual for safe transition to community living, within available resources.

IT IS THE UNDERSTANDING OF BOTH PARTIES THAT THE STEPS DESCRIBED BELOW WILL SERVE AS THE PROCESS FOR ACCOMPLISHING THE INTENT OF THIS MOU AS FOLLOWS:

Jail Services Program (JSP) Expedited Process

The following processes have been developed to facilitate smooth and timely processing of PCMHC JSP applications:

1. Clallam County Correctional Facility staff will administer a medical questionnaire to all inmates as a part of the booking process. When information gathered via the questionnaire indicates a possible need for mental health follow up, Clallam County Correctional Facility medical staff will notify the Peninsula Community Mental Health Center Community Support Services supervisor by phone at 457-0431 or fax sent to 457-0493.

2. Referrals for mental health services to persons in the jail may also come from other sources such as the inmate, the inmate's family members, attorneys, or other community agencies.
3. The Community Support Services supervisor will ensure that a Peninsula Community Mental Health Center provider will visit the inmate within one business day of the initial referral. This MOU does not supersede access to crisis intervention services, which are available 24 hours a day, seven days a week.
4. If an intake assessment is needed, the Community Support Services supervisor, or designee, will conduct the assessment within three business days of the initial referral date and provide follow up mental health services as needed in jail, and up to 90 days following release.
5. When the Peninsula Community Mental Health Center provider identifies an individual incarcerated at the Clallam County Jail who is mentally ill and need General Assistance (GA) or Medicaid benefits due to that illness the mental health provider will assist the inmate to complete an Application for Benefits. The inmate will also sign DSHS 14-012 Release of Information consent form authorizing the Peninsula Community Mental Health Center provider to share the applicant's confidential information with DSHS. The Peninsula Community Mental Health Center provider will submit the application within one business day to the local CSO office located at 201 West First Street, Port Angeles, Washington, 98362.
6. The PCMHC representative will annotate PCMHC/Jail Services Program in bold at the top of the *Application for Benefits* form. The PCMHC representative will then mail the 1.) *Application for Benefits*, 2.) *Release of Information* – consent form, 3.) Medical information, 4.) Financial eligibility and, 5.) If applying for GA, the CSHS 14-050 *Statement of Education, Health, and Employment* form to the local CSO office, 201 West First Street, Port Angeles, WA 98362.
7. Any time during the application process that the Clallam County Jail establishes the applicant's actual release date, the Jail staff will notify the CSO and the Community Support Services supervisor (fax number 457-0493) of the release date.
8. ***Upon receipt of the completed Release of Information consent form, CSO staff will add the PCMHC representative to the ACES AREP screen under type "NO" to ensure that the PCMHC representative receives all DSHS notices, including appointment notification.**
9. If applying for GA:
 - The CSO Screener will schedule a telephone interview with the applicant in Jail

**PCMHC will bill for copying costs on all medical reports that are used towards reaching an incapacity decision. Social Services will complete payment via the SSPS system.*

via phone contact w/Jail staff.

- The assigned CSO financial worker will call the Jail at 417-2458 to make arrangements with the duty Sergeant for a telephone interview with the applicant.
- At the time of the interview, the CSO financial worker will verbally inform the applicant of the status of financial eligibility. If additional information of verification is needed to establish financial eligibility, the CSO financial worker will send written notification to the applicant at the Jail address.
- When financial eligibility is established, with the exception of the final release date, the CSO financial worker will complete a communication referral to the CSO Incapacity Social Worker (ISW) and mail a copy of the same to PCMHC @ 118 East Eighth Street, Port Angeles, WA 98362.
- The CSO ISW will determine eligibility for the GA program based upon applicable Washington Administrative Code policies using the Progressive Evaluation Process (PEP). The customer will not be required to attend a GA orientation. If additional medical information is necessary, the CSO ISW will contact the applicant at the Jail and notify him/her of the additional information necessary to determine incapacity eligibility.
- The CSO ISW will notify the CSO financial worker of the GA Incapacity decision.
- When the applicant's final release date is known, the CSO financial worker will process the GA application.

