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

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

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

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

8. SUBCONTRACTING

8.1. The obligations and duties of the CONTRACTOR under this Contract shall not be subcontracted without the prior written consent of TMRSN.

8.2. All Subcontracts must be in writing and specify all duties, responsibilities and reports that are appropriate to the service or activity delegated under the Subcontract and require compliance with all applicable local, State and federal laws, rules and regulations. No Subcontract terminates the legal responsibility of the CONTRACTOR to TMRSN to perform the terms of this Contract. The CONTRACTOR shall be responsible for the acts and omissions of any Subcontractor, and the CONTRACTOR is responsible for all contractual obligations, financial or otherwise, to its Subcontractors. TMRSN has no contractual obligations to any Subcontractor under contract to the CONTRACTOR. Subcontractors must abide by the requirements of Section 1128A(b) of the Social Security Act prohibiting RSN'S and other providers from making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to recipients.

8.3. In accordance with Medicaid being the payer of last resort, Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Contract.

8.4. The Contractor must make available upon request copies of all Subcontracts and/or Subcontract amendments to TMRSN.

8.5. The CONTRACTOR shall not assign all or any portion of this Contract to a third party.

9. CONFIDENTIALITY

9.1. The CONTRACTOR shall protect all Personal Information, records and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307; RCWs chapters 70.02, 71.05 and 71.34; and, for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW chapter 70.96A. The CONTRACTOR shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services.

9.2. The CONTRACTOR shall comply with all confidentiality requirements of HIPAA under 45 CFR Parts 160-164 and confidentiality requirements under 42 CFR Parts 438.

9.3. Confidential Information collected, used or acquired in connection with this Contract shall be used solely for the purpose of this Contract. The CONTRACTOR shall not release, disclose, publish, transfer, sell or otherwise make known any such information to any other party, except: as provided by law; or, in the case of Personal Information, as provided by law or with the prior written consent of the person or personal representative of the person who is the subject of the Personal Information.

9.4. The CONTRACTOR shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss. This duty requires the CONTRACTOR to employ reasonable security measures, which include restricting access to the Confidential Information by: (a) allowing access only to staff that have an authorized business requirement to view the Confidential Information; and (b) physically securing any computers, documents, or other media containing the Confidential Information.

9.5. To the extent allowed by law, when the Contract term has ended or the Contract terminated, or when Confidential Information is no longer needed, the CONTRACTOR shall return the Confidential Information or certify in writing the destruction of Confidential Information upon written request by TMRSN.

9.6. The CONTRACTOR shall obtain written consent from an individual prior to the use of the individual's picture(s) or personal story.

9.7. The CONTRACTOR agrees to implement physical, electronic and managerial safeguards to prevent unauthorized access to Personal Information. TMRSN reserves the right to monitor, audit, or investigate the use of Personal Information collected, used or acquired by the CONTRACTOR through this Contract.

9.8. Paper documents with Confidential Information may be recycled through a contracted firm, provided the contract with the recycler specifies that the confidentiality of information will be protected, and the information destroyed through the recycling process. Paper documents with Confidential Information must be destroyed through shredding, pulping, or incineration.

9.9. The compromise or potential compromise of Confidential Information must be reported to TMRSN within three (3) business days of discovery for breaches of less than 500 persons' protected data, and within one (1) business day of discovery for breaches of over 500 persons' protected data. The parties must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law.

9.10. Any breach of this Section may result in termination of the Contract and the demand for return of all records in connection with this Contract. The CONTRACTOR agrees to indemnify and hold harmless Thurston County, Mason County, and TMRSN for any damages related to the CONTRACTOR's unauthorized use or disclosure of Confidential Information.

9.11. The provisions of this Section shall be included in any CONTRACTOR's Subcontract relating to the services provided under this Contract.

10. FRAUD AND ABUSE

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

10.1.1. Create and maintain a mandatory compliance plan that includes provisions to educate CONTRACTOR employees of the false claim act and whistle blower protections.

10.1.2. Develop written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable federal and State standards.

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

10.1.4. Provide effective ongoing training and education for the compliance officer, CONTRACTOR's employees, interns, volunteers, contracted employees, and any Subcontractors.

10.1.5. Facilitate effective communication between the compliance officer and the CONTRACTOR's employees, interns, volunteers, contracted employees, and any Subcontractors.

10.1.6. Enforce standards through well-publicized disciplinary guidelines.

10.1.7. Conduct self internal monitoring and auditing.

10.1.8. Respond promptly to detected offenses and develop corrective action initiatives.

10.1.9. Report fraud and/or abuse information to TMRSN as soon as it is discovered to include the source of the complaint, the involved individual, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

11. FUTURE SUPPORT

11.1. The TMRSN makes no commitment to future support and assumes no obligation for future support of the services contracted for, except as expressly set forth in this Contract.

12. RELATIONSHIP OF PARTIES

12.1. The parties intend that an independent contractor relationship between the CONTRACTOR and TMRSN shall be created by this Contract. The TMRSN is interested primarily in the results to be achieved. The conduct, control and implementation of services shall lie solely with the CONTRACTOR. No official, officer, agent, employee, servant or representative of the CONTRACTOR shall be or deem to be or act or purport to act as an official, officer, agent, employee, servant, or representative of Thurston County or TMRSN for any purpose, and the employees of the CONTRACTOR are not entitled to any of the benefits Thurston County provides for Thurston County employees. The CONTRACTOR shall indemnify and hold harmless Thurston County and TMRSN from all obligations to pay or withhold federal or state taxes or contributions on behalf of the CONTRACTOR or the CONTRACTOR's employees. The CONTRACTOR shall be solely and entirely responsible for its acts and for the acts of its officials, officers, agents, employees, servants, representatives, Subcontractors, or otherwise during the performance of this Contract.

12.2. The results of the work contemplated herein must meet the approval of TMRSN and shall be subject to TMRSN's general rights of inspection and review to secure the satisfactory completion thereof.

12.3. In the event that any of the CONTRACTOR's officials, officers, agents, employees, servants, representatives, Subcontractors, or otherwise, carry on activities or conduct themselves in any manner which may jeopardize the funding of this Contract, the CONTRACTOR shall be responsible for taking adequate measures to prevent said officials, officers, agents, employees, servants, representatives or Subcontractors from performing or providing any of the services contained in this Contract.

12.4. The Contractor and any Subcontractors must comply with 42-USC §1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or an employee, Subcontractor, or consultant who is significant or material to the provision of services under this Contract, who has been, or is affiliated with someone who has been debarred, suspended, or otherwise excluded by any federal agency.

13. POLITICAL ACTIVITY PROHIBITED

13.1. None of the funds, materials, property or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office.

14. INSPECTION; MAINTENANCE AND RETENTION OF RECORDS

14.1. The CONTRACTOR shall provide access to its records and place of business during the term of this Contract and for one (1) year following termination or expiration of this Contract for the purposes of monitoring, auditing, and evaluating CONTRACTOR's compliance with this Contract, and compliance with applicable State and federal laws, rules, and regulations as existing now or as later amended. CONTRACTOR shall allow access to its records and place of business to DSHS, the Department of Health and Human Services, External Quality Review Office, Centers for Medicare & Medicaid Services, the Comptroller, the Office of the State Auditor, and TMRSN or their authorized representatives. The CONTRACTOR and its Subcontractors shall cooperate in all reviews, including but not limited to, financial audits, contract monitoring, surveys, and research. Evaluations shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services performed under this Contract and to determine whether the CONTRACTOR and its Subcontractors are providing service to individuals in accordance with the requirements set forth in this Contract and applicable State and federal laws, rules, and regulations.

14.2. During the term of this Contract and for six (6) years following expiration or termination of this Contract, the CONTRACTOR shall retain all books, records, documents, and other material relevant to this Contract. All hospitals, clinics, or nursing facilities shall retain those records as prescribed in chapters 70.41 and 18.51 RCW. If any audit, claim, litigation, or other legal action involving this Contract is started before the expiration of the six (6) year period or the period set out in chapters 70.41 and 18.51 RCW (retention period), the records shall be retained until completion and resolution of all issues arising therefrom or until the end of the retention period, whichever is later.

14.3. The CONTRACTOR shall maintain books, records, documents and other material relevant to this Contract which sufficiently and properly reflects all direct and indirect costs expended in the performance of the services described herein and the performance of all acts required by the Contract and applicable laws, rules, and regulations. The CONTRACTOR shall maintain the content of all medical records in a manner consistent with utilization of control requirements of 42 CFR §456, 42 CFR §434.34 (a), 42 CFR §456.111, and 42 CFR §456.211. The CONTRACTOR shall maintain books, records, documents, and other materials relevant to this Contract which sufficiently and properly reflects all payments made, TMRSN rate setting activities related to the CONTRACTOR, or other actions taken in regard to the CONTRACTOR's performance of the services described in the Program Contracts.

14.4. Records will enable identification of all federal funds received and expended by Catalog of Federal Domestic Assistance Number (CFDA#), federal program, award number and year, name of federal, state and pass-through agency. Records will meet the requirements of OMB Circular A-102 Grants and Cooperative Contracts with state and local Governments, and also OMB Circular A-110 Uniform Administrative Requirements for Grants and Contracts with institutions of higher education, hospitals and other non-profit organizations.

14.5. The CONTRACTOR will include in their financial statements a schedule of expenditures of all federal awards. The schedule will include the name of the federal agency, the pass-through entity, the CFDA#, any other identification number, the amount of expenditures for the program, identification of any major programs, and any notes that pertain to the significant accounting policies used to account for the federal programs.

14.6. The CONTRACTOR's financial statements will also include a schedule of prior audit findings,

along with any corrective action taken or any corrective action planned with the anticipated completion date.

14.7. The provisions of this Section shall be included in any CONTRACTOR's Subcontracts relating to the services provided under this Contract.

15. SINGLE AUDIT ACT

15.1. If the CONTRACTOR is a Subrecipient and expends $500,000 or more in federal awards from all funding sources in any fiscal year, the CONTRACTOR shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the CONTRACTOR shall:

15.1.1. Submit to the TMRSN contact person, listed on the first page of this Contract, the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor. For purposes of "Subrecipient" status under the rules of OMB Circular A-133 205(i) Medicaid payments to a Subrecipient for providing patient care services to Medicaid eligible individuals are not considered federal awards expended under this part of the rule unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis; and

15.1.2. Follow-up and develop corrective action for all audit findings, in accordance with OMB Circular A-133, and prepare a "Summary Schedule of Prior Audit Findings."

16. SUBRECIPIENTS

16.1. If the CONTRACTOR is a Subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Contract, the CONTRACTOR shall:

16.1.1. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity;

16.1.2. Maintain internal controls that provide reasonable assurance that the CONTRACTOR is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant contracts that could have a material effect on each of its federal programs;

16.1.3. Prepare appropriate financial statements, including a schedule of expenditures of federal awards;

16.1.4. Incorporate OMB Circular A-133 audit requirements into all contracts between the CONTRACTOR and its Subcontractors who are Subrecipients;

16.1.5. Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation;

16.1.6. Comply with the applicable requirements of either 2 CFR Part 225 (OMB Circular A-87) or 2 CFR Part 230 (OMB Circular A-122), any future amendments, and any successor or replacement Circular or regulation; and

16.1.7. Comply with the Omnibus Crime Control and Safe streets Act of 1968, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and The Department of Justice Non-Discrimination Regulations at 28 CFR Part 42, Subparts C, D, E, and G, and 28 CFR

Parts 35 and 39. (See http://www.ojp.usdoj.gov/about/offices/ocr.htm for additional information and access to the aforementioned federal laws and regulations.)

17. TITLE TO PROPERTY

17.1. Except as otherwise provided in this Contract, title to all property purchased or furnished by TMRSN for use by the CONTRACTOR during the term of this Contract shall remain with TMRSN. Title to all property purchased or furnished by the CONTRACTOR for which the CONTRACTOR is entitled to reimbursement by TMRSN under this Contract shall pass to and vest in TMRSN. The term “reimbursement” as used in this paragraph means and is limited to reimbursement made by TMRSN to CONTRACTOR under cost-reimbursement program contracts in effect between TMRSN and CONTRACTOR during the term hereof; “reimbursement” as used in this paragraph does not mean and does not include compensation received or to be received by CONTRACTOR under fee-for-service (FFS) contracts in effect between TMRSN and CONTRACTOR during the term hereof, including without limitation the FFS components of any State or Medicaid funded Program Contracts in effect between TMRSN and CONTRACTOR during the term hereof. The CONTRACTOR shall take reasonable steps to protect and maintain all TMRSN property in its possession against loss or damage and shall return TMRSN property to TMRSN upon Contract termination or expiration, reasonable wear and tear excepted.

18. TREATMENT OF CLIENT PROPERTY

18.1. Except as otherwise provided by court order or this Contract, the CONTRACTOR shall ensure that any adult client for whom the CONTRACTOR is providing services under this Contract shall have unrestricted access to the client's personal property. The CONTRACTOR shall not interfere with any adult client's ownership, possession, or use of the client’s personal property. The CONTRACTOR shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client’s age, development, and needs. Upon termination or completion of this Contract, the CONTRACTOR shall promptly release to the client and/or the client’s guardian or custodian the entire client's personal property. This Section does not prohibit the CONTRACTOR from implementing such lawful and reasonable policies, procedures and practices as the CONTRACTOR deems necessary for safe, appropriate, and effective service delivery.

19. NONDISCRIMINATION

19.1. The CONTRACTOR or its Subcontractors shall not discriminate against any employee in the performance of any of its obligations hereunder on the basis of race, color, creed, religion, national origin, ethnicity, age, sex, marital status, veteran or military status, sexual orientation, or the presence of any disability.

19.2. The CONTRACTOR or its Subcontractors shall not on the basis of race, color, creed, religion, national origin, ethnicity, age, sex, marital status, veteran or military status, sexual orientation, or the presence of any disability:

19.2.1. Deny an individual any services or other benefits provided under this Contract;

19.2.2. Provide any service(s) or other benefits to an individual which are different, or are provided in a different manner from those provided to others under this Contract;

19.2.3. Subject an individual to segregation or separate treatment in any manner related to his or her receipt of any service(s) or other benefits provided under this Contract; or

19.2.4. Deny any individual an opportunity to participate in any program provided by this Contract through the provision of services or otherwise or afford an opportunity to do so which is different from that afforded others under this Contract.

19.3. If subcontracting has been authorized, said Subcontract shall include appropriate safeguards against discrimination in client services binding upon each Subcontractor. The CONTRACTOR shall take such action as may be required to ensure full compliance with the provisions of this Section.

20. HOLD HARMLESS AND INDEMNIFICATION

20.1. The CONTRACTOR shall hold harmless, indemnify and defend THURSTON COUNTY, MASON COUNTY, TMRSN, its officers, officials, employees and agents, from and against any and all claims, actions, suits, liability, losses, expenses, damages, and judgments of any nature whatsoever, including costs and attorneys fees in defense thereof, for injury, sickness, disability or death to persons or damage to property or business, caused by or arising out of the CONTRACTOR'S acts, errors or omissions or the acts, errors or omissions of its employees, agents, Subcontractors or anyone for whose acts any of them may be liable, in the performance of this Contract. PROVIDED HOWEVER, that the CONTRACTOR'S obligations hereunder shall not extend to injury, sickness, disability, death or damage caused by or arising out of the sole negligence of THURSTON COUNTY, MASON COUNTY, TMRSN, its officers, officials, employees or agents. PROVIDED FURTHER, that in the event of the concurrent negligence of the parties, the CONTRACTOR'S obligations hereunder shall apply only to the percentage of fault attributable to the CONTRACTOR, its employees, agents or Subcontractors. Claims shall include, but not be limited to, assertions that information supplied or used by the CONTRACTOR or Subcontractor infringes any patent, copyright, trademark, trade name, or otherwise results in an unfair trade practice.