10. If applying for Medicaid only and no disability determination is available:

- The CSO financial worker will make the appropriate Non-Grant Medical Application (NGMA) referral. The referral will note that the application is for PCMHC JSP and give the release date, if known.

This MOU may be amended by written consent of all parties and all amendments shall be attached to this agreement and made a part of thereof.

Peter O. Casey
Peter O. Casey, Executive Director
Peninsula Community Mental Health Center

Date: August 30, 2010

Patricia Busse
Patty Busse, Administrator

Date: 9.17.10

Port Angeles CSO, DSHS



W.L. Benedict, Sheriff
Clallam County Sheriff's Office

Date: 9-7-2010



Ronald Sukert, Jail Superintendent
Clallam County Sheriff's Office

Date: 09-07-10

WORKING AGREEMENT
between

PENINSULA REGIONAL SUPPORT NETWORK
WEST END OUTREACH SERVICES
and
FORKS CITY JAIL

Parties:

This Agreement, is made and entered into by the Peninsula Regional Support Network (PRSN), West End Outreach Services (WEOS), and the Forks City Jail hereinafter referred to as the "Jail".

Intent:

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

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

Purpose:

The purpose of this Agreement is to create a structure that promotes a productive working relationship between public mental health services and the Jail. It is understood that, for mutually served clients, the Jail is responsible to provide a safe and secure environment for inmates. WEOS is responsible to provide the mental health services needed by mutually served clients who qualify for public mental health services, including transitional services.

It is not the responsibility of WEOS to provide services to inmates who do not meet the State established access to services guidelines.

Subcontractor (WEOS) responsibilities:

- 1) Coordinate with local law enforcement and jail personnel in the contractors' service area to facilitate a referral process for individuals with mental illness who are incarcerated and need mental health services.
- 2) Provide transition services to individuals with mental illness to expedite, facilitate, and coordinate their return to the community.

- 3) Identify and accept referrals for intake of individuals who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. WEOS shall conduct mental health intake assessments for these individuals and provide transition services prior to their release from jail.
- 4) Coordinate with local community service offices toward the facilitation of expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. WEOS shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.
- 5) Provide a quarterly report to the Jail and PRSN on services provided with this funding in accordance with the Report Schedule listed below;

Jail Services Program Report Schedule

Service Period	Due Date
September – November 2010	December 15, 2010
December 2010 – February 2011	March 15, 2011
March – May 2011	June 15, 2011
June – August 2011	September 15, 2011

A similar schedule shall apply for the service period September 2011-September 2012.

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

- 1) Daily cross-reference between new bookings and the PRSN data base to identify newly booked, persons known to the PRSN.
- 2) Development of individual alternative service plans (alternative to the jail) for submission to the courts – if receptive.
- 3) Pre-release transition planning (e.g. assessments, mental health services, co-occurring services, and housing).
- 4) Intensive post-release outreach to ensure individuals follow up with Community Service Office (CSO) and appointments for mental health and other services (e.g. substance abuse.)
- 5) Inter-local agreements with juvenile detentions facilities.

- 6) Training to local law enforcement and jail services personnel.
- 7) Provision of some direct mental health services to individuals who are in small jails which have no mental health staff.

Jail responsibilities:

1. Identify those individuals who may meet priority populations as defined in RCW 71.24 and make timely referrals to WEOS.
2. Provide a referral packet containing pertinent information and appropriate releases to WEOS designated staff.
3. Appropriate Jail staff will participate in the mental health assessment and treatment as needed or requested by WEOS.
4. Upon request of either party, Jail staff will participate in interagency staffing for mutually shared inmates. This will allow for updating treatment planning, sharing of information and collaborative problem-solving.
5. For inmates served by both the Jail and WEOS, service planning will be collaborative and focused on transitional outcomes.

REVIEW AND AMENDMENTS:

For each county served by the PRSN, a description of the specific implementation of the Agreement will be attached to this Agreement. (See attachment A.)

The parties will review the Agreement and its attachments at least every two years. The Agreement will remain in effect until a new agreement is signed or funding ceases.