20.2. In any and all claims against THURSTON COUNTY, MASON COUNTY, TMRSN, its officers, officials, employees and agents by any employee of the CONTRACTOR, Subcontractor, anyone directly or indirectly employed by any of them, or anyone for whose acts any of them may be liable, the indemnification obligation under this Section shall not be limited in any way by any limitation on the amount or type of damages, compensation, or benefits payable by or for the CONTRACTOR or Subcontractor under Worker's Compensation acts, disability benefits acts, or other employee benefits acts, it being clearly agreed and understood by the parties hereto that the CONTRACTOR expressly waives any immunity the CONTRACTOR might have had under Title 51 RCW. By executing the Contract, the CONTRACTOR acknowledges that the foregoing waiver has been mutually negotiated by the parties and that the provisions of this Section shall be incorporated, as relevant, into any contract the CONTRACTOR makes with any Subcontractor or agent performing work hereunder.

20.3. The CONTRACTOR'S obligations hereunder shall include, but are not limited to, investigating, adjusting and defending all claims alleging loss from action, error or omission, or breach of any common law, statutory or other delegated duty by the CONTRACTOR, the CONTRACTOR'S employees, agents or Subcontractors.

21. INSURANCE

21.1. **Professional Legal Liability:** The CONTRACTOR, if a licensed professional, shall maintain Professional Legal Liability or Professional Errors and Omissions coverage appropriate to the CONTRACTOR's profession and shall be written subject to limits of not less than $2,000,000 per loss and a $5,000,000 aggregate.

21.2. The coverage shall apply to liability for a professional error, act or omission arising out of the scope of the CONTRACTOR's services defined in this Contract. Coverage shall not exclude bodily injury or property damage. Coverage shall not exclude hazards related to the work rendered as part of the Contract or within the scope of the CONTRACTOR's services as defined by this Contract including testing, monitoring, measuring operations, or laboratory analysis where such services are rendered as part of the Contract.

21.3. Workers' Compensation (Industrial Insurance): The CONTRACTOR shall maintain workers' compensation insurance as required by Title 51 RCW, and shall provide evidence of coverage to the Thurston County Risk Management Division.

21.4. The CONTRACTOR shall send to Thurston County at the end of each quarter written verification that premium has been paid to the Washington State Department of Labor and industries for Industrial Insurance coverage. Alternatively, the CONTRACTOR shall provide certification of approval by Washington State Department of Labor and Industries if self-insured for Workers Compensation.

21.5. **Commercial General Liability:** The CONTRACTOR shall maintain Commercial General Liability coverage for bodily injury, personal injury and property damage, subject to limits of not less than $1,000,000 per loss. The general aggregate limit shall apply separately to this Contract and be no less than $3,000,000.

21.6. The CONTRACTOR will provide Commercial General Liability coverage that does not exclude any activity to be performed in fulfillment of this Contract. Specialized forms specific to the industry of the CONTRACTOR will be deemed equivalent, provided coverage is no more restrictive than would be provided under a standard Commercial General Liability policy, including contractual liability coverage.

21.7. The CONTRACTOR shall secure employers' liability coverage with limits not less than $100,000 as part of their CGL policy or separately.

21.8. **Automobile Liability:** The CONTRACTOR shall maintain automobile liability insurance as follows:

21.8.1. The CONTRACTOR shall maintain Business Automobile Liability Insurance with a limit of not less than $1,000,000 each accident combined Bodily Injury and Property Damages. Coverage shall include owned, hired and non-owned automobiles.

21.9. **Other Insurance Provisions:**

21.9.1. The CONTRACTOR's liability insurance provisions shall be primary with respect to any insurance or self-insurance programs covering Thurston County, its elected and appointed officers, officials, employees and agents.

21.9.2. Where such coverage is required, the CONTRACTOR's Commercial General Liability insurance shall include Thurston County, its officers, officials, employees and agents with respect to performance of services.

21.9.3. Where such coverage is required, the CONTRACTOR's Commercial General Liability insurance shall contain no special limitations on the scope of protection afforded to Thurston County as additional insured.

21.9.4. Any failure to comply with reporting provisions of the policies shall not affect coverage provided to Thurston County, its officers, officials, employees or agents.

21.9.5. The CONTRACTOR's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

21.9.6. The CONTRACTOR shall include all Subcontractors as insured under its policies or shall furnish separate certificates and endorsements for each Subcontractor. All coverage for Subcontractors shall be subject to all of the requirements stated herein.

21.9.7. The insurance limits mandated for any insurance coverage, required by this Contract, are not intended to be an indication of exposure nor are they limitations on indemnification.

21.9.8. The CONTRACTOR shall maintain all required policies in force from the time services commence until services are completed. Certificates, policies, and endorsements expiring before completion of services shall be promptly replaced. If the CONTRACTOR's liability coverage is written as a claim made policy, then the CONTRACTOR must evidence the purchase of an extended reporting period or "tail" coverage for a three (3) year period after project completion.

21.9.9. Verification of Coverage and Acceptability of Insurers: The CONTRACTOR shall 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 minus 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.

21.9.10. The CONTRACTOR shall furnish Thurston County with properly executed Certificates of Insurance or a signed policy endorsement which shall clearly evidence all insurance required in this Section 22 prior to commencement of services. The certificates will, at a minimum, list limits of liability and coverage. The certificate will provide that the underlying insurance contract will not be canceled, allowed to expire, or be materially reduced in coverage except on 30 days prior written notice to Thurston County.

21.9.11. The CONTRACTOR shall furnish Thurston County with evidence that the additional insured provision required above is been met. Acceptable form of evidence is the endorsement page(s) of the policy showing Thurston County as an additional insured.

21.9.12. Written notice of cancellation or change shall be mailed to Thurston County at the following address:

Thurston County Public Health & Social Services
Attn: Kristy Lysell
412 Lilly Road NE
Olympia, WA 98506-5132

21.9.13. The CONTRACTOR or its broker shall provide a copy of any, and all insurance policies specified in this Contract upon request of the Thurston County Risk Management Division.

22. AMENDMENTS AND CHANGES IN WORK

22.1. In the event of any errors or omissions by the CONTRACTOR in the performance of any work required under this Contract, the CONTRACTOR shall make any and all necessary corrections without additional compensation. All work submitted by the CONTRACTOR shall be certified by the CONTRACTOR and checked for errors and omissions. The CONTRACTOR shall be responsible for the accuracy of the work, even if the work is accepted by TMRSN.

22.2. No amendment, modification or renewal shall be made to this Contract unless set forth in a written amendment to the General Terms and Conditions and/or Program Contract and signed by an authorized representative of each of the parties hereto. Work under a Program Contract amendment shall not proceed until the Program Contract amendment is duly executed on or before the start date by TMRSN.

22.3. The Contractor shall not make any changes to service delivery requirements under any Program Contract due to changes in federal or State law, rules or regulations applicable to said service delivery without TMRSN approval.

22.4. TMRSN may withhold the CONTRACTOR'S payment in part or whole, if there is a delay in the

timely execution of Program Contracts and/or Program Contract amendments.

23. DISPUTES

23.1. Differences between the CONTRACTOR and TMRSN, arising under and by virtue of this Contract, shall be brought to the attention of TMRSN at the earliest possible time in order that such matters may be settled or other appropriate action promptly taken. Any dispute relating to the quality or acceptability of performance and/or compensation due the CONTRACTOR shall be submitted to the appropriate TMRSN staff, representative, or designee. If the dispute cannot be resolved by CONTRACTOR and TMRSN's staff representative informally, then all entities have access to TMRSN formal dispute resolution process as follows:

23.1.1. The CONTRACTOR and TMRSN shall attempt to resolve the dispute through informal means between the CONTRACTOR and TMRSN.

23.1.2. If the CONTRACTOR is not satisfied with the outcome, the CONTRACTOR may submit the disputed issue, in writing to TMRSN Administrator Thurston County Public Health and Social Services, 412 Lilly Rd NE, Olympia, WA 98506, to be reviewed. The written submission must contain the following information:

23.1.2.1. The CONTRACTOR's Contact for the issue.

23.1.2.2. The Issue in dispute.

23.1.2.3. The CONTRACTOR's position on the issue.

23.2. The Administrator may request additional information from the CONTRACTOR. The Administrator shall issue a written review decision to the CONTRACTOR within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the CONTRACTOR.

23.3. If the CONTRACTOR disagrees with the written review decision of the Administrator, the CONTRACTOR may request the Public Health and Social Services Director to review all information supplied by both parties up to that point. The Public Health and Social Services Director may request any additional information necessary to make the final decision for TMRSN. Timelines for production of any such additional information will be clearly marked within the request. The Public Health and Social Services Director shall issue a final written decision to the CONTRACTOR within thirty (30) calendar days of receipt of all requested information.

23.4. Both parties agree to make their best efforts to resolve disputes arising under this Contract and agree that this dispute resolution process is the sole and final administrative relief available to the parties and shall precede any judicial action.

24. TERMINATION

24.1. This Contract may be terminated in whole or in part as follows:

24.1.1. **Termination for Convenience**

24.1.1.1. Except as otherwise provided in this Contract, either party may terminate any Program Contract for convenience upon thirty (30) calendar days written notification by certified mail to the other party as listed on the first page of the General Terms and Conditions. The effective date of termination shall be the 30th day after receipt of written notification to the other party or the last day of a calendar month in which the 30th day occurs, whichever is later.

24.1.2. **Termination for Default**

24.1.2.1. TMRSN may terminate this Contract for default in whole or in part, without limiting remedies, by written notice to the CONTRACTOR if TMRSN has a reasonable basis to believe that the CONTRACTOR has:

24.1.2.1.1. Failed to perform under any provision of this Contract;

24.1.2.1.2. Failed to take satisfactory action as directed by TMRSN or its authorized representative within the time specified by the same;

24.1.2.1.3. Failed to satisfactorily substantiate its compliance with the terms and conditions of this Contract within the time specified by TMRSN or its authorized representative;

24.1.2.1.4. Violated any law, regulation, rule or ordinance applicable to this Contract; and/or

24.1.2.1.5. Otherwise breached any provision or condition of this Contract.

24.1.2.2. If this Contract is terminated for default, TMRSN may withhold a sum from the final payment to the CONTRACTOR that TMRSN determines necessary to protect TMRSN against loss or additional liability.

24.1.2.3. If, subsequent to termination, it is determined for any reason that (1) the CONTRACTOR was not in default, or (2) the CONTRACTOR's failure to perform was not its fault or its Subcontractor's fault or negligence, the termination shall be deemed to be a "termination for convenience."

24.1.3. **Termination Due to Change in Funding**

24.1.3.1.1. Notwithstanding any other termination provisions of this Contract, in the event funding from State, federal, or other sources upon which TMRSN relied to establish any Program Contract is withdrawn, reduced, or limited in any way, or if additional or modified conditions are placed on such funding, TMRSN may terminate that Program Contract by providing at least fifteen (15) calendar days written notice to the CONTRACTOR. The termination shall be effective on the date specified in the notice of termination.

24.1.4. **Termination of Regional Support Networks**

24.1.4.1. In the event that TMRSN becomes a nonparticipating RSN or in the event that the Department terminates or does not renew its contract with TMRSN, TMRSN may terminate this Contract by providing at least 60 days written notice to the CONTRACTOR. In this event, the Termination Procedure of the General Terms and Conditions shall be followed.

24.1.5. **Termination Procedure**

24.1.5.1. The following provisions shall survive and be binding on the parties in

the event this General Terms and Conditions and/or Program Contract is terminated in whole or in part:

24.1.5.1.1. Each party shall be responsible only for its performance in accordance with the terms of this Contract rendered prior to the effective date of termination. The CONTRACTOR shall assist in the orderly transfer/transition of the service recipients served under this Contract. The CONTRACTOR shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

24.1.5.1.2. The CONTRACTOR shall cease to perform any services required by the Contract as of the effective date of termination and shall comply with all of the instructions contained in the notice of termination.

24.1.5.1.3. The TMRSN shall be responsible for payment only for those services authorized and provided in accordance with the terms of this Contract rendered up to the effective date of termination. TMRSN shall withhold 20% of the final payment under this Contract until all final Contract deliverables, reports, client data, and any mutual transition plans under this General Terms & Conditions and/or Program Contracts are received and accepted by TMRSN.

24.1.5.1.4. The CONTRACTOR shall submit, within thirty (30) calendar days after the effective date of termination of this Contract, all financial, performance, and other reports required by this Contract.

24.1.5.1.5. Should this Contract be terminated in part, the CONTRACTOR shall complete performance of such part of the work not terminated.

24.1.5.1.6. The rights and remedies of TMRSN provided in this Section are in addition to any other rights and remedies available at law, in equity, or under this Contract.

25. TERMINATION OF DEPARTMENT CONTRACT

25.1. In the event that TMRSN's contract with the Department is terminated in whole or in part due to the CONTRACTOR's breach of its duties as set out in this Contract, the CONTRACTOR shall be liable for any charges TMRSN incurs from the Department including, but not limited to, procurement of similar services.

26. CHOICE OF LAW, JURISDICTION AND VENUE

26.1. This Contract has been and shall be construed as having been made and delivered within the State of Washington, and it is agreed by each party hereto that this Contract shall be governed by laws of the State of Washington, both as to interpretation and performance.

26.2. Any action at law, suit in equity, or judicial proceeding arising out of this Contract shall be instituted and maintained only in any of the courts of competent jurisdiction in Thurston County, Washington.

27. SEVERABILITY

27.1. If a court of competent jurisdiction holds any part, term, or provision of this Contract to be illegal, or invalid in whole or part, the validity of the remaining provisions shall not be affected, and the parties' rights and obligations shall be construed and enforced as if the Contract did not contain the particular provision held to be invalid.

27.2. If any provision of this Contract is in direct conflict with any statutory provision of the State of Washington, or federal statutes, that provision which may conflict shall be deemed inoperative and null and void insofar as it may conflict, and shall be deemed modified to conform to such statutory provision. Such modification will be effective on the effective date of the statutes necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

27.3. Should TMRSN determine that the severed portions substantially alter this Contract so that the original intent and purpose of the Contract no longer exists, TMRSN may, in its sole discretion, terminate this Contract.

28. TIME OF THE ESSENCE

28.1. Both parties recognize that time is of the essence in the performance of the provisions of this Contract.

29. ENTIRE CONTRACT

29.1. The parties agree that this Contract, including all documents attached or incorporated by reference, is the complete expression of its terms and conditions. Any oral or written representations or understandings not incorporated in this Contract are specifically excluded.

30. ORDER OF PRECEDENCE

30.1. In the event of an inconsistency in the terms of this Contract, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:

30.1.1. Thurston Mason Regional Support Network Contract on General Terms and Conditions;

30.1.2. Program Contract(s) and any Exhibits or other documents attached or incorporated by reference.

30.2. Notwithstanding the order of precedence listed above, additional details and more stringent requirements contained in a lower priority document will control unless the requirements of the lower priority document present an actual conflict with the requirements of the higher level document.

31. OWNERSHIP OF MATERIAL

31.1. Material created by the CONTRACTOR and paid for by TMRSN as a part of this Contract shall be owned by TMRSN and shall be "work made for hire" as defined by Title 17 USC, Section 101 et seq. This material includes, but is not limited to: books, computer programs and code, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes, and/or training materials. Material that the CONTRACTOR uses to perform this Contract but is not created for or paid for by TMRSN is owned by the CONTRACTOR and is not “work made for hire”; however, TMRSN and the Department shall have a perpetual license to use this material for TMRSN and the Department internal purposes at no charge to TMRSN or the Department, provided that such license shall be limited to the extent that the CONTRACTOR has a right to grant such a license.

31.2. The TMRSN agrees that if it uses any materials prepared by the CONTRACTOR for purposes other than those intended by this Contract, it does so at its sole risk and it agrees to hold the CONTRACTOR harmless therefore.

32. HEADINGS

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

33. NON-WAIVER OF RIGHTS

33.1. The parties agree that the excuse or forgiveness of performance or waiver of any provision(s) of this Contract does not constitute a waiver of such provision(s) or future performance, or prejudice the right of the waiving party to enforce any of the provisions of this Contract at a later time.