If at any time the Agreement becomes a barrier to good practice, or inhibits positive innovations in service delivery, the parties will meet to eliminate the barriers to services. The Agreement may be reviewed at any time at the request of one of the parties.

Either party may submit to the other party an amendment to this Agreement. The amendments shall be accepted when both parties sign the amended Agreement.

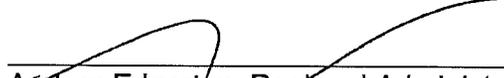
The PRSN contact person regarding this Agreement is the Administrator. The WEOS contact person regarding this Agreement is Chuck Smith, MA,

DMHP. The Jail contact person regarding this Agreement is Sgt. Ed Klahn.

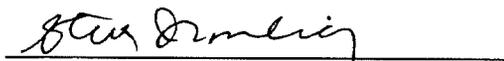
A. WEOS and the Jail agree to abide by the following process in resolving disputes, including disputes related to services or cost responsibility:

1. Each party agrees to begin dispute resolution as close to direct client care as possible. The initial attempts to resolve the dispute will occur between the local Jail staff and the WEOS staff.
2. If resolution efforts fail at that level, the issue shall be referred to the WEOS contact person and the Jail Supervisor within three working days. Both the mental health provider and Jail supervisor will be given the opportunity to provide information, preferably through a conference call or, if this is not possible, in writing, to both the PRSN Administrator.
3. If the WEOS contact person and the Jail supervisor are not able to resolve differences, the matter will be referred to the PRSN Administrator.
4. If resolution cannot be reached through the above process, the matter may be referred by either party to DSHS Headquarters.
5. This process does not interfere with the right of PRSN to involve the Ombudsman for the mental health system.

For the Peninsula Regional Support Network:


Date: 9-16-10
Anders Edgerton, Regional Administrator
Peninsula Regional Support Network

For West End Outreach Services:


Date: 8-12-2010
Steve Ironhill
Director

For the Forks City Jail:


Date: 8-12-2010
Bryon Mohohon
Mayor, City of Forks



PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: GRIEVANCE FILING PROCEDURE FOR
PRSN FOR PROVIDERS

Policy Number: 6.06

Reference: DSHS and Provider Contracts

Effective Date: 2/2000

Revision Date(s): 9/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Monitoring of Contractors

PURPOSE

The Peninsula Regional Support Network (PRSN) provides a filing procedure for network providers and subcontractors in the event that they have a complaint or grievance against the PRSN.

DEFINITIONS

A Grievance is any expression of dissatisfaction by a provider agency with RSN related services, contracts, and formal working agreements.

Grievances filed by the PRSN providers involve issues related to the overall system.

PROCEDURE

Informal Process:

1. Contact the PRSN Regional Administrator to discuss the grievance concerns and attempt a resolution on an informal basis
2. If the Grievant is not satisfied with the resolution, contact:
Attn: Director, Human Services Department of Kitsap County
614 Division Street MS-23
Port Orchard, WA 98366-4676

Formal Process:

1. If the grievance is not resolved to the contractor/subcontractors satisfaction on an informal basis, submit a formal written appeal, within thirty (30) days, detailing the grievance concerns to the:
Chairperson of the PRSN Executive Board
c/o Director, Human Services Department of Kitsap County
614 Division Street MS-23
Port Orchard, WA 98366-4676
2. The chairperson may decide to convene an Appeal Review Board comprised of a member from the PRSN Advisory Board, a member of the Executive Board, and the Director of Kitsap County Human Services or ,
convene an Executive Session of the PRSN Executive Board depending on the sensitivity of the Grievance issue.
 - The Grievant will receive written disposition regarding his/her appeal within thirty (30) days of filing the appeal.
3. The PRSN assures that there will be no retaliation, formal or informal, against any contractor, subcontractor, or individual associated with the agency filing or participating in the complaint/grievance process.

MONITORING

This policy is a contract mandate.

Due to the nature of this policy the PRSN Executive Board Chair, or their designated alternate (such as the QUIC), will instruct the PRSN how this policy will be monitored.



PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: GRIEVANCE OVERSIGHT AND
RECORDKEEPING

Policy Number: 6.07

Reference: 42 CFR 438.416;
PIHP and SMHC contract

Effective Date: 9/2005

Revision Date(s): 9/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: Grievance Forms
- Form: PRSN Authorization Tracking Log
- Form: Quarterly Agency Grievance Tracking Forms
- Policy: Grievance tracking Report Instructions

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a centralized process for recording and providing oversight to track all complaints, grievances, appeals/ denials, and Fair Hearings.

DEFINITIONS

A Grievance is any expression of dissatisfaction by an individual with RSN related services. Filing grievances should be a common standard practice at the provider agency and PRSN level; and not described to individuals in any way that discourages the process. It is expected that the network provider agencies and PRSN will encourage and support an individual using the formalized grievance system.

- 1st level grievances are filed by an individual at the provider level.
- 2nd level grievances are filed by the individual at the PRSN level, either as an initial grievance or filed as a result of dissatisfaction with the 1st level grievance.

Issues of dissatisfaction that are filed by ancillary systems or unauthorized family member are resolved outside the formal grievance system. Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

Appeal means a request for review and reconsideration of an action outlined in a written Notice of Action (NOA). There is an expedited appeal process that can be activated.

An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested services, this includes individuals that do not meet Access To Care standards for authorized outpatient services and non-covered services.
- The reduction, suspension, or termination of a previously authorized service that are not mutually agreed upon.
- The denial in whole or in part, of payment for a service.
- The denial of a request for inpatient authorization.
- Disagreement of treatment plan or treatment goals between an individual and provider. This can include medication decisions.
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b), or
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network.

Administrative Fair Hearing means a hearing conducted through the auspices of the state Office of Administrative Hearings in accordance with Washington Administrative Code (WAC) 388-02. An issue of dissatisfaction must complete the PRSN Grievance/and Grievance Appeal process prior to requesting a DSHS Administrative Fair Hearings.

- The term Fair Hearing is synonymous with Administrative Hearing.

PROCEDURE

1. Standard procedure for establishing a centralized process for recording and providing oversight to agency and PRSN grievances shall include:
 - a. The PRSN compiles the following reports:
 - Quarterly Agency Grievance Forms
 - Monthly Ombuds Activity Sheet
 - Six-month Grievance Medicaid, non-Medicaid, and Appeals Forms
 - Monthly PRSN Denial and Appeal Tracking Reports

2. All grievances will be recorded by the network agencies and Ombuds on the quarterly agency complaint form (combined Medicaid/ non-Medicaid forms) and submit to the PRSN quarterly for QUIC review.
3. The Grievance forms compiles the number of formal grievances to the PRSN, appeals requests through the contracted Administrative Service Organization (ASO), Office of Administrative Hearings Fair Hearings, and the Department.
 - a. The forms track the PRSN system-wide information, in a consistent and standardized way.
 - The forms provide the information in aggregate for Medicaid recipients and non-Medicaid recipients for adult and children's services.
 - The forms include the number and nature of the issues reported throughout the PRSN system.
 - The forms includes timeframes within the matter of concern was resolved or disposed.
 - The number and nature of how the issues were resolved (i.e. meditation).
 - The forms tabulate the number of cases included Ombuds involvement
 - b. The PRSN provides a summary report and analysis of the data for six-month trends identifying findings and plausible explanations. The PRSN includes information about how the system will adjust given the findings, including what measures may be taken to address undesirable patterns.
4. The PRSN Quality Improvement Committee (QUIC) provides the oversight to the grievances, appeal and Fair Hearing filed. The PRSN QUIC reviews the PRSN compiled Grievance and Appeal summary report and forms submitted to the Department. The QUIC will identify trends and establish procedural steps to resolve trends.
 - The QUIC may appoint subcommittees to address specific trends, such as the PRSN Utilization Management (UM) Committee for access issues or the PRSN clinical directors for dignity and respect issues.
 - The QUIC may require PRSN corrective action.
5. The PRSN subcontractor for authorization of services (ASO) shall keep a separate tracking log for outpatient, inpatient, and residential authorizations requested and the determination. The tracking sheet shall indicate when an appeal was conducted.
6. The PRSN shall maintain these records for at least six (6) years after the completion of the grievance issue. The records will be kept in confidential files, apart from the clinical record.