34. SURVIVABILITY

34.1. The terms and conditions contained in this Contract that by their sense and context are intended to survive the expiration or termination of this Contract shall survive. Surviving terms include, but are not limited to: Recapture Provisions, Confidentiality, Relationship of Parties, Inspection/Maintenance and Retention of Records, Title to Property, Hold Harmless and Indemnification, Disputes, Termination for Default, Termination Procedure, Ownership of Material, and Choice of Law, Jurisdiction, and Venue.

35. OPERATION OF TMRSN CONTRACT ON GENERAL TERMS AND CONDITIONS

35.1. This Thurston Mason Regional Support Network Contract on General Terms and Conditions is incorporated by reference into each Program Contract between TMRSN and the CONTRACTOR in effect on or after the start date of this Thurston Mason Regional Support Network Contract on General Terms and Conditions. This Thurston Mason Regional Support Network Contract on General Terms and Conditions govern and apply only to work performed under Program Contracts between the parties.

OLDER ADULT OUTPATIENT PROGRAM CONTRACT

Program Contract Number: 2015-20109

This Program Contract is between the Thurston Mason Regional Support Network (TMRSN) and the Contractor identified below. This Program Contract, exhibits, and attachment(s) are valid only when the Contractor and the TMRSN have executed the Contract on General Terms and Conditions. The Contract on General Terms and Conditions is incorporated herein by reference as if fully set forth herein. The Contract on General Terms and Conditions, Program Contract, and all exhibits, attachment(s) and other documents attached or incorporated by reference contain all of the terms and conditions agreed to by the parties.

Thurston Mason RSN Contract Manager:	Kristy Lysell, Provider Network Coordinator		
Address:	412 Lilly Road NE, Olympia WA 98506		
Contact Information:	**Phone:** 360.867.2560	**Email:** lysellk@co.thurston.wa.us	
Contractor:	Providence Health & Services – WA d/b/a Providence St. Peter Hospital	**Contact:**	Sue Beall, Manager
Address:	413 Lilly Rd Ne, Olympia WA 98506		
Contact Information:	**Phone:** 360.493.7809	**Email:** Beall.sue@providence.org	

Is this contractor a Subrecipient for purposes of this contract? ☐ **Y** ☒ **N** | **CFDA #:**

TOTAL FUNDING DURING CONTRACT PERIOD: **$373,856**

Fund Source:	☐ Federal	☒ Medicaid	☒ State	☐ TST	☐ Inter-Gov	☐ Local	☒ Reserves
Amount:	$	$244,800	$7,200	$	$	$	$121,856

Contract Start Date: January 01, 2015	**Contract End Date:** December 31, 2015
Exhibits: **A:** Statement of Work **B:** Compensation **C:** **Not included under this contract** **D:** Data Security **E:** Modality Definitions **F:** Access to Care Standards **G:** **Not included under this contract** **H:** TMRSN Invoice Schedule 2015	**Attachments:** **1:** Intensive Outpatient Services Staffing Roster [Excel]

This Program Contract, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties. No other understandings and representations, oral or otherwise, regarding the subject matter of this Contract shall be deemed to exist or bind the parties. The parties signing below warrant that they have read and understand this Contract, and have authority to enter into this Program Contract. By their signatures below, the parties hereto agree to this Program Contract and execute it in duplicate originals.

Contractor Signature:	**Printed Name and Tile:**	**Date:**
M Colucci	Medrice Coluccio, Chief Executive	2/23/15
Thurston County Signature:	**Printed Name and Title:**	**Date:**
[signature]	Don Sloma, Director	2-27-15

EXHIBIT A
STATEMENT OF WORK

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1. PURPOSE OF CONTRACT

1.1. Operate a Licensed Community Mental Health Agency (CMHA) to provide mental health services to Medicaid enrollees and services to non-Medicaid individuals as described hereunder this Contract. Services provided shall be culturally competent, medically necessary, and clinically appropriate pursuant to:

1.1.1. Federal 1915 (b) Mental Health Waiver and the Medicaid State plan or any successors;

1.1.2. Thurston Mason RSN's Contract on General Terms and Conditions;

1.1.3. Thurston Mason RSN's policies, procedures, protocols, guidelines, and instructions provided or referenced herein, and any successors, amended or replaced;

1.1.4. CFR 42 CFR 438, or any successors;

1.1.5. RCW 70.02, 71.05, 71.24, and 71.34, or any successors;

1.1.6. WAC Chapter 388-865 and 388-877, or any successors; and

1.1.7. Other applicable state and federal laws and regulation, administrative policies, or any successors.

2. DEFINITIONS

2.1. **Access to Care Standards** are a set of standards published by the Mental Health Division that defines the eligibility requirements for initial authorization of outpatient services for Medicaid and Non-Medicaid adults, older adults, and children. The guidelines define the minimum eligibility criteria that can be applied, and are not intended to be applied as continuing stay criteria. The Standards provide guidelines on the goals and periods of authorization, a list of covered diagnoses, identifying functional impairments within life domains, supports and environment, and a minimum modality set for treatment services identified at two levels - brief intervention and community support. The most current Access to Care Standards is dated January 01, 2006.

2.2. **Action** in the context of Regional Support Network ("RSN") services means:

2.2.1. the denial or limited authorization of a requested service, including the type or level of service.

2.2.2. the reduction, suspension, or termination of a previously authorized service.

2.2.3. the denial, in whole or in part, of payment for a service.

2.2.4. the failure to provide services in a timely manner, as defined by the state.

2.2.5. the failure of a RSN to act within the timeframes provided in section 42 CFR 408(b).

2.3. **Administrative Cost** means costs for the administration of this Contract for the general operation of the public mental health system. These activities cannot be identified with a specific direct services or direct services support function as defined in the BARS supplemental instructions and must be limited to no more than 10%.

2.4. **Appeal** means a request for review of an action.

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

2.6. **Child Study and Treatment Center ("CSTC")** means the Department of Social and Health Services child psychiatric hospital.

2.7. **Children's Long Term Inpatient Programs ("CLIP")** means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from Children's Long Term Inpatient Programs.

2.8. **Community Mental Health Agency ("CMHA")** means a Community Mental Health Agen licensed by the State of Washington to provide mental health services and Subcontracted to p services covered under this Contract.

2.9. **Consumer** means a person and/or Enrollee who has applied for, is eligible for, or who has re mental health services. For a child under the age of thirteen (13), or for a child age thirteen (older whose parents or legal representatives are involved in the treatment plan, the definition consumer includes parents or legal representatives.

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

2.11. **Day** for purposes of this Contract means calendar days unless otherwise indicated in the Con

2.12. **Deliverable** means items that are required for submission to TMRSN to satisfy the work requirements of this Contract and that are due by a particular date or on a regularly occurring schedule.

2.13. **Denial** means the decision by a RSN, or their formal designee, not to authorize a covered M id mental health service that has been requested by a provider on behalf of an eligible Medicaid Enrollee. It is also a denial if an intake is not provided upon request by a Medicaid Enrollee.

2.14. **Direct Care Staff** means persons employed by community mental health agencies whose pri y responsibility is providing direct treatment and support to people with mental illness, or who primary responsibility is providing direct support to such staff in areas such as client schedul client intake, client reception, client records-keeping, and facilities maintenance.

2.15. **Division of Behavioral Health and Recovery or DBHR** means the DSHS-designated state ntal health authority to administer the state and Medicaid funded mental health programs authori by RCW chapters 71.05, 71.24, and 71.3.

2.16. **Early Periodic Screening Diagnosis and Treatment ("EPSDT")** means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act as a nded for children who have not reached their 21st birthday.

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

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

2.19. **Enrollee** means a Medicaid recipient who is enrolled in an RSN.

2.20. **Evidence Based Practice** means a program or practice that has had multiple site random co olled trials across heterogeneous populations demonstrating that the program or practice is effectiv for the population.

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

2.22. **Family** means:

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

2.22.2. For adult consumers, family means those the consumer defines as family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the consumer.

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

2.24. **"High Risk"**

2.24.1. Persons who are not Medicaid eligible but are determined to meet the criteria for "state priority populations" as defined in RCW 71.05, 71.24. 71.34 or any successors,

2.24.2. Who meet the Federal Poverty Level, with special attention to children, older adults and minorities shall be served based on available state only funding.

2.24.3. The level of need, risk for inpatient and jail (due to M.I.) and severity of illness shall determine the order of precedence for utilizing available resources for serving those without Medicaid.

2.24.4. Those with the highest priority shall be at imminent risk of psychiatric hospitalization or jail due to their disorder or just released

2.24.5. Those individuals who are on a "spend down", who can achieve Medicaid consumer status within the first month of their spend down period, shall be served based on available resources through State only funding to assist the individual prior to achieving their spend down level.

2.25. **Level of Care Guidelines** means the criteria the Contractor uses in determining which individuals within the target groups identified in the Contractor's policy and procedures will receive services.

2.26. **Medicaid Funds** means funds provided by Centers for Medicare and Medicaid (CMS) Authority under Title XIX of the Social Security Act.

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

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

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

2.29. **Mental Health Professional** means:

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

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

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

2.29.4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the regional support network and granted by the DSHS prior to July 1, 2001; or

2.29.5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by DBHR consistent with WAC 388-865-0265.

2.30. **Network Provider** means a Community Mental Health Agency, Professional Service, or other identified service such as a Clubhouse that is contracted directly with Thurston Mason RSN for the delivery, or support of delivery, of mental health services in the Provider Network.

2.31. **Notice of Determination** means a written notice that must be provided to Enrollees to inform them that medically necessary services have been authorized or that, following an intake no additional services have been requested and/or authorized, and the reason for this determination. This notice also must provide information about the Enrollees' right to a second opinion and the right to file a grievance, appeal and a Fair Hearing.

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

2.33. **Provider Network** means all Thurston Mason RSN contracted agencies within the Thurston Mason service area that provide either direct or indirect services to Enrollees.

2.34. **ProviderOne** means the Department's Medicaid Management Information Payment Processing System.

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

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

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

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

2.39. **Reduction** means the decision by a RSN to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

2.40. **Regional Support Network ("RSN")** means a county authority or group of county authorities or other entity recognized by the secretary to administer mental health services in a defined region.

2.41. **Request for Service** means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an enrollee or the person authorized to consent to treatment for that enrollee. For purposes of this Contract, an EPSDT referral is only a Request for Service when the enrollee or the person authorized to consent to treatment for that enrollee has confirmed that they are requesting service.

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

2.43. **Routine Services** means non-emergent and non-urgent services are offered within fourteen (14) calendar days to individuals authorized to receive services as defined in the Access to Care Standards. Routine services are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health. These services do not meet the definition of Urgent or Emergent Care.

2.44. **Service Area** means the geographic area covered by this Contract for which the Contractor is responsible.

2.45. **Suspension** means the decision by a RSN, or their formal designee, to temporarily stop previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

2.46. **Termination** means the decision by a RSN, or their formal designee, to stop previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.

2.47. **Under-Utilization** means the failure to provide appropriate and/or indicated services, or provision of a lower quantity or level of services than required or than is usually considered sufficient or indicated.

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

3. ENROLLMENT

3.1. **Service Area:** The Contractor is responsible for providing services to the target population of TMRSN within the boundaries of Thurston and Mason Counties. If the Contractor does not maintain facilities in both Counties, the Contractor must have the ability to provide outreach services to both Counties, unless approved otherwise by TMRSN.

3.2. Enrollees who reside within the Contractor's service area and who are enrolled in any of the programs included in the Federal 1915 (b) Mental Health Waiver are eligible for medically necessary mental health services provided under this contract. The Contractor shall serve Enrollees:

3.2.1. 60 years and older;

3.2.2. Under the age of 60 but have been identified as an individual who functions like an older adult;

3.2.3. Between the ages of 18-60, if the Enrollee enrolled through the Intensive Outpatient Services Program, or if the Enrollee has been pre-authorized by TMRSN to receive services by the Contractor.

3.3. The Contractor shall screen all individuals requesting mental health services for eligibility and offer an intake assessment accordingly.

3.3.1. If the individual is determined to meet Medicaid eligibility, Access to care Standards, and medical necessity, TMRSN will authorize services per Section 6.

4. ENROLLEE BENEFITS

4.1. All Medicaid enrollees requesting covered Mental Health Services must be offered an intake evaluation as outlined in the Access to Care Standards and authorization must be based on Medical Necessity and the Access to Care Standards.

4.1.1. An initial assessment must be conducted by a mental health professional consistent with WAC 388-877-0610 and must be culturally relevant and age appropriate. The intake evaluation must include the Co-Occurring Disorder Screening and Assessment requirement

described in Section 6.8 that is required by RCW 70.96C. Routine services may begin before the completion of the intake once medical necessity is established.

4.2. If the Contractor is unable to provide the services covered under this Contract, the services must be purchased within 28 calendar days for an enrollee with an identified need. The Contractor must continue to pay for medically necessary mental health services outside the service area until the Contractor is able to provide them within its service area.

4.3. The Contractor must provide the following mental health services for each enrollee when they are Medically Necessary. If the Contractor is unable to provide medically necessary services covered under the contract to a particular enrollee, the entity must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them within the network. These out of network services must be provided at no additional cost to the enrollee. Enrollees are entitled to access Crisis Services, Freestanding Evaluation and Treatment, Stabilization and Rehabilitation Case Management prior to an intake evaluation.

4.4. State Plan Modalities:

4.4.1. Enrollees are entitled to receive one or more service modalities if determined to be medically necessary and meet Access to Care Standards. The Contractor must provide the modalities in accordance with the treatment standards described and required in this contract hereunder. If the Contractor is not licensed to or able to provide a listed modality, the Contractor must notify the enrollee in writing and facilitate the service through a referral to another TMRSN Network Provider or by subcontracting for the service. For complete modality definitions, please see Exhibit E. Available to enrollees:

4.4.1.1. Brief Intervention Treatment

4.4.1.2. Family Treatment

4.4.1.3. Group Treatment Services

4.4.1.4. High Intensity Treatment

4.4.1.5. Individual Treatment Services

4.4.1.6. Intake Evaluation

4.4.1.7. Medication Management

4.4.1.8. Medication Monitoring

4.4.1.9. Psychological Assessment

4.4.1.10. Rehabilitation Case Management

4.4.1.11. Special Population Evaluation

4.4.1.12. Therapeutic Psychoeducation

4.4.1.13. Mental Health Services Provided in a Residential Setting

4.4.1.14. Peer Support

4.4.1.15. Day Support

4.4.1.16. Crisis Services

4.4.1.17. Stabilization Services

4.4.1.18. Evaluation and Treatment

4.5. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

4.6. The Contractor shall incorporate the Washington State Children's Mental Health System Principles and Core Practice Model as guidelines for providing care to children, youth, and their families as referenced in Exhibit G.

5. ACCESS TO CARE

5.1. Access Standards: A request for services may be made through a telephone call, walk-in, or written request from an enrollee or those defined as Family in this Contract or the receipt of a written EPSDT referral.

5.1.1. The Contractor must verify eligibility for Medicaid prior to the provision of non-crisis services to an enrollee.

5.1.2. The Contractor must maintain documentation of all requests for service even if no service occurs including documenting the reason no service was delivered.

5.1.3. The Contractor shall not refer a Healthy Options enrollee to the enrollee's Healthy Options managed care plan for mental health services if the enrollee is determined to be eligible based on medical necessity and the Access to Care Standards.

5.1.4. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

5.1.4.1. The Contractor shall not deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

5.1.5. The Contractor shall not discriminate against difficult to serve enrollees. Examples include a refusal to treat an enrollee because the enrollee is deemed too dangerous, because housing is not available in the community, or that a particular type of residential placement is not currently available.

5.1.6. Maintain the ability to provide an intake evaluation at an enrollee's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to persons discharged from a state hospital or evaluation & treatment facilities to such placements when the enrollee requires an on-site service due to medical needs.

5.1.7. Maintain the ability to adjust the number, mix, and geographic distribution of treatment providers to meet Access Standards as the population or enrollees needing mental health services shift within the service area.

5.1.8. Maintain the ability to provide services to enrollees in their residence, including adult family homes, assisted living facilities, and skilled nursing facilities when required due to medical needs.

5.2. Appointment Standards: The Contractor shall comply with appointment standards that are consistent with the following:

5.2.1. The Contractor shall make available crisis mental health services on a 24-hour, 7 days per week basis, as defined in Section 16.

5.2.2. The Contractor shall comply with appointment standards that are consistent with the following:

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

5.2.2.2. Urgent care must occur with 24 hours of a request for mental health services from any source.

5.2.2.3. A routine intake evaluation appointment must be available and offered to every enrollee within 10 business days of the request unless the following condition is met:

5.2.2.3.1. An intake evaluation has been provided in the previous 12 months that establishes medical necessity and the intake is updated accordingly to reflect any changes identified by the enrollee.

5.2.2.3.2. The intake evaluation must include the Co-Occurring Disorder Screening described in Section 6.8 that is required by RCW 70.96C.

5.2.2.4. The time period from request for mental health services to first Routine services appointment offered must not exceed 28 calendar days.

5.2.2.4.1. The Contractor must document the reason for any delays. This includes documentation when the enrollee declines an intake appointment within the first 10 business days following a request, or declines the first routine appointment offered within the 28 day timeframe.

5.3. Network Capacity: The Contractor shall maintain sufficient capacity, including the number, mix, and geographic distribution of Mental Health Care Providers (MHCPs) to meet Access Standards and the needs of the anticipated and/or projected number of enrollee's being served by the Contractor within the contracted service area.

5.3.1. The Contractor shall monitor and adjust to situations in which there is:

5.3.1.1. A need identified by TMRSN to meet levels of productivity standards within the network;

5.3.1.2. Unanticipated need for MHCPs with particular types of experience; or

5.3.1.3. Unanticipated limitation of the availability of such MHCPs including identifying the numbers of MHCPs who are not accepting new enrollees.

5.4. Changes in Capacity

5.4.1. If any portion of this Contract in whole or in part is terminated, or if the Contractor terminates a Subcontract that provides any portion of services under this Contract, the Contractor must notify TMRSN per the termination section under the TMRSN Contract on GT&C prior to any public announcement and/or media release.

5.4.2. The Contractor shall notify TMRSN of any other changes in capacity that results in the Contractor being unable to meet any of the productivity or Access Standards as required in this Contract.

5.4.2.1. Events that affect capacity include: decrease in the number or frequency of a required service, employee strike or other work stoppage related to union activities, or any changes that result in the Contractor being unable to provide timely, medically necessary services.

5.4.3. If any event in section 5.4 occurs, the Contractor must submit a plan to TMRSN for enrollees and services that include at a minimum:

5.4.3.1. Notification to Ombuds services.

5.4.3.2. Crisis services plan.

5.4.3.3. Client notification plan.

5.4.3.4. Plan for provision of uninterrupted services.

5.4.3.5. Any information released to the media.

5.5. Distance Standards

5.5.1. The Contractor shall support TMRSN's efforts to ensure that when enrollees travel to service sites, the sites are accessible within a standard of:

5.5.1.1. The drive time to the closest Network Provider from the primary residence of the enrollee in does not exceed 30 minutes in a rural area, 90 minutes in a large rural area, or 90 minutes each way in an urban area with public transportation.

5.5.1.2. Distance standard does not apply: a) when the enrollee chooses to use service

sites that require travel beyond the distance standards; b) when the service provided is at a level not available at the closest CMHA provider, such as crisis stabilization, services provided by PACT, or psychiatric inpatient services including E&T; c) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

6. UTILIZATION MANAGEMENT

6.1. The Contractor shall develop and maintain a utilization management plan that is consistent with the requirements under this contract. The plan may not be structured in such a way as to provide incentives to individual providers or other entities to deny, limit, or discontinue medically necessary services.

6.1.1. The Contractor shall have a medical director who is qualified to provide guidance, leadership, oversight, utilization, and quality assurance for the mental health programs. These following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the medical director to oversee:

6.1.1.1. Utilization reviews with the following components:

6.1.1.1.1. Services requested in comparison to services identified as medically necessary.

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

6.1.1.1.3. A review of which goals identified in the Individual Service Plan have been met, have been discontinued or have continued need.

6.1.1.1.4. Patterns of denials of services.

6.1.1.1.5. Use of Evidence-Based and other identified practice guidelines.

6.1.1.1.6. Use of discharge planning guidelines.

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

6.1.1.1.8. Coordination with Tribal and Recognized American Indian Organizations (RAIO) and other TMRSN Network Providers.

6.1.2. The Contractor must meet TMRSN's criteria for, including documenting and monitoring:

6.1.2.1. Consistent application of Medical Necessity criteria and TMRSN's Level of Care Guidelines including the use of Access to Care Standards, and the Level of Care Utilization System (LOCUS/CALOCUS) for Adults and Children;

6.1.2.2. Over and under-utilization of services.

6.2. General Authorization Requirements

6.2.1. The Contractor must maintain a written policy and procedure that incorporates the consistent application and use of medical necessity and Access to Care criteria, and TMRSN eligibility, level of care, and continuing care and discharge criteria guidelines.

6.2.2. The Contractor shall base the request for an initial authorization for covered mental health services on the medical necessity criteria, the current Access to Care Standards, and the most current TMRSN Level of Care and Authorization Criteria Guidelines.

6.2.3. The Contractor shall base the request for a reauthorization on the medical necessity criteria, and the continuing care and discharge criteria in the most current TMRSN Level of Care and Authorization Criteria Guidelines.

6.2.4. All Level of Care requests shall be based on the enrollees expressed needs and the most appropriate fit of services recommended to effectively address the enrollee's treatment

goals.

6.2.5. Intake evaluations are pre-authorized by TMRSN for all Medicaid enrollees and do not require a separate authorization request.

6.2.6. If after the intake further treatment services are determined to be medically necessary the Contractor must request authorization from TMRSN.

6.2.6.1. If after the intake further treatment services are determined not to be medically necessary or do not meet the Access to Care standards, Contractor must fax the completed intake to TMRSN Care Management for review prior to denying services.

6.2.6.2. If there is no medical necessity for mental health treatment or the Access to Care criteria is not met at intake, enrollees must be offered and if requested, provided a second opinion assessment within 30 calendar days at no cost to the enrollee.

6.2.7. If further treatment services are recommended, after the intake, routine treatment must be available, offered and initiated timely, but at least within 28 calendar days of the enrollee's request for mental health services.

6.3. Level of Care Utilization System

6.3.1. The Contractor shall administer the LOCUS or CALOCUS instrument including the Score Sheet, provided by TMRSN, for each individual for whom an initial authorization is requested. A LOCUS or CALOCUS shall also be required at the time of each reauthorization request.

6.3.1.1. The Contractor must ensure that the instrument be administered after the completion of the mental health intake, using the appropriate LOCUS/CALOCUS Score Sheet. The enrollee does not need to be present for the LOCUS/CALOCUS process.

6.3.1.2. The Contractor must develop a brief narrative on the Score Sheet, which includes the recommended Level of Care that the Contractor is requesting and an explanation for any significant scores found during the administration of the instrument.

6.3.1.3. If the LOCUS/CALOCUS score does not correspond to the recommended Level of Care from the Contractor, the Contractor must request an exception from TMRSN. The exception request must include a written explanation justifying the reason for the request.

6.3.1.4. The LOCUS/CALOCUS Score Sheet must be included with the Intake Evaluation when requesting initial authorization for services. Authorization requests sent to TMRSN that do not have a completed LOCUS/CALOCUS score sheet will not be authorized.

6.3.1.5. The LOCUS/CALOCUS Score Sheet must be included with each request for reauthorization. Reauthorization of services is dependent upon the Level of Care that is being requested, according to TMRNS Policy and Procedure GL-1006: Level of Care Guidelines with ACS. Reauthorization requests sent to TMRSN that do not have a completed LOCUS/CALOCUS score sheet will not be authorized.

6.3.1.6. Use of the LOCUS and CALOCUS shall be implemented as follows:

6.3.1.6.1. January 1, 2014 – all initial authorizations must include a LOCUS/CALOCUS Score Sheet.

6.3.1.6.2. January 1, 2014 – all reauthorizations (regardless of initial entry

into the agency) must include a LOCUS/CALOCUS Score Sheet.

6.3.1.6.3. March 1, 2014 – initial quality improvement activities, including clinical chart reviews, to begin.

6.3.1.6.4. April 1, 2014 – initial data pull to determine distribution of assigned Levels of Care, and utilization management.

6.3.1.6.5. July 1, 2014 – Recommendations for rate change realignment based on actual utilization and assignment of LOC.

6.4. Authorization Requests

6.4.1. The Contractor shall develop and maintain an efficient and timely authorization request process that incorporates TMRSN procedures and timeline requirements specified in the TMRSN Policy and Procedure Manual.

6.4.2. The Contractor shall submit an electronic authorization request to TMRSN within seven (7) calendar days after initiation of the intake and recommendation for a level of care.

6.4.2.1. At a minimum, all initial authorization requests must electronically include:

6.4.2.1.1. Electronic authorization request

6.4.2.1.2. Intake assessment (submitted through IRMS)

6.4.2.1.3. LOCUS/CALOCUS Score Sheet (submitted through IRMS)

6.4.2.1.4. Other program specific documents, as required by individual program requirements in Contract Attachments.

6.4.2.2. If the request for authorization exceeds 10 calendar days beyond the intake, a request for an extension must be documented with reason for delay, and submitted to TMRSN. The Contractor must also notify the enrollee of the delay.

6.4.2.3. Routine treatment services must still occur within 28 calendar days of the initial request for services.

6.4.3. At the end of an authorized benefit period, the Contractor shall collaborate with the enrollee to document a clinical evaluation of enrollee progress in treatment, the effectiveness of services provided during the previous benefit period, and a recommendation for clinical discharge or for continuing care in accordance with the medical necessity criteria and TMRSN Level of Care Guidelines.

6.4.3.1. If an authorized benefit period is nearing expiration and continuing services are still medically necessary and recommended, the Contractor must submit a reauthorization request for continuing care prior to the end of the benefit period to promote continuity of care. If a reauthorization for continuing services is requested, the Contractor must complete a new LOCUS or CALOCUS instrument. The Contractor must submit the following documentation for a reauthorization of services:

6.4.3.1.1. Electronic reauthorization request

6.4.3.1.2. Treatment plan review (discussing progress from last treatment planning period – submitted through IRMS)

6.4.3.1.3. Revised Treatment plan (for new treatment planning period – submitted through IRMS)

6.4.3.1.4. New LOCUS/CALOCUS Score Sheet (submitted through IRMS)

6.4.3.1.5. Other program specific documents as required by individual

program requirements in Contract Attachments.

6.5. Authorization Decisions

6.5.1. TMRSN retains the authority and the responsibility for all authorization decisions, and for the utilization and resource management of contracted services.

6.5.2. TMRSN's initial decision to authorize requested mental health services will be made promptly, but must be made within 14 calendar days from the date of initiation of the intake assessment, unless the enrollee or the Contractor requests an extension of the authorization request from the RSN. An extension of up to 14 additional calendar days to make the authorization decision is also possible if the TMRSN justifies the need for additional information and it is in the enrollee's best interest.

6.5.3. The initial decision to authorize mental health services may be expedited if the enrollee presents a potential risk to self or others, or if their condition affects their ability to maintain or regain functioning. An expedited decision shall be made within three (3) calendar days if requested.

6.6. Enrollee Notification

6.6.1. TMRSN will maintain the responsibility for sending all letters of notification to enrollees, including Notice of Determinations and Notice of Actions, regardless of funding source, specifying the TMRSN authorization decision and benefit period as applicable.

6.6.1.1. A copy of each notice will be sent to the Contractor and the Contractor is responsible for filing and maintaining the notice in the client's chart.

6.6.2. TMRSN's decision not to authorize the recommended medically necessary services or to limit the services requested by the Contractor constitutes an "action" by TMRSN.

6.6.2.1. TMRSN will initiate and release/mail all TMRSN Notice of Action (NOA) letters to Medicaid enrollees when TMRSN denies authorization or denies, reduces or terminates previously authorized services.

6.6.3. TMRSN's decision is subject to appeal by the enrollee or the Contractor on his/her behalf in accordance with TMRSN Grievance and Appeal procedures in Section 15 of this contract.

6.7. Group Services

6.7.1. Prior to providing group services, the Contractor shall develop and submit to TMRSN, for review and approval, a Group Plan for each proposed group service. The Contractor shall use the TMRSN Group Service Plan form attached herein. The Group Plan must include the purpose:

6.7.1.1. Design or practice model (may attach descriptive marketing materials);

6.7.1.2. Specific therapeutic interventions;

6.7.1.3. Proposed group size and hours for group session;

6.7.1.4. Duration of the group service (anticipated days, weeks, months, etc.);

6.7.1.5. Practitioners leading and/or participating in the group and their credentials including any special training; and

6.7.1.6. Objectives and expected outcomes.

6.7.2. A copy of the approved Group Plans must be included in the Enrollee's chart **and** be signed by the clinical supervisor.

6.7.3. Group services shall be provided only when:

6.7.3.1. The group service is included in the Enrollees treatment plan;

6.7.3.2. There is medical necessity documented for the group service and the Enrollee is reasonably expected to benefit therapeutically from the interventions proposed; and

6.7.3.3. Chart documentation can clearly identify the individual Enrollees response to each group intervention.

6.7.4. In addition to the above, group services shall:

6.7.4.1. Not exceed more than four (4) hours per group per event;

6.7.4.2. Only be allowable for Medicaid Enrollees;

6.7.4.3. Include at a minimum three (3) Enrollees and a maximum of twelve (12) Enrollees;

6.7.5. Not exceed a ratio of more than 1clinician per 8 Enrollees. A second clinician may participate and submit encounters in the group if there are seven (7) or more Enrollees in the group. If a second clinician participates, the second clinician must be an MHP and each Enrollee must only be assigned to one clinician per group session to prevent duplicate billing and documentation.

6.8. Co-Occurring Disorder Screening and Assessment: The Contractor must maintain the implementation of the integrated, comprehensive screening and assessment process for chemical dependency and mental disorders as required by RCW 70.96C. Failure to maintain the Screening and Assessment process shall result in remedial actions up to and including financial penalties as described in Section 21, Remedial Actions, of this Contract.

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

6.8.1.1. All new intakes.

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

6.8.1.2.1. The service results in a referral for an intake assessment.

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

6.8.1.2.3. The contact is by telephone only.

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

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

6.8.3. The results of the GAIN-SS screening, including refusals and unable-to-completes, must be reported to TMRSN through the MIS system.

6.8.4. Staff utilizing the tool must attend ongoing DBHR trainings on the use of the screening and assessment process that includes use of the tool and quadrant placement.

6.8.5. The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by DBHR and outlined in the SAMHSA Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a two (2) or higher on either of the first two (2) scales (ID Screen & ED Screen) and a two (2) or higher on the third (SD Screen).

6.8.6. The HRSA-GAIN-SS screening form, along with the quadrant score, must be placed within the enrollee's clinical chart even if the enrollee refused or was unable to complete it.

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

and treatment facilities. The assessment is not required during crisis interventions or ITA investigations. The quadrant placements are defined as:

6.8.7.1. Less severe mental health disorder/less severe substance disorder.

6.8.7.2. More severe mental health disorder/less severe substance disorder.

6.8.7.3. Less severe mental health disorder/more severe substance disorder.

6.8.7.4. More severe mental health disorder/more severe substance disorder.

6.8.8. The quadrant placement must be reported to TMRSN through the MIS system.

7. ENROLLEE RIGHTS AND PARTICIPATION IN SERVICES

7.1. The Contractor and affiliated service providers shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff takes those rights into account when furnishing services to enrollees. Any changes to applicable law must be implemented with 90 days of the effective date of change.

7.2. The Contractor shall maintain written policies and procedures addressing all requirements under this section. Polices must comply with all regulations, laws, contract, and documents as listed under Section 1 of this contract.

7.3. The Contractor must ensure that each enrollee is free to exercise his or her rights, and that the exercising of those rights does not adversely affect the way the Contractor and its providers treat the enrollee.