MONITORING

This policy is a federal statute and contract mandate.

1. The PRSN Grievance Oversight and Tracking policy and procedures are routinely monitored through:
 - 100% PRSN review of faxed copies of NOA letters mailed
 - PRSN Authorization Tracking Log submitted by CommCare, upon request
 - Annual PRSN Provider and Subcontractor Administrative Review
 - PRSN Grievance Tracking Reports
 - Random checks of provider Grievance files with a cross-reference chart review
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations, such as the biennial ancillary provider satisfaction survey.
 - Review of previous Provider Corrective Action Plans related to Age and Cultural Competence policy, including provider profiles related to performance on targeted indicators
 - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.

2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

PRSN Grievance Report-- Medicaid Funded Services

Reporting Period _____

Agency _____

Contact Name: _____

Contact Number: _____

Total Unduplicated Number of Adult Cases

Total Unduplicated Number of Children Cases

Category	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Adult (21 Yrs. and over)				
Access				
Dignity and Respect (complete subcategory below)				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Violation of Confidentiality				
Physicians and ARNPs				
Financial & Admin Svs				
*Residential				
*Housing				
*Transportation				
Emergency Services				
Participation in Treatment				
Other Rights Violations				
Other				
Total	0	0	0	0

Category	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Children (0-20 Yrs.)				
Access				
Dignity and Respect (complete subcategory below)				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Violation of Confidentiality				
Physicians and ARNPs				
Financial & Admin Svs				
*Residential				
*Housing				
*Transportation				
Emergency Services				
Participation in Treatment				
Other Rights Violations				
Other				
Total	0	0	0	0

Dignity and Respect Subcategories:

Lack of compassion, courtesy and kindness
Lack of cooperation and support
Lack of personal respect
Not honoring the client's voice
Lack of cultural sensitivity
Lack of honesty
Condescending attitude toward client
Secondary issue
Other:

Dignity and Respect Subcategories:

Lack of compassion, courtesy and kindness
Lack of Cooperation and support
Lack of personal respect
Not honoring the client's voice
Lack of cultural sensitivity
Lack of honesty
Condescending attitude toward client
Secondary issue
Other:

Identify Agency Program:

Outpatient
Inpatient
Residential
Non-Clinical

Identify Agency Program:

Outpatient
Inpatient
Residential
Non-Clinical

Resolutions	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Adult (21 Yrs. and over)			
Info/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	0	0	0

Resolutions	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Children (0-20 Yrs.)			
Info/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	0	0	0

Ombuds Cases	
Level 1 Grievances	Level 2 Grievances

PRSN Grievance Report-- State Funded Services Only

Reporting Period _____

Agency _____

Contact Name: _____

Contact Number: _____

Total Unduplicated
Number of Adult Cases

--

Total Unduplicated Number
of Children Cases

--

Category	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Adult (21 Yrs. and over)				
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Participation in Treatment				
Physicians and ARNPs				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Other Rights Violations				
Other				
Total	0	0	0	0

Category	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Children (0-20 Yrs.)				
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Participation in Treatment				
Physicians and ARNPs				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Other Rights Violations				
Other				
Total	0	0	0	0

Dignity and Respect Subcategories:

<i>Lack of compassion, courtesy and kindness</i>
<i>Lack of cooperation and support</i>
<i>Lack of personal respect</i>
<i>Not honoring the client's voice</i>
<i>Lack of cultural sensitivity</i>
<i>Lack of honesty</i>
<i>Condescending attitude toward client</i>
<i>Secondary issue</i>
<i>Other:</i>

Dignity and Respect Subcategories:

<i>Lack of compassion, courtesy and kindness</i>
<i>Lack of cooperation and support</i>
<i>Lack of personal respect</i>
<i>Not honoring the client's voice</i>
<i>Lack of cultural sensitivity</i>
<i>Lack of honesty</i>
<i>Condescending attitude toward client</i>
<i>Secondary issue</i>
<i>Other:</i>