7.4. The Contractor shall require that mental health professionals and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to:

7.4.1. The enrollee's mental health status;

7.4.2. Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally-competent manner;

7.4.3. Any information the enrollee needs in order to decide among all relevant mental health treatment options;

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

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

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

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

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

7.5. Enrollee's Rights

7.5.1. The Contractor shall ensure enrollee's, prospective enrollee's and legally responsible others are informed, in prevalent non-English languages as described in under this section, of their rights per 42 CFR Part 438.100 and WAC 388-877-0600 or any successors.

7.5.2. Post a written statement of enrollee rights in public areas with a copy available to enrollees on request.

7.5.3. Ensure the statement of enrollee rights incorporates DBHR enrollee's rights listed in the DBHR Handbook.

7.5.4. The Contractor shall ensure that all enrollees on LRAs are informed as to their rights

pertaining to Chapter 71.05 RCW, or any successor, and provided all applicable services.

7.6. Enrollee Voice in Treatment and Decision Making

7.6.1. The Contractor shall ensure informed consent to treatment and enrollee access to his or her medical records in accordance with WAC 388-877-0650 or any successor.

7.6.2. For enrollee's under the age of 13 or adults with a legal guardian, appropriate documentation of the informed consent of the guardian must be in the enrollee's medical record chart.

7.6.3. Every enrollee, and their family, and/or other natural supports, if appropriate and authorized by the enrollee, have a voice in the ongoing process of treatment planning and decision-making. Enrollee voice shall be demonstrated through:

7.6.3.1. Enrollee signature, if age 13 or older;

7.6.3.2. Enrollee's parent or guardian or legal representative, if age 12 or under;

7.6.3.3. Enrollee quotes and input on treatment plans and 180-treatment plan reviews.

7.6.4. Enrollee quotes and input during the discharge planning process, to include the discharge summary.

7.6.5. Every enrollee has a choice of contracted CMHA (if more than one is available) within his/her county of residence from which to receive mental health services.

7.6.6. An enrollee may change providers and/or direct service staff based on need and fit of service.

7.7. Family Participation

7.7.1. For services to children, the Contractor shall provide, when medically necessary, treatment services, which incorporate family involvement and participation. This shall be offered unless there is reason to believe this shall put the child at risk.

7.7.2. TMRSN enrolled children who meet the requirements of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines shall receive mental health services that comply with Section 9 of this contract and services shall be reported in accordance with requirements to the TMRSN Data Dictionary.

7.7.3. The Contractor shall ensure that adults and adolescents that are able to consent for treatment on their own behalf may choose whether to involve family members in their treatment.

7.7.4. The Contractor shall provide parenting skills, when appropriate, for parents of children in treatment. The goal of skills training is to empower parents; reduce their anxiety; increase their sense of competence and confidence in their ability to manage their own children; and reduce their reliance on formal system intervention.

7.8. Individual Service Plans must be developed in compliance with WAC 388-877-0620 and 388-877A-0135.

7.8.1. In addition, the Contractor shall require that enrollees are actively included in the development of their individualized service plans, periodic (every 180 days) service plan reviews, advance directives for psychiatric care, and crisis plans (Section 7.9).

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

7.8.2. At a minimum, individual service plans must include:

7.8.2.1. A problem or needs statement that is in the words of the enrollee to be best extent possible;

7.8.2.2. Services mutually agreed upon by both the individual and provider for this treatment episode;

7.8.2.3. At least one goal that is in the words of the enrollee to the best extent possible, and that directly relates to the problem or needs statement, and to identified needs from the intake assessment;

7.8.2.4. Measurable outcomes and strategies. These are measurable steps the enrollee agrees to attempt in order to meet his/her overarching goal. These are sometimes referred to as objectives or benchmarks;

7.8.2.5. Service modalities; and

7.8.2.6. Discharge criteria, agreed upon between the Contractor and the enrollee, that clearly specifies when the treatment goal has been reached and the enrollee can either be discharged, or a new service plan developed.

7.8.3. Individualized service plans must be reviewed upon re-authorization requests, per the TMRSN LOC Guidelines, or at a minimum every six (6) months, and must include the following elements:

7.8.3.1. An evaluation of service modality effectiveness towards treatment progress;

7.8.3.2. A review of unmet treatment goals and needs;

7.8.3.3. The enrollee's voice in describing personal progress towards their stated goals and measurable outcomes; and

7.8.3.4. A method of determining if the enrollee has met discharge criteria or if further treatment is warranted.

7.8.4. The Individual Service Plan shall address the overall identified needs of the enrollee, including those that may be best met by another service delivery system, such as education, primary medical care, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections and juvenile justice as appropriate. If the treatment plan identifies one of those services, the Contractor shall ensure coordination with the other service delivery systems that shall be responsible for meeting those identified needs.

7.8.5. An individual peer support plan may be incorporated into the Individual Service Plan.

7.9. Risk Assessment and Crisis Plans

7.9.1. The Contractor shall adopt a standardized risk assessment instrument that will assist the mental health professional (MHP) in determining future crisis prevention services.

7.9.2. The Contractor shall perform a risk assessment when it is clinically indicated and in the best interest of the enrollee.

7.9.2.1. At the time of the initial intake assessment the enrollee presents with current and significant risk of harm to self or others.

7.9.2.2. At the time of the initial intake assessment the enrollee presents with a history of significant self-injurious or suicidal behaviors within the past six (6) months from the date of the intake.

7.9.2.3. Any time during the episode of care the enrollee presents with self-injurious or suicidal behaviors, or presents a risk to others.

7.9.3. The Contractor shall utilize the risk assessment tool as a guide to evaluate the level of risk of the enrollee and to determine if the level of risk requires a crisis plan. If it is determined a crisis plan is required, the plan:

7.9.3.1. Shall be written with the enrollee and other natural supports, as available.

7.9.3.2. Can be written in the form of an advance directive.

7.9.3.3. Shall be entered into the MIS within thirty (30) days.

7.9.3.4. Shall include the following elements:

7.9.3.4.1. Date completed;

7.9.3.4.2. Dependent record , to include information on persons and pets;

7.9.3.4.3. Prescriber name;

7.9.3.4.4. Prescriber phone number;

7.9.3.4.5. Current substance abuse/chemical dependency issues;

7.9.3.4.6. High risk and de-compensation patterns; and

7.9.3.4.7. Plan for care providers, emergency personnel and others who might be responding to the actual crisis.

7.9.4. The Contractor shall ensure that the enrollee is provided with a copy of their crisis plan upon completion.

7.9.5. The Contractor shall re-evaluate the enrollee's risk to self or others as determined by the risk assessment score and will complete a new risk assessment at every treatment plan review, per TMRSN's Level of Care Guidelines, until the risk assessment score is at an acceptable level (less than 4). An updated crisis plan shall be developed at six (6) months if necessary.

7.10. Choice of Mental Health Care Provider (MHCP)

7.10.1. The Contractor shall offer each enrollee a choice of an open MHCP accepting new client's within the Contractor's agency. If the enrollee does not make a choice, the Contractor or its designee must assign an MHCP no later than 14 calendar days following the request for mental health services. The enrollee may change MHCPs during the first 90 calendar days of enrollment and once during a twelve-month period for any reason. Any additional change of an MHCP requested by an enrollee during a twelve-month period may be approved at the Contractor's discretion, provided that justification for the change is documented.

7.10.2. For continuity of care, the Contractor shall encourage the subcontractor(s) to assign enrollees to clinicians who are anticipated to provide services to the enrollee throughout the authorization period.

7.11. Second Opinions

7.11.1. The Contractor shall provide, upon request, a second opinion from another Network Provider within the Service Area. If an additional Provider is not currently available within the network, the Contractor must provide or pay for a second opinion provided by a Network Provider outside the network at no cost to the enrollee. The Provider providing the second opinion must hold a contract with a RSN to provide mental health services to Medicaid enrollees. The appointment for a second opinion must occur within 30 calendar days of the request. Only the enrollee may request to postpone the second opinion to a date later than 30 calendar days.

7.12. Enrollees Non-Liability

7.12.1. The Contractor shall ensure enrollees are not held liable for any of the following covered metal health services:

7.12.1.1. Provided by insolvent community psychiatric hospitals with which the Contractor has directly contracted.

7.12.1.2. Including those purchased on behalf of the enrollee.

7.12.1.3. For which the State does not pay the Contractor.

7.12.1.4. Provided to the enrollee, for which the State or TMRSN does not pay the Contractor that furnishes the services under a contractual, referral, or other arrangement.

7.12.1.5. Payments for covered services furnished under a Contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

7.12.1.6. Provided by insolvent federally funded RSNs.

7.13. Thurston Mason RSN Mental Health Ombuds Services

7.13.1. The Contractor shall:

7.13.1.1. Provide information to enrollees regarding the availability of Ombuds' services for assistance in resolving a specific enrollee's concern or grievance.

7.13.1.2. Respond to the Ombuds' requests or inquiries within 24 hours of the initial contact by the Ombuds'.

7.13.1.3. Provide the Ombuds with reasonable access to enrollees, service sites, and records relating to the enrollee, with written consent, for the purpose of outreach and resolving concerns and grievances.

7.13.1.4. Take no measure or action that might threaten, intimidate, or otherwise diminish the ability of the Ombuds to fairly and independently execute her duties, and assure there will be no retaliation against the enrollee/grievant.

7.13.1.5. Respond in writing to recommendations of the Ombuds regarding possible changes in the delivery of services to meet enrollee needs within 30 calendar days of any recommendation from the Ombuds.

7.13.1.6. Comply with WAC 388-865-0250 or any successor.

7.13.1.7. Continue to serve the enrollee while addressing the issue contained in a concern or grievance.

7.13.1.8. Work with the enrollee and Ombuds towards an agreeable resolution in the best interest of the enrollee.

7.13.1.8.1. If the Contractor and the Ombuds do not agree on a suggested resolution, the Contractor and the Ombuds shall contact the TMRSN Grievance Coordinator for assistance.

7.13.1.9. Identify the staff that is responsible for coordinating the agency's information and response regarding the resolution of any concern or grievance.

7.14. Advance Directives

7.14.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects enrollees' Advance Directives for psychiatric care and medical Advance Directives. If State law changes, TMRSN shall send notice to the Contractor who must then ensure the provision of notice to enrollees within 90 days of the change.

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

7.14.3. The Contractor shall inform all Enrollees of their right to a Mental Health Advance Directive, and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.

7.14.4. The Contractor shall inform enrollees that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with HRSA by contacting the Compliance section at (360) 236-2620.

7.14.5. The Contractor shall attend trainings on Advance Directives through DBHR, TMRSN, or Ombuds and disseminate information to enrollees and family members of enrollees.

7.14.6. Inform enrollees in writing about an Advance Directive in anticipation of clinical situations where enrollees are unable to advocate or provide clear information for him or herself.

7.14.7. Assist and/or refer the enrollee to the Ombuds for assistance in developing and implementing Advance Directives for psychiatric care.

7.14.8. Inform the enrollee in writing that he/she has the right to choose whether or not to have an Advance Directive. A record of the enrollees signed statement of their choice shall be maintained in the enrollee's record per 42 CFR 438.10 (g) or any successor.

7.14.9. Advance Directives shall be used as ancillary assistance to any concurrent psychiatric assessment or community based needs assessment for an acute episode, provided that the directive is clinically appropriate to the enrollee's needs and condition at the time.

7.14.10. Make available as part of, or in lieu of the crisis plan, an advanced directive, if the enrollee so chooses.

7.14.11. Assist the enrollee in making their Advance Directive available to those individuals identified in the plan.

7.14.12. Provide access and support to all TMRSN identified individuals including but not limited to the Ombuds, to provide training and support to enrollees interested in developing an Advance Directive, on site, at the Contractor's facility.

8. INFORMATION REQUIREMENTS

8.1. The Contractor must provide information to enrollees that complies with the requirements of 42 CFR §438.100, §438.10, §438.6(i)(3) or any successor.

8.2. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall;

8.2.1. Ensure equal access to mental health services for enrollees with communication barriers or sensory impairments.

8.2.2. Ensure that Mental Health Professionals and MHCPs have an effective mechanism to communicate with Enrollees with sensory impairments.

8.2.3. Provide interpreter services if necessary for enrollees with a primary language other than English for all interactions between the enrollee and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a concern or grievance.

8.2.3.1. The Contractor and affiliated service providers must maintain a log of all enrollee requests for interpreter services, or translated written material.

8.2.3.2. Provide written translations of generally available materials including, at minimum, applications for services, consent forms and *Benefits Booklets*, in each of the DSHS prevalent languages that are spoken by five percent (5%) or more of the population of the State of Washington based on the most recent US census. Currently, Spanish is the language requiring written translations.

8.2.3.3. The other DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. The Mental Health Benefits booklet which includes client rights has been provided to the Contractor by DBHR. The expectation is that this material is readily available to enrollees at all times from the Contractor.

8.2.3.4. These materials may be provided in English if the enrollee's primary language is other than English but the enrollee can understand English and is willing to receive the materials in English. The enrollee's consent to receiving information and materials in English must be documented in the enrollee's chart.

8.2.3.5. For enrollees whose primary language is not identified above and translated, the requirement may be met by providing the information through audio or video recording in the enrollee's primary language, having an interpreter read the materials in the enrollee's primary language or providing materials in an alternative format that is acceptable to the enrollee. If one of these methods is

used it must be documented in the enrollee's chart.

8.2.3.6. The Contractor and affiliated service providers shall post a multilingual notice in each of the DSHS prevalent languages, which advises consumers that information is available in other languages and how to access this information.

8.2.3.7. The Contractor and affiliated service providers shall post a translated copy of the consumer rights as listed in the Mental Health Benefits Booklet in each of the DSHS prevalent languages.

8.3. Upon an enrollee's request, the Contractor shall make available and provide:

8.3.1. Oral interpretation service free of charge to the enrollee;

8.3.2. Information regarding benefits and authorization requirements;

8.3.3. Identification of individual Mental Health Care Providers (MHCP) who are accepting new enrollees;

8.3.4. Community Mental Health Agency (CMHA) licensure, certification and accreditation status; and

8.3.5. Information that includes but is not limited to, education, licensure, and Board certification and/or re-certification of mental health professionals and MHCPs.

8.4. **Medicaid Enrollees ONLY**

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

8.4.2. The Contractor shall inform every Enrollee at the time of an intake evaluation that the Benefits Booklet produced by DBHR and the Benefits Booklet produced by TMRSN are available anytime upon request. Booklets may be downloaded from: http://www.co.thurston.wa.us/health/ssrsn and http://www1.dshs.wa.gov/Mentalhealth/benefits.shtml.

8.4.3. The Contractor shall provide interpreter services for Enrollee's who speak a primary language other than English and shall use a DSHS authorized vendor, which may include CTS Language link; http://hca.ctslanguagelink.com/.

8.4.3.1. The Contractor shall maintain a log of all requests for interpreter services or written translated materials. Logs must be made available to TMRSN upon request.

8.5. Customer Service

8.5.1. The Contractor shall provide Customer Service that is customer friendly, flexible, proactive, and responsive to Consumers, families, and stakeholders. The Contractor shall provide a local calling area telephone number and a toll free number.

8.5.2. At a minimum, Customer Services shall include:

8.5.2.1. Prompt answering of telephone calls with minimum wait time, from Consumers, family members and stakeholders from 8 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.

8.5.2.2. Maintenance of an after hours and holiday telephone answering system that informs callers of hours of operation, scheduled closings, and options for reaching on call staff after hours.

8.5.2.3. Responding to Consumers, family members and stakeholders in a manner that resolves their inquiry. Staff must have the ability to respond to those with limited English proficiency or hearing loss.

8.5.2.4. Staff that are trained to route calls to the appropriate staff or department with minimal redialing.

9. CARE COORDINATION

9.1. Medicaid enrollees, including others with identified health indicators, upon intake, are referred for physical healthcare screening if they have not been screened within the past year. Enrollees over the age of 60 who have not had a physical examination in the past 90 days shall be referred for a health screen. Health screen referrals shall be documented in each enrollee's chart.

9.2. Services shall be based on enrollee strengths, skill level and developmental stage within the context of medical necessity. Services shall emphasize the development and utilization of natural, community-based resources.

9.3. Prioritize and make all appropriate efforts to engage into services individuals who are high risk and resistant to treatment, or homebound due to medical or psychiatric conditions.