Identify Agency Program:

Outpatient
Inpatient
Residential
Non-Clinical

Identify Agency Program:

Outpatient
Inpatient
Residential
Non-Clinical

Resolutions	Level 1 Grievances	Level 2 Grievances	Outstanding g from Last Period
Adult (21 Yrs. and over)			
Info/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	0	0	0

Resolutions	Level 1 Grievances	Level 2 Grievances	Outstanding g from Last Period
Children (0-20 Yrs.)			
Info/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	0	0	0

Ombuds Cases	
Level 1 Grievances	Level 2 Grievances



SALISH BHO

PROVIDER MONITORING POLICIES AND PROCEDURES

Policy Name: CORRECTIVE ACTION PLANS

Policy Number: 9.11

Reference: DSHS and Provider Contract

Effective Date: 7/2005

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: SBHO Executive Board

CROSS REFERENCES

- Plan: Quality Management Plan
- Policy: Provider and Subcontractor Non-Compliance Penalties

PURPOSE

The Salish Behavioral Health Organization (SBHO) monitors contracted agencies according to the monitoring policy. The SBHO shall require contracted providers to develop corrective action plans when a provider is found to not be in compliance with the contract or when other monitored functions and services are found to be deficient.

PROCEDURE

1. Reasons the SBHO may request a Corrective Action Plan (CAP) include, but are not limited to the following:
 - The provider is found to be out of compliance with contract or working agreement requirements.
 - Provider performance is below the standard as outlined in the SBHO Quality Management Plan
 - A trend of sub-standard performance has been identified.
 - A problem exists that negatively impacts individuals receiving services.
 - The provider has failed to perform any of the contractually required mental health services.

- The provider has failed to develop, produce, and/or deliver to the SBHO any requested statements, reports, data, data corrections, accountings, claims, and/or documentation.
 - The provider has failed to implement corrective action required by the SBHO within prescribed time frames.
2. Corrective action plans developed by the provider must be submitted for approval to the SBHO within 30 calendar days of notification.
 3. Corrective action plans may require modification of any policies or procedures by the provider relating to the fulfillment of its contractual obligations.
 4. The SBHO may extend or reduce the time allowed for corrective action depending upon the nature of the situation.
 5. Corrective action plans are reviewed by the SBHO, which determines if they are acceptable.
 6. The Corrective Action Plan will include:
 - Date of the Plan
 - Identified item of non-compliance
 - Any specified actions specifically required by the SBHO
 - Any dates specified by the SBHO by which the provider must be compliant
 - Specific action(s) the provider proposes to bring the item into compliance
 - Specific goal(s) and/or outcome(s) the provider's action addresses
 - Date by which the action(s) will be completed
 - Date by which the goal(s) and/or outcome(s) will be attained
 - Proposed documentation evidencing completion of the action(s) and
 - Attainment of the goal(s)/outcome(s)
 7. Performance in the identified area is monitored by the SBHO to determine if the corrective action plan has been successfully implemented. If compliance and/or performance continues to be insufficient, the SBHO may:
 - Require a revised corrective action plan
 - Offer technical assistance to the provider
 - Reject the plan
 - Require the provider to obtain outside technical assistance
 - Following the corrective action steps included the subcontract, withhold payments and /or invoke financial penalties
 8. The SBHO may inform the provider of any substantial noncompliance, which places the provider at risk of punitive action. Any such notification, if verbal, will be

followed by a written memorandum generated within 36 hours of the verbal notification.

MONITORING

This policy is a mandated by contract and statue.

1. This policy is monitored through use of SBHO:
 - Annual SBHO Provider and Subcontractor Administrative Review
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations
 - Annual Provider Chart rev Reviews
 - Review of previous Provider Corrective Action Plans related to policy, including provider profiles related to performance on targeted indicators

2. If a contractor or subcontractor consistently performs below expected standards during a contract period, the SBHO has the option of imposing punitive action and/or financial penalties as outlined in the contract.



Salish BHO

PROVIDER MONITORING POLICIES AND PROCEDURES

Policy Name: UNIFORM INPATIENT & OUTPATIENT
INTER-BHO TRANSFER PROTOCOL

Policy Number: 11.25

Reference: DSHS Contract, Inter-BHO Transfer Agreement

Effective Date: 7/01/2014

Revision Date(s):

Reviewed Date: 8/2015

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plans
- Policy: Monitoring of Contractors
- Policy: Outpatient Discharge Planning

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure all transfers between Behavioral Health Organizations (BHOs) are conducted in a standardized manner across the state.

DEFINITIONS

“Multiple” means, for the purpose of defining risk factors, multiple three or more.

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

“Receiving BHO” means the BHO into whose region the Referring BHO is pursuing the transfer.

“Risk factors” include the following:

- Transfer is being requested due to availability of specialized non-Medicaid resource.
- High inpatient utilization – 2 or more inpatient admissions in the previous 12 months, an inpatient stay in a community hospital for 90 days or more in the previous 12 months, or discharge from a state hospital in the previous 12

months.

- History of felony assaults, ORCSP eligibility, or multiple assaultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).
- Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia (the BHO would need to be involved even though HCS might be arranging placement), and co-morbid serious medical issues.
- Other confounding clinical risk factors.

“Specialized Non-Medicaid services” includes, for purposes of this protocol, IMD admissions, residential placement, and state hospital census.

PROCEDURE

BHOs in our state acknowledge and agree that:

1. Medicaid enrollees are entitled to Medicaid covered services in the community where they live.
2. Individuals who participate in mental health services have the right to freely move to the community of their choosing.
3. There are circumstances when an BHO (referring BHO) wishes to place an individual in another BHO’s region (receiving BHO) to better meet the needs of that individual, or moving to another BHO’s region would allow the individual to be closer to family and/or other important natural supports.
4. Some individuals require specialized, non-Medicaid services to meet their needs.
5. Due to the scarcity of specialized, non-Medicaid services, these may not be immediately available upon the request of the transferring individual.
6. The receiving BHO assumes immediate financial risk for crisis services and Medicaid covered services at the time of transfer.
7. The referring BHO will continue the financial responsibility for “specialized non-Medicaid services” provided to the individual for the duration of time as determined by the number of risk factors identified at the time of transfer.

Number of Risk Factors	Duration
One risk factor	6 months
Two risk factors	9 months
Three or more risk factors	12 months

8. After completion of the risk factor time frame, the receiving BHO will assume all financial responsibility for the individual.
9. The referring BHO will retain the individual on their state hospital census until the individual is discharged. The referring BHO will accept on their census any individual

placed in the receiving BHO who returns to the state hospital during the period of financial responsibility as defined above.

10. This protocol is intended to ensure a seamless transition for individuals with no more than minimal interruption of services.

Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol: Outpatient Services Transfers

1. If a Medicaid enrollee re-locates to a region outside of their current BHO they are entitled to an intake assessment in the new region and are then provided all medically necessary mental health services required in the PIHP contract, based on the BHO's level of care guidelines and clinical assessment.
2. When an enrollee is transferring to SBHO from another area, the receiving agency will contact the enrollee's current provider and request clinical records and other relevant information from that provider.
3. All Medicaid enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the PIHP. The availability of Specialized Non-Medicaid Services cannot be the basis for determining if the enrollee is offered an intake for services in the desired community of their choice.
4. There are circumstances when moving between BHOs is necessary to better meet the needs of the individual, or moving to another BHO would allow the individual to be closer to family and/or other natural supports.
5. The receiving BHO will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.