9.4. Ensure communication between community psychiatric support treatment (CPST) staff and crisis services to improve continuity of care.

9.5. Coordination with Primary Medical Care Services:

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

9.5.2. The Contractor must ensure that for enrollees who have a suspected or identified physical health care problem the following shall occur:

9.5.2.1. Appropriate referrals are made to a physical health care provider.

9.5.2.2. The individualized service plan identifies medical concerns and plans to address them.

9.6. Allied System Coordination

9.6.1. The Contractor shall make reasonable efforts to coordinate with allied system's to provide continuity of care for enrollees. Allied systems may include:

9.6.1.1. Other TMRSN Network Providers;

9.6.1.2. Aging and Disability Services Administration (ADSA);

9.6.1.3. Chemical Dependency and Substance Abuse services;

9.6.1.4. Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Healthy Options Plans;

9.6.1.5. Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections);

9.6.1.6. Division of Vocational Rehabilitation;

9.6.1.7. Juvenile Rehabilitation Administration; and

9.6.1.8. Any Community Integration Assistance Program (CIAP) within the boundaries of the RSN that is not a Subcontractor of the RSN.

9.7. Housing Support Program

9.7.1. Housing support includes a single, centralized coordinator/lead staff person to facilitate placement coordination with the enrollee, landlord, and RSN to facilitate the development of housing and residential placements in the community to meet enrollee need. This would include the development of subcontracts with adult family homes and other settings to facilitate placement.

9.7.2. The Contractor shall collaborate with TMRSN in identifying resources and plans for development of options and placement of enrollees requiring housing/residential care. The priority is for individuals being discharged from WSH or any inpatient setting and jail.

10. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

10.1. All performance measures, reviews, and audits included under this contract shall meet the minimum standard of 90% to be considered compliant. For any measure that has a varying percentage, TMRSN will identify that measure separately. Measures that fall below 90% are subject to corrective and/or remedial actions per Section 21.

10.2. The Contractor shall maintain an ongoing, planned and systematic organization-wide quality management process to measure, asses, analyze and improve its performance. At minimum, the Contractor shall monitor their internal quality management systems and provide monitoring results/outcomes to TMRSN upon request. Monitoring shall include;

- 10.2.1. Quality Improvement activities including Performance Improvement Projects.
- 10.2.2. Implementation of Practice Guidelines and Evidence Based Practices.
- 10.2.3. Staff productivity which is driven by the most current actuarial performed by DSHS. Productivity levels shall meet or exceed a minimum of 50% towards direct care services.
- 10.2.4. Staff training requirements per Section 12.
- 10.2.5. Data accuracy, integrity, and encounter validation
- 10.2.6. Coordination efforts with primary medical care.

10.3. The Contractor shall monitor their access standards and provide reports upon request to TMRSN. Timeliness of services that meet the Access Standards of this Contract include:

- 10.3.1.1. Routine intake evaluation – 14 days from request for service;
- 10.3.1.2. First routine outpatient service – 28 days from request for service;
- 10.3.1.3. Number and disposition of second opinion requests;
- 10.3.1.4. Number and reason for requests for extensions of authorization requests that are greater than 14 days from the intake date.
- 10.3.1.5. Requests for all services even if no service occurs.

10.4. The Contractor shall conduct internal chart reviews and submit results to TMRSN upon request. Review shall include the quality and timeliness of clinical record requirements, including, but not limited to;

- 10.4.1. Intake Evaluations;
- 10.4.2. Individualized Service Plans/Treatment Plans;
- 10.4.3. Consumers rights;
- 10.4.4. Efforts to create and support mental health services that are driven by and incorporate the voice of the enrollee and those they identify as family;
- 10.4.5. The degree to which mental health services delivered are age, culturally and linguistically competent;
- 10.4.6. Monitoring activities to ensure that services are offered and provided in the most appropriate and least restrictive environment;
- 10.4.7. Efforts to create and support services that promote enrollee recovery and resiliency;
- 10.4.8. Efforts to provide services that are integrated and coordinated with other formal/informal allied service delivery systems;

10.5. The Contractor shall also monitor additional quality activities and provide reports upon request to TMRSN. Activities shall include;

- 10.5.1. Service utilization, with particular attention to outliers (over and under utilization of services).
- 10.5.2. Cumulative responses to enrollee surveys and how they are included into overall quality improvement.

10.5.2.1. Surveys included may be those solicited by the Contractor, DSHS, and TMRSN QRT.

10.5.3. Enrollee concerns and grievances and how they are included into overall quality improvement. Reports on concerns and grievances must be submitted to TMRSN per Section15.

10.6. Quality Review Activities

10.6.1. Thurston Mason RSN will engage in ongoing quality improvement activities throughout the year. This includes conducting clinical, program, and utilization reviews. Ongoing quality improvement reviews are announced and the Contractor is expected to participate by:

10.6.1.1. Ensuring that clinical records are available for review;

10.6.1.2. Ensuring that staff are present for interviews during program reviews;

10.6.1.3. Creating Program Improvement Plans (PIPs) in response to any TMRSN findings as a result of the quality improvement review; and

10.6.1.4. Enacting recommended programmatic and clinical changes once the PIP has become finalized.

10.6.2. Thurston Mason RSN and Thurston County or any of their duly-authorized representatives, may conduct announced and unannounced:

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

10.6.2.2. Contract, chart, and data quality compliance;

10.6.2.3. Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Contract; and

10.6.2.4. Inspections and/or audits of financial records.

10.6.3. The Contractor shall notify TMRSN when an entity other than TMRSN performs any audit or review described above related to any activity contained in this Contract.

10.6.4. The Contractor shall submit to working with TMRSN annually for the EQRO monitoring review and schedule a time for the monitoring review that works for both parties.

10.6.5. The Contractor shall participate with TMRSN and DSHS in completing the annual Mental Health Statistics Improvement Project (MHSIP) surveys. Participation must include at a minimum:

10.6.5.1. Provision of accurate enrollee contact information to TMRSN.

10.6.5.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis.

10.6.5.3. Incorporation of the results into specific quality improvement activities.

10.7. Agency Licensing and Credentialing

10.7.1. The Contractor shall meet licensing requirements for a community mental health agency as defined in WAC 388-877 and 388-877A, as they now exist or are hereinafter amended. The Contractor shall ensure that appropriately licensed and certified staff is employed when required by State and Federal regulations and statutes.

10.7.2. All services to adults, older adults, children, and special populations shall include those requirements as described in State WACs 388-865 and 388-877 and any successor. The Contractor shall submit copies to TMRSN of agency licenses, certifications, and proof of insurance annually when renewed.

10.7.3. The Contractor must participate in an agency credentialing process at least every two years. Type of credentialing application, either a complete or recredential, as well as the date of the application process, shall be determined by TMRSN.

10.7.4. The Contractor shall notify TMRSN immediately if there is any change in licensing status or in the event a license or certification is revoked or not renewed.

11. STAFF CREDENTIALS AND TRAINING

11.1. The Contractor, through delegation, shall verify all staff credentials, education, and competency prior to initiating work with clients.

11.1.1. Ensure Mental Health Professionals and Mental Health Specialists are credentialed in accordance with *TMRSN Policy SD230 Credentialing of Mental Health Professionals and Specialists*.

11.2. The Contractor shall conduct upon hire and at every annual employee review a criminal background check and an excluded provider check through the Office of Inspector General (OIG).

11.2.1. Any staff to be found on the OIG Excluded Provider Lists or to have committed a crime listed on the DSHS Secretary Lists of Crimes and Negative Actions (available at http://dshs.wa.gov/bccu/bccucrimeslist.shtml), must immediately stop providing any services under this contract or any other contract between TMRSN and the Contractor.

11.3. Document that staff, clinical supervisors, and management staff are qualified, as set forth in WAC 388-865-0551, for the positions they hold and have the education, experience, or skills to perform job functions.

11.4. Assign, orient, supervise, monitor and perform regularly scheduled performance review sessions for all staff positions.

11.5. The Contractor shall conduct or make available formal training for all staff pertinent to their position. An individualized annual training plan must be implemented for each direct service staff person and supervisor, to include at a minimum:

11.5.1. The skills he or she needs for his/her job description and the population served;

11.5.2. Least restrictive alternative options available in the community and how to access them;

11.5.3. Managing assaultive/aggressive behavior, including proper use of seclusion and/or restraint procedures;

11.5.4. Safety and violence prevention per RCW 49.19.030;

11.5.5. Confidentiality of records and client information;

11.5.6. Quality assurance and process improvement;

11.5.7. Emergency / Disaster Response;

11.5.8. Consumer's Rights;

11.5.9. TMRSN Grievance System;

11.5.10. Professional Ethics and Fraud and Abuse;

11.5.11. Suicidal risk identification and intervention;

11.5.12. Cultural diversity and sensitivity training;

11.5.13. Strategies for treatment-resistant Consumers and discharge planning;

11.5.14. Utilizing natural supports, building on Consumer strengths, and recovery and resiliency;

11.5.15. Basic Life Support (CPR and first aid);

11.5.16. Infection control, including HIV / AIDS;

11.5.17. Customer Service with Behaviorally Challenged Consumers; and

11.5.18. Psychotropic medications (if applicable).

11.6. The Contractor shall maintain a central record of all trainings provided and who attended, as well as document in staff personnel files completion of trainings, and other educational pursuits, and whether staff attended in person or training was obtained through electronic media.

11.7. Ensure all trainings are provided as required by federal or state laws, rules and regulations, and in accordance with professional standards of practice and the terms of this Contract, including provisions for annual training and staff development under individualized staff training plans.

12. INCIDENT REPORTING

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

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

12.1.2. The Contractor must report and follow-up on all incidents involving Enrollees, listed below.

12.1.3. The Contractor must report incidents to TMRSN by phone, fax, or an approved electronic incident reporting system. The report must contain:

12.1.3.1. A description of the incident;

12.1.3.2. The date and time of the incident;

12.1.3.3. Incident location;

12.1.3.4. Incident type;

12.1.3.5. Names and ages, if known, of all individuals involved in the incident;

12.1.3.6. The nature of each individual's involvement in the incident;

12.1.3.7. The service history with the Contractor, if any, of individuals involved;

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

12.1.3.9. Any legally required notifications made by the Contractor.

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

12.1.4.1. Category One Incidents: the Contractor must report and also notify the TMRSN Incident Manager by telephone or email immediately upon becoming aware of the occurrence of any of the following Category One incidents involving any individual that was served within 365 days of the incident.

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

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

12.1.4.1.3. Any violent act to include rape or sexual assault, as defined in RCW 71.05.020 and RCW 9.94A.030, or any homicide or attempted homicide committed by a client.

12.1.4.1.4. Any event involving an individual or staff that has attracted media attention.

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

12.1.4.2.1. Alleged client abuse or client neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another client.

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

12.1.4.2.3. Any breach or loss of client data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of client personal information. In addition to the standard elements of an incident report, the Contractor shall document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.

12.1.4.2.4. Any allegation of financial exploitation as defined in RCW 74.34.020.

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

12.1.4.2.6. Any event involving a client or staff, likely to attract media attention in the professional judgment of the Incident Manager.

12.1.4.2.7. Any event involving: a credible threat towards a staff member that occurs at a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. A credible threat towards staff is defined as "A communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan.

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

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

12.2. Comprehensive Review: TMRSN or DSHS may require the Contractor to initiate a comprehensive review of an incident.

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

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

12.2.3. DSHS may request medication management information.

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

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

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

12.3.2. Whether the person is in custody (jail), in the hospital, or in the community, and if in the community whether the person is receiving services. If the client cannot be located, the

Contractor will document in the Incident reporting system the steps that the Contractor took to attempt to locate the client by using available local resources;

12.3.3. Documentation of whether the client is receiving or not receiving mental health services from the Contractor at the time the incident is being closed.

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

12.3.5. In the case of a telephonic verification, the Contractor will document the date of the contact and both the name and official duty title of the person verifying the information.

12.3.6. If this information is unavailable, the attempt to retrieve it will be documented.

13. MANAGEMENT INFORMATION SYSTEM

13.1. Data Submission and Error Correction

13.1.1. The Contractor shall provide TMRSN with all data and encounters described in the *TMRSN Data Dictionary* that includes the Reporting Guidelines for programs and services, the *TMRSN HIPAA* and *Native Transaction Companion Guides*, and the *TMRSN File and Data Submission Guide*, or, any successors, incorporated herein by reference.

13.1.2. The Contractor shall have in place policies, procedures and/or instructions that address all requirements under Section 14 of the contract.

13.1.3. The Contractor shall electronically submit to or enter encounters directly into the TMRSN Managed Care Organization (MCO) Management Information System (MIS) within 45 calendar days from the date of service.

13.1.3.1. Accurate encounters accepted by TMRSN will be included for payment according to Exhibit B, the Compensation section of this contract, including any amendments to Exhibit B. The cut-off dates for service submission and payment is the Friday before "Date Invoice for Review by Thurston County & Providers" as listed in Exhibit B.

13.1.3.2. No submitted encounter shall be accepted for initial entry/submission or data correction after one year from the date of service, unless by special exception.

13.1.4. The Contractor shall submit or enter all other required staff data, client data, and electronic documentation within ten (10) calendar days from the date of collection or receipt, as this data is required for encounter submissions/entries to be processed and accepted.

13.1.4.1. Periodic Review data shall be submitted or entered upon admission, at change, and at discharge for enrolled clients. At a minimum, the primary case manager of record shall review the entire periodic review record for accuracy and submit changes for entry into the Contractor MIS at least every six (6) months.

13.1.4.2. If a crisis plan is necessary, the Contractor must submit an electronic file of the client's crisis plan to the RSN MCO MIS within 30 days of admit or when it is determined a crisis plan is needed, per Section 7.9.

13.1.5. Upon receipt of Contractor data and encounters, TMRSN will generate error reports. The Contractor shall have in place documented procedures to ensure that data submitted/entered and pended/denied due to provider errors or incompleteness are corrected and resubmitted within 30 calendar days of initial submission to TMRSN.

13.1.5.1. Pended or denied encounters that are not corrected, resubmitted, and accepted within the 45-day requirement for encounter submission timeliness will not be considered timely.

13.1.5.2. In addition, the Contractor shall have in place documented procedures to ensure that Contractor data submitted by TMRSN that is rejected by DBHR and/or ProviderOne due to Contractor errors is corrected and resubmitted

within ten (10) calendar days of notification by TMRSN.

13.1.6. The Contractor shall incur all costs including, but not limited to, hardware, equipment maintenance, software, and connection costs necessary to transmit data and transactions to the TMRSN MCO MIS and/or access the TMRSN MIS/MCO MIS, the DBHR Enrollee Information System (DBHR-CIS), and the HRSA ProviderOne system.

13.1.7. The Contractor shall participate in regularly scheduled TMRSN MIS System Operator (SysOp) Committee meetings. TMRSN and the Contractor's designated SysOp member(s) shall work together to respond to inquiries or to assist in TMRSN decisions regarding data requirements and compliance. Meetings may include changes to data collection and information systems to meet the terms of this and other contracts, implementation of data collection requirements, monitoring of MIS access and security, error correction, incomplete or invalid data issues, and data timeliness.

13.1.8. The Contractor shall implement data-related changes and requirements as directed by and in coordination with TMRSN Contracts and/or Protocols.

13.1.8.1. Changes shall be implemented within 90 days from the date of published changes or as otherwise specified by TMRSN and/or by DBHR. These changes may be the result of an update to DBHR requirements in the DBHR Service Encounter Reporting Instructions for RSNs (SERI), the DBHR-CIS Data, and/or the ProviderOne Encounter Data Reporting Guide for MCOs and RSNs, or any of their successors, incorporated herein by reference.

13.1.8.2. The Contractor shall send at least one test batch of data containing the required changes no later than 15 days prior to the implementation date.

13.1.8.2.1. The test batch must include a sample of all Programs / Project codes, Service Activity Codes, and/or other data elements affected by the change in requirement.

13.1.8.2.2. The processed test batch must result in at least 90% successfully posted transactions or an additional test batch is required.