When an enrollee is re-locating **and may benefit from specialized non-Medicaid services** beyond medically necessary services required in the PIHP, the BHOs agree to the following protocol:

- a. The placement is to be facilitated by the joint efforts of both BHOs.
- b. The referring BHO will provide all necessary clinical information along with the completed Inter-BHO transfer form.
- c. The receiving BHO will acknowledge the request within 3 working days.
- d. The receiving BHO will follow established procedures for prioritizing the referred enrollee and must offer an intake assessment to the enrollee for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.
- e. The placement may not be completed without written approval on the inter-BHO transfer form from both BHO administrators, and their designees.
- f. The receiving BHO shall make a placement determination within 2 weeks of

receiving all necessary information/documentation from the referring BHO. The enrollee and the referring BHO will receive information regarding the placement policy of the receiving BHO for the specialized non-Medicaid service.

- g. Placement will only occur when the specialized non-Medicaid service becomes available. If the specialized non-Medicaid service is not available at the time of the intended transfer, the receiving BHO will notify the referring BHO and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring BHO will keep the individual and others involved in the individual's care informed about the status of the transfer.
- h. Payment responsibility for individuals transferring between BHOs will be described in this protocol and specified on the inter-BHO transfer form.

Uniform Transfer Agreement: State Hospital Inter-BHO Transfer Protocol

1. This section describes the inter-BHO transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.
2. Generally, individuals are discharged back to the BHO in whose region they resided prior to their hospitalization (designated by the state hospitals as the "BHO of responsibility").
3. For **all individuals in a state hospital** (regardless of risk factors) who intend to discharge to another BHO, an Inter-BHO transfer request is required and will be initiated by the BHO of responsibility (hereinafter referred to as the referring BHO).
4. The financial benefits section at the state hospital will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.
5. The placement is to be facilitated through the joint efforts of the state hospital social work staff and the BHO liaisons of both the Referring BHO and Receiving BHO.
6. A *Request for Inter-BHO Transfer* form and relevant treatment and discharge information is to be supplied by the Referring BHO to the Receiving BHO via the liaisons.
7. The Referring BHO will remain the primary contact for the state hospital social worker and the individual until the placement is completed.
8. The Receiving BHO will supply the state hospital social worker with options for community placement at discharge.
9. Other responsible agencies must be involved and approve the transfer plan and placement in the Receiving BHO when that agency's resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).
10. Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the individual, state hospital social worker or representative of the state hospital treatment team, liaisons, the mental health care provider from the referring BHO, and other responsible agencies.

11. Once the discharge plan has been agreed upon, the *Request for Inter-BHO transfer* will be completed within two weeks. The Receiving BHO has two weeks to complete and return the form to the Referring BHO. This process binds both the Referring and Receiving BHOs to the payment obligations as detailed above.

MONITORING

This policy is mandated by state contract.

1. This policy will be monitored through use of SBHO:
 - Annual Provider Chart Reviews
 - Grievance Tracking Reports
 - Targeted provider clinical chart review of transfer
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.

INTER-BHO TRANSFER AGREEMENT

Consumer name: _____ DOB: _____

Responsibility for outpatient and crisis services is assumed by the receiving BHO upon transfer, regardless of risk factors. Responsibility for specialized non-Medicaid services remains with the referring BHO as below. Specialized non-Medicaid services include IMD admissions, residential placement, and state hospital census.

- One risk factor: 6 months
- Two risk factors: 9 months
- Three or more risk factors: 12 months

Indicate which risk factors are present:

- Transfer is being requested due to availability of specialized non-Medicaid resource.
- High inpatient utilization – 2 or more inpatient admissions in the previous 12 months, an inpatient stay in a community hospital for 90 days or more in the previous 12 months, or discharge from a state hospital in the previous 12 months.
- History of felony assaults, ORCSP eligibility, or multiple assaultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).
- Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia, and co-morbid serious medical issues.

Indicate type of transfer

- State hospital discharge.
- Outpatient individual requiring specialized non-Medicaid resources moving to another BHO.

Payment Agreement (Circle number of months based on risk factors)			
Service Type	Referring BHO Responsibility		
Outpatient treatment and Crisis Services	N/A: Responsibility of accepting BHO immediately.		
Specialized non-Medicaid services (IMD, Residential, State Hospital)	6mo	9mo	12mo

Signature of referring BHO administrator or designee _____

Date: _____

Signature of accepting BHO administrator or designee: _____

Date: _____