13.1.9. For data/information not covered by the TMRSN or DBHR-CIS Data Dictionaries or the DBHR Service Encounter Reporting Instructions, the Contractor shall ensure that TMRSN receives requested information in a manner that shall allow for a timely response to requests or inquiries from TMRSN, Centers for Medicaid Services (CMS), the State Legislature, DBHR/DSHS, and other parties.

13.2. Contractor and Subcontractor Data Quality Verification

13.2.1. The Contractor shall have in place mechanisms to verify the health information collected and submitted by the Contractor to TMRSN, as well as all data received from any Subcontractors. Mechanisms shall include the following:

13.2.1.1. Verifying the accuracy of Contractor and Subcontractor data by a review of DBHR, TMRSN, or Contractor error reports, error resolution reports and/or timeliness reports;

13.2.1.2. Screening and performing data quality monitoring on all data for accuracy, completeness, logic, consistency, and timeliness of submission. This includes, but is not limited to ensuring appropriate services are provided by allowable staff, that only allowable services are provided within programs, and that all data requirements and guidelines have been adhered to according to the TMRSN and DBHR-CIS Data Dictionaries and the DBHR Service Encounter Reporting Instructions (SERI) for RSNs.

13.2.1.3. Verifying that duplicative or overlapping services are not submitted to TMRSN.

13.2.1.4. In addition, the following is information that is required, at a minimum, for reporting an encounter to a consumer, documenting that encounter in a progress note, and submitting that encounter to TMRSN and DBHR:

13.2.1.4.1. Be of sufficient duration to accomplish the therapeutic intent;

13.2.1.4.2. The record must be legible to someone other than the writer;

13.2.1.4.3. Each printed page (front and back if two-sided) of the record must contain the consumer's name and agency record number;

13.2.1.4.4. Clinical entries must include the Author identification, which may be a handwritten signature or unique electronic identifier, but must be clearly identifiable as to whom the rendering clinician/staff is;

13.2.1.4.5. Date of the service;

13.2.1.4.6. Time of the service;

- For providers that are unable to submit time of day for the service in their 837P electronic transaction, this information must be provided within 7 days of the initial service submission date to the RSN in a format that can be imported into the MCO MIS.

13.2.1.4.7. Location of the service;

13.2.1.4.8. Provider credentials, which must be appropriate to the service (e.g., medication management can only be done by a prescriber);

13.2.1.4.9. Length of time/service duration;

13.2.1.4.10. Narrative description of the service provided as evidenced by sufficient documentation that can be translated to a service description title or code number (this may be standard CPT/HCPCS or local nomenclature with a RSN approved crosswalk) and describes therapeutic content;

13.2.1.4.11. The service addresses an issue on the care plan or issue addressed is added to the care plan; and

13.2.1.4.12. The service is specific to the consumer; e.g., group therapy progress note is specific to the consumer.

13.2.2. The Contractor shall submit to an administrative and/or on-site MIS audit and Encounter Data Validation chart audits by TMRSN during this contract period. The audits shall be IS- and/or IT-related and shall include, but not be limited to, the review of data, encounters and data/encounter documentation, internal IS and IT policies and procedures, MIS data accuracy, timeliness, completeness, and consistency practices, and MIS training practices.

13.3. Data Certification

13.3.1. The Contractor shall provide certification of data and encounters required by this Contract and submitted to TMRSN. The data and encounters shall be certified by one of the following:

13.3.1.1. The Contractor's Chief Executive Officer (CEO),

13.3.1.2. The Contractor's Chief Financial Officer (CFO),

13.3.1.3. An individual who has delegated authority to sign for and who reports directly to the CEO or CFO.

13.3.2. The certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and encounters submitted to TMRSN

according to the following:

13.3.2.1. For Contractors using TMRSN's Direct Data Entry (DDE) process to submit data/encounters, a certification must be provided to TMRSN for each month of the contract period for all data and encounters submitted within the given month.

13.3.2.2. For Contractors submitting electronic transactions/files, a certification must be provided to TMRSN for each month of the contract period for the batches/files submitted within the given month.

13.3.2.3. Data and encounters that contain errors shall not be considered certified until corrections for all errors are successfully received and processed by TMRSN.

13.3.3. The Contractor shall use only the TMRSN-supplied certification form as provided in TMRSN Policy IS801: Provider Data Certification.

13.3.3.1. The Contractor shall submit a signed certification form in either electronic format or by mail within 60 calendar days from the end of each month in the contract period. The Contractor shall ensure that each certification contains an original signature of the signing authority.

13.4. Information System Security and Protection of Confidential Information

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

13.4.2. The Contractor shall ensure that confidential information provided through or obtained by way of this Contract or services provided is protected in accordance with the Data Security Requirements contained in Exhibit D.

13.4.3. The Contractor shall maintain a statement on file for each employee and all Subcontractor employees that have access to the Contractor's electronic health record database or the RSN MIS/MCO database (such as RSN Look) that is signed by the individual and attested to by a witness's signature acknowledging that the individual understands and agrees to follow all regulations on confidentiality.

13.4.3.1. Contractor staff requiring access to the TMRSN database must be granted access based on "need-to-know" or role-based security standards in accordance with HIPAA Security Rule guidelines, TMRSN policies and procedures, the Business Associate Agreement Addendum, and TMRSN MIS Instructions.

13.4.3.2. The Contractor shall provide the appropriate confidentiality and security training to personnel that have access to client confidential data (Protected Health Information or PHI).

13.4.4. The Contractor shall take appropriate action if a Contractor or Subcontractor employee wrongly or willfully releases confidential information according to HIPAA requirements and applicable TMRSN Policy and Procedures.

13.5. Business Continuity and Disaster Recovery

13.5.1. The Contractor shall demonstrate a primary and backup system for electronic submission of data required or requested by TMRSN and DBHR. This must include the use of the Inter-Governmental Network (IGN), Information Systems Services Division (ISSD), Thurston County approved secured Virtual Private Network (VPN), or other approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission shall be considered based on TMRSN and/or DBHR approval.

13.5.2. The Contractor shall create and maintain a business continuity and disaster recovery plan

that ensures timely reinstitution of their connectivity and access to the MIS following a total loss of primary connection or a substantial loss of functionality. The plan must be in written format, have an identified update process (at least annually), and a copy must be stored off site.

13.5.3. The Contractor must require a business continuity and disaster recovery plan for all Subcontractors that are required to submit data and/or encounters either electronically or by other means such as a Service Activity Log (SAL), an MIS Demographic or Short Form, or a copy of a Subcontractor's invoice if TMRSN-required data is entered and submitted to TMRSN from these documents.

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

13.5.4.1. A mission or scope statement;

13.5.4.2. An appointed Information Services Disaster Recovery Team;

13.5.4.3. Provisions for Backup of Key personnel; Identified Emergency Procedures; Visibly listed emergency telephone numbers

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

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

13.5.4.6. Off-site storage of system and data backups; Ability to recover data and systems from back-up files;

13.5.4.7. Designated recovery options, which may include use of a hot or cold site; and

13.5.4.8. Evidence that disaster recovery tests (data recovery from a back-up file) or drills have been performed.

14. GRIEVANCE SYSTEM

14.1. The Contractor is required to have a Grievance system that complies with the requirements of TMRSN Policy QM603: Grievances and TMRSN AP1101: Grievance Plan, as well as the requirements of this Contract.

14.2. The Contractor must provide information about the Grievance System to all Enrollee's.

14.3. The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract.

14.4. The Contractor shall provide enrollees with any assistance necessary to complete forms and other procedural steps for Grievances. Assistance may be provided by the Ombuds serving the Contractors geographic area, the Enrollee's provider, the Contractor, or any other person of the enrollee's choice.

14.5. An Enrollee or their authorized representative may file a Grievance either orally or in writing with the Contractor or its providers.

14.6. Recordkeeping and Reporting Requirements:

14.6.1. If an Enrollee expresses a concern that can be categorized into one of the topics below, it shall be considered a grievance and shall be reported to TMRSN. The Contractor shall report all Grievances to the TMRSN Quality Manager on the Provider Grievance Notification Form attached herein. Topics include:

14.6.1.1. Access to Outpatient

14.6.1.2. Dignity and Respect
14.6.1.3. Quality/Appropriateness
14.6.1.4. Phone Call Not Returned
14.6.1.5. Service: Intensity, Not Available, Coordination
14.6.1.6. Consumer Rights
14.6.1.7. Physicians and Medications
14.6.1.8. Financial and Admin Services
14.6.1.9. Transportation
14.6.1.10. Emergency Services
14.6.1.11. Violation of Confidentiality
14.6.1.12. Access to Inpatient Services

14.6.2. The Contractor shall complete the report form located on the TMRSN website at https://ftp.co.thurston.wa.us/tmrsn-report/index.aspx for each concern or grievance received by the Contractor.

14.6.3. The Quality Manager will review the concern/grievance and determine the appropriate action, which may include follow-up by the Ombuds, TMRSN, or the Contractor.

14.6.4. The Contractor's grievance system must maintain records of all concerns and Grievances originating at the Contractor.

14.6.5. The Contractor shall incorporate the results of concerns and grievances, appeals and fair hearings into its quality management plan and address any trends in a quality improvement plan.

14.7. **Fair Hearings – This function is only available to Medicaid Funded enrollees**

14.7.1. Enrollees may request a Fair Hearing conducted by independent state agency in accordance with WAC 388-02 and provisions of mental health services per WAC 388-865 and 388-877.

14.7.2. The parties to a Fair Hearing include TMRSN, the Contractor as well as the enrollee and his or her representative or the legal representative of a deceased enrollee's estate.

14.7.3. A Fair Hearing may be requested from the State of Washing Office of Administrative Hearings when:

14.7.3.1. An enrollee believes there has been a violation of DSHS rule.

14.7.3.2. The Contractor does not provide a written response to a grievance within the required timeframes.

14.7.3.3. An enrollee receives an adverse ruling by the Contractor or its agent to a grievance.

14.7.3.4. If the enrollee elects to request a Fair hearing, the request must be filed within 20 calendar days from the date of notice of adverse ruling.

14.7.3.5. TMRSN and/or DBHR will notify the Contractor of hearing determinations. The Contractor will be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision.

15. CRISIS SERVICES

15.1. Crisis Mental Health Services: The Contractor must provide 24-hour, 7 day a week crisis mental health services to individuals, including tribal members, who are within the Contractor's Service Area and report they are experiencing a mental health crisis. There must be sufficient staff available to respond to requests for crisis services. Crisis services must be provided regardless of the individual's ability to pay. Crisis mental health services may include each of the following:

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

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

15.1.3. Involuntary Treatment Act Services: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 RCW 71.24. 300 and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional (DMHP) determines an individual must be evaluated for involuntary treatment. The decision making authority of the DMHP must be independent of the RSN administration. ITA services continue until the end of the involuntary commitment.

15.1.4. Freestanding Evaluation and Treatment Services provided in freestanding inpatient residential (non-hospital) facilities licensed by the Department of Health and certified by DBHR to provide Medically Necessary evaluation and treatment to the individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

15.2. If an Enrollee is a Tribal Member and is referred to or presents for non-crisis services and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the Enrollee.

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

15.3.1. Emergent Care within 2-hours of the request received from any source for crisis mental health services.

15.3.2. Urgent care within 24-hours of the request received from any source for crisis mental health services.

15.3.3. Enrollees/Consumers may access Crisis and Stabilization Services prior to an intake evaluation and without prior authorization. These services may be provided without an intake evaluation or screening process.

15.3.4. The Contractor has the primary responsibility to ensure availability and provision for crisis services for enrollees/Consumers identified under this Contract that is available 24 hours per day, seven days a week.

15.3.5. The Contractor shall maintain primary responsibility for intervening with a enrollees/Consumers **prior to** referring to the ER or Evaluation & Treatment Facility, whenever possible.

15.3.6. The Contractor shall work with the enrollees/Consumers to resolve a crisis at the lowest level possible. In the event further crisis services are required the Contractor shall coordinate crisis services with the Thurston County Evaluation and Treatment Facility per an established protocol. The protocol shall include identification of linkage and transition services, participation in discharge planning and facilitation of any community residential or placement issue.

15.3.7. The Contractor shall utilize its resources to the full extent possible prior to referring a enrollee/Consumer to the local hospital Emergency Room (ER) and/or other community inpatient setting. The Contractor shall retain responsibility for coordinating and facilitating community placement and discharge planning for any Western State Hospital, ER or Community psychiatric inpatient. See Section 17 of this Contract for additional information.

15.3.8. Crisis response for enrollees/Consumers shall include the availability of face-to-face after hour's services, in-home crisis stabilization and crisis respite which shall be available 24 hours per day, 7 days a week under this contract.

15.3.9. The Contractor must have policies and procedures for crisis services that implement the following requirements:

15.3.9.1. No crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis unless a second trained individual accompanies them.

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

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

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

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

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

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

16. PSYCHIATRIC INPATIENT SERVICES

16.1. State Hospitals

16.1.1. The Contractor shall reimburse TMRSN 50% of the total monthly reimbursement amount for Western State Hospital days of care that exceed the daily allocation of State Hospital beds. TMRSN's daily allocation of **State Hospital beds is 30**.

16.1.2. Ensure Consumers are medically cleared, if possible, prior to admission to a State Psychiatric Hospital.

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

16.1.4. The Contractor shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320.

16.1.5. The Contractor shall offer mental health services to assist with compliance with LRA requirements.

16.1.6. The Contractor shall respond to requests for participation, implementation, and monitoring of individuals receiving services on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide mental health services to assist with compliance with CR requirements.

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

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

16.1.9. The Contractor shall ensure provision of mental health services to individuals on a Conditional Release under RCW 10.77.150.

16.1.10. The Contractor shall:

16.1.10.1. Provide support to Adult Family Homes, families and other home like settings to minimize involuntary and long term inpatient admissions, and to support transition back into the community.

16.1.10.2. Provide coordination of care with the TMRSN WSH Liaison by providing information on enrollee's treatment history, by participating in discharge planning and placements as requested by the Liaison, and by providing timely outpatient services upon discharge.

16.2. Community Hospital Inpatient Services

16.2.1. The Contractor shall provide the following services when an enrollee is admitted to a community psychiatric hospital or Evaluation and Treatment inpatient facility:

16.2.1.1. Continue to provide community support services to enrollees and their families as appropriate.

16.2.1.2. Contact the inpatient unit within three (3) calendar days of admission.

16.2.1.3. Provide any available information regarding the enrollee's treatment history to the inpatient unit at the time of admission, including all available information related to payment resources and coverage.

16.2.1.4. Participate in treatment and discharge planning with the inpatient treatment team, and provide timely face to face follow up within at least seven (7) calendar days of discharge.

16.2.2. For Enrolled individuals that meet Medical Necessity and Access to Care Standards the Contractor shall:

16.2.2.1. Offer covered mental health services to meet compliance with LRA requirements for enrollees on Less Restrictive Alternatives (LRA)

16.2.2.2. Respond to requests for participation, implementation, and monitoring of enrollees on Conditional Releases (CR) consistent with RCW 71.05.340.

16.2.2.3. Ensure provision of covered mental health services to enrollees on a Conditional Release under RCW 10.77.150

16.2.3. Continuity of Care

16.2.3.1. The Contractor shall:

16.2.3.1.1. Provide care management functions and strategies to utilize community resources and covered mental health services to minimize inpatient admissions.

16.2.3.1.2. Provide the necessary linkages between community inpatient facilities and outpatient services through a designated hospital liaison function.

16.2.3.1.3. Provide a continuum of care that supports and maintains the stability gained by the provision of services at a higher level of care and that maintains tenure in the community.

16.2.3.1.4. Offer timely services and follow up for enrollees treated in and transitioning from inpatient settings and/or Emergency Departments.

16.2.3.2. Upon request by TMRSN, be available for case reviews as necessary to care manage high utilizers of more restrictive and higher cost services.

17. STATE FUNDED OUTPATIENT SERVICES

17.1. Within the resources provided under this Section, the Contractor shall provide access to or provide the service benefits directly for, State Funded Services to Non-Medicaid individuals or to Medicaid individuals when the service is not covered by Medicaid. The primary target services for this State Funded Services are Crisis, limited Outpatient Mental Health Services for non-Medicaid individuals, Residential, Rehabilitation Case Management Services, and Medicaid Personal Care (MPC) as non covered services to Medicaid enrollees. The following range of benefits for State Funded Services are:

17.1.1. Crisis Mental Health Services for all enrolled individuals within the contracted services area. See Section 16 for a service description.

17.1.1.1. The Contractor shall provide access to the full range of Crisis Mental Health Services to the non-enrolled.

17.1.2. Rehabilitation Case Management Services in State Hospitals as described in Section 17 of this Contract.

17.1.3. Medicaid Personal Care as described in Section 19.3 for individuals who reside within the contracted service area and are Medicaid-Individuals.

17.2. Residential Services in an inpatient facility in coordination of this section for Medicaid enrolled individuals who reside within the contracted service area and who are members of priority populations (RCW 71.24) are provided services within available resources. The Contractor shall provide the following services as described in Crisis Mental Health, Inpatient, Ancillary Costs and Residential Programs Sections and prioritize such services above any other services unless otherwise specified in this Contract.

18. ITA FUNCTIONS AND SUPERIOR COURT

18.1. Superior court judicial proceedings shall occur at Providence St. Peter Hospital.

18.2. With regard to ITA court functions Contractor shall:

- 18.2.1. Provide coordination of involved parties;
- 18.2.2. Notify parties of hearing dates, times, and locations;
- 18.2.3. Adhere to timelines as determined by Washington State Law;
- 18.2.4. When applicable, arrange client transportation to Western State Hospital;
- 18.2.5. Recommend conditions for least restrictive alternatives (LRAs) in conjunction with case manager of record or DMHP;
- 18.2.6. Ensure that the appropriate clinical staff are available for testimony when required;
- 18.2.7. Provide all necessary paperwork including but not limited to chapters 71.05 and 71.34 RCW.

18.3. With regard to ITA Court Hearings the Contractor shall:

- 18.3.1. Ensure court testimony by professional staff at probable cause hearings or trials;
- 18.3.2. Provide reports of client history, circumstances of admission and course of treatment;
- 18.3.3. Accompany and provide care of clients during court proceedings within and away from the hospital;
- 18.3.4. Monitor court process;
- 18.3.5. Assess court milieu for safety and intervene when there are disruptions;
- 18.3.6. Provide support to the County Prosecutor's office, Assigned Counsel office and State Attorney General's office in the form of consultation, live and telephonic testimony, records and reports, where required, at ITA proceedings for specific individuals;
- 18.3.7. Provide or arrange for expert witness testimony by a licensed physician, psychiatrist or licensed psychologist.

18.4. With regard to education the Contractor shall:

- 18.4.1. Assess learning needs of patient and family and provide information regarding ITA status and process.

18.5. With regard to documentation the Contractor shall:

- 18.5.1. Provide legal documents pertaining to the involuntary detention of persons at the hospital as required by the Thurston County Superior Court;
- 18.5.2. Ensure completion and filing of all ITA related court orders or accompanied documents including but not limited to Least Restrictive Orders and involuntary detention orders;
- 18.5.3. When necessary for judicial proceedings, Contractor shall promptly supply a certified copy of all medical and psychological records and make available, if necessary, a records custodian capable of testifying;
- 18.5.4. The Contractor shall ensure entry and submission of ITA investigations, detentions, revocations and hearing events and data as set forth in Section 13 of Exhibit A.

19. COMMUNITY COORDINATION

19.1. Disaster Response

- 19.1.1. The Contractor must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by TMRSN and/or DBHR. The Contractor shall:

19.1.1.1. Attend TMRSN and DBHR-sponsored training regarding the role of the public mental health system in disaster preparedness and response.

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

19.1.1.3. Provide Disaster Outreach in Contractor's Service Area in the event of a disaster/emergency; "Disaster Outreach" means contacting person's in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.

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

19.1.1.4.1. Locating persons in need of disaster relief services.

19.1.1.4.2. Assessing their needs.

19.1.1.4.3. Engaging or linking persons to an appropriate level of support or disaster relief services.

19.1.1.4.4. Providing follow-up mental health services when clinically indicated.

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

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

19.1.1.7. Provide the name and contact information to TMRSN for person(s) coordinating the Contractor's disaster/emergency preparedness and response upon request.

19.1.1.8. Provide information and preliminary disaster response plans to TMRSN within seven days following a disaster/emergency or upon request.

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

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

19.1.1.9.2. Coordination of disaster outreach activities following an event.

19.2. For individuals enrolled with DDD, formerly hospitalized at WSH or ESH, currently living in the community, who are in the contracted service area the Contractor shall:

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

19.2.2. Work directly with TMRSN and Regional Division of Developmental Disabilities (DDD) representatives in coordinating and conducting these reviews. The Contractor representative, TMRSN staff, and the Regional DDD Quality Assurance Manager shall be "lead staff" for Regional Review Teams (RRTs). In addition to coordinating for, and participating in these

reviews the "lead staff' will be responsible for preparing and submitting final reports from the reviews to the DBHR Program Administrator.

19.2.2.1. Develop a corrective action plan to address deficiencies based on the results of a review. The Contractor shall respond to any identified deficiency and develop and implement a corrective action plan. The corrective action timelines are specific to this section of this Contract are:

19.2.2.1.1. No more than 20 days following the date of the review, TMRSN shall provide the Contractor a copy of the review and the corrective action required.

19.2.2.1.2. No more than 20 days following the receipt of the review the Contractor must provide the corrective action plan to TMRSN.

19.3. Medicaid Personal Care (MPC)

19.3.1. Contractor may request that a Comprehensive Assessment Reporting Evaluation (CARE) assessment be performed by Home and Community Services, if personal care services would enable a Medicaid enrollee to remain in the most appropriate and least restrictive community setting.

19.3.2. MPC services may be requested for Medicaid enrollees who require personal care services on the basis of a psychiatric disability. TMRSN will authorize these MPC services funded with State Mental Health dollars.

19.3.2.1. TMRSN shall review all MPC requests to determine if the individual is currently entitled to Medicaid and is enrolled and authorized to receive community mental health services.

19.3.2.2. TMRSN shall review the MPC request and determine if the individual's needs are based solely on a psychiatric disability, and if their needs could be met through provision of RSN funded mental health services.

19.3.2.3. If TMRSN determines that the individual's needs can be met by network provider services, TMRSN shall forward the CARE Assessment to the provider to develop and implement a plan of care that incorporates the needs identified in the CARE Assessment.

19.3.2.4. The Contractor must provide upon request by TMRSN, a copy of the plan developed and implemented to meet the individual's needs.

19.3.3. The Contractor must respond to requests for mental health services and residential placement recommendations identified in the CARE Assessment performed by Home and Community Services (H&CS) on Medicaid enrolled individuals.

20. TRIBAL RELATIONSHIPS

20.1. The Contractor shall attempt to build relationships as well as support the efforts of TMRSN to develop Coordination Implementation Plans with each Tribe and any Recognized American Indian Organization (RAIO) identified in the Thurston Mason service area.

20.1.1. Supporting efforts may consist of taking part in plan development, having a role in the process and outcome of the plan, and/or providing training about the mental health system and how to access outpatient services provided by the Contractor to Tribes and RAIO's.

20.1.2. The Tribes or RAIOs listed below have service areas within the contracted Service Area of the RSN which are defined in the following documents:

20.1.2.1. The Indian Health Services map that represents Contract Health Service Delivery areas as published in the Federal Register;

20.1.2.2. The Bureau of Indian Affairs Service Area map; and

20.1.2.3. The DSHS 7.01 Policy, which identifies the Recognized American Indian Organizations (RAIOs).

Chehalis, Cowlitz, Nisqually, Puyallup, Skokomish, Squaxin Island, Suquamish.

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

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

21. REMEDIAL ACTIONS

21.1. TMRSN may initiate remedial action if it is determined that any of the following situations exist:

21.1.1. The Contractor has failed to perform any of the mental health services required in this Contract.

21.1.2. The Contractor has failed to develop, produce, and/or deliver to TMRSN any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Contract.

21.1.3. The Contractor has failed to perform any administrative function required under this Contract. For the purposes of this section, “administrative function” is defined as any obligation other than the actual provision of mental health services.

21.1.4. The Contractor has failed to implement corrective action required by TMRSN and within prescribed timeframes.

21.2. TMRSN may impose any one or more of the following remedial actions in any order:

21.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to TMRSN within 30 calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Contract. TMRSN may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

21.2.1.1. Corrective action plans must include:

21.2.1.1.1. A brief description of the situation requiring corrective action.

21.2.1.1.2. The specific actions to be taken to remedy the situation.

21.2.1.1.3. A timetable for completion of the actions.

21.2.1.1.4. Identification of individuals responsible for implementation of the plan.

21.2.1.2. Corrective action plans are subject to approval by TMRSN, which may:

21.2.1.2.1. Accept the plan as submitted.

21.2.1.2.2. Accept the plan with specified modifications.

21.2.1.2.3. Request a modified plan.

21.2.1.2.4. Reject the plan.

21.2.1.3. Any corrective action plan that was in place as part of a previous Contract shall be applied to this Contract in those areas where the Contract requirements are substantially similar.

21.2.2. Withhold up to five percent of the next monthly payment and each monthly payment thereafter until the situation has been resolved. TMRSN, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

21.2.2.1. Increase withholdings identified above by up to an additional three percent for each successive month during which the remedial situation has not been resolved.

21.2.3. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Contract or any other arrangement by which TMRSN provides incentives.

21.2.4. Terminate for Default as described in the General Terms and Conditions; this may include releasing a Request for Proposals to re-procure the services provided under this Contract.

21.2.4.1. If the Contract is terminated for default the Contractor may not respond to the released Request for Proposal as described above unless authorized by TMRSN.

22. CONTRACT DELIVERABLES

22.1. The Contractor is responsible for submitting all deliverables described in this section and throughout the Contract in a timely manner. Deliverables shall be submitted in the format that is identified or provided by TMRSN and shall be submitted through one of the following mechanisms; the SFTP site, email, fax, or hard copy mail. All deliverables shall be submitted to Kristy Lysell. If a deliverable is submitted through the SFTP site, a notification shall be emailed to lysellk@co.thurston.wa.us indicating a deliverable is available.

22.2. If this Contract requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Contract between the parties the Contractor may provide one (1) report or deliverable that contains the information required by both Contracts.

22.3. Excluded Providers

22.3.1. The Contractor shall submit an Employee Roster for the purpose of monitoring excluded providers, which must include employees' first name, last name, and date of birth. The Report shall be submitted electronically, in an Excel spreadsheet, by no later than the 10th of each month

22.3.2. The Roster shall include any individuals/entities with a direct or indirect ownership or control interest of 5% or more, including, but not limited to;

22.3.2.1. Providers that furnish mental health services, to include supervisory employees even if they don't provide direct service;

22.3.2.2. Individuals directly or indirectly conducting day-to-day operations;

22.3.2.3. Employees who exercise operational or managerial control (e.g. CEO, general manager, business manager, accountant, claims processor, utilization reviewer, administrator or director);

22.3.2.4. Any other employee, consultant or subcontractor that provides items or services significant or material to entity's obligations under the contract with TMRSN;

22.3.2.5. Board members, Interns, and Volunteers.

22.3.3. TMRSN may require the Contractor to submit additional employee information if there is a possible name match between the Employee Roster and the OIG Excluded Provider database. Additional information may include; middle names, address, and type of license and/or specialty.

22.4. Staff Training

22.4.1. The Contractor shall submit on a quarterly basis, a roster of all employees who attended the training identified in Section 12.5.4 of this Contract.

22.5. Staff Roster

22.5.1. The Contractor shall submit the staffing report, provided by TMRSN as an Excel document, per 22.1 on a quarterly basis. All columns of the report must completed or an N/A must be entered.

22.6. Deliverable Table

Deliverable	Submitted	Report Period Example	Report Due Date	Format
Excluded Provider	Monthly	Active employees as of the 1st of each month	By the 10th of each month	Excel File
Staff Training	Quarterly	Employees completed training between Jan 1 – Mar 31	May 10th	Provider List
Staffing Report	Quarterly	Active employees	April 10, 2015 July 10, 2015 Oct 10, 2015 January 10, 2016	TMRSN Provided Excel File

ATTACHMENT 1

Intensive Outpatient Program
STATEMENT OF WORK

Services provided under this Contract Attachment will be delivered in accordance with all laws, regulations, and service delivery requirements as described above in Exhibit A: Statement of Work.

1. PROGRAM DESCRIPTION

1.1. The Intensive Outpatient Program is a day program for Medicaid eligible adults, ages 18 and older challenged by mental health symptoms. The program offers an intensive stabilizing and supportive environment to reduce symptoms and return clients to optimal functioning. This service is designed to be interactive and supportive of client independence and recovery, as the individual is empowered to guide the treatment team and attain specific goals. Services offered may include:

- 1.1.1. Pre-screening for eligibility and appropriateness for treatment;
- 1.1.2. Individualized assessment and goal-oriented treatment planning;
- 1.1.3. Group therapy and psychoeducation: examples are problem solving focus, coping skills, social skills, education about symptoms and course of treatment;
- 1.1.4. After-care group for support and transition upon completion of the Intensive Outpatient Program;
- 1.1.5. Medication prescription and management when necessary to accomplish program goals;
- 1.1.6. Linkage to additional resources in the community;
- 1.1.7. Active involvement of treatment team and patient with family/natural supports and community resources.

2. ELIGIBILITY

2.1. Clients eligible for Intensive Outpatient Program services must meet the following criteria:

- 2.1.1. Have a current Medicaid benefit, **and**
- 2.1.2. Be 18 year of age or older; **and**
- 2.1.3. Reside in Thurston or Mason Counties; **and**
- 2.1.4. Have an established history of a chronic and severe mental illness covered under the Access to Care Standards; **and**
- 2.1.5. Have a history of multiple psychiatric inpatient admissions and/or frequent crisis or Emergency Department utilization as a first priority, or a lengthy history of high utilization of services without significant progress towards recovery or independence; **and**
- 2.1.6. Be enrolled with a TMRSN Network Provider (for clients not currently enrolled see section 3.4 below), **and**
- 2.1.7. Be expected to benefit from a more intensive outpatient goal-oriented and supportive environment.

2.2. Services may be provided to an individual with a Co-Occurring Mental Health and Substance Abuse disorder, as long as the primary diagnosis is a covered mental health diagnosis and there is no diagnosis of chemical dependency.

3. ACCESS

3.1. Services must be pre-approved and authorized by TMRSN.

3.2. Participation in the Intensive Program will serve as an ancillary service to regular outpatient mental

health services.

3.3. Access to Intensive Services is first coordinated with the Contractor who screens the referral for eligible and appropriateness, and requests authorization from TMRSN (see Referral/Authorization section).

3.4. If a potential client is not already enrolled with a TMRSN Network Provider, prior to the request for authorization the Contractor shall:

3.4.1. Provide an Intake assessment and enroll the client into Contractor's outpatient services as the primary provider while client is receiving Intensive Services; **or**

3.4.2. Make a referral to another TMRSN Network Provider for an Intake assessment and outpatient enrollment if Access to Care Standards is met.

3.5. To support continuity of care and treatment plan coordination, clinical care should be coordinated with the client's outpatient provider. Contractor must facilitate the client's transition and transfer of care to their outpatient provider prior to discharge from the Intensive Program.

3.6. Priority for access to TMRSN funded Intensive Program services will be given to persons referred by TMRSN, a TMRSN Network Provider, or persons diverting from or stepping down from an inpatient level of care.

4. REFERRAL/AUTHORIZATION

4.1. Referrals for TMRSN funded Intensive Program services may come from individual clients (self-referral) or another party on their behalf, including: outpatient program managers, clinical supervisors, case managers or therapists, or crisis or inpatient staff.

4.2. Referrals can be submitted directly to the Intensive Program for screening.

4.3. Referrals can also be submitted to TMRSN Care Management staff for pre-screening. If TMRSN approves the referral, the TMRSN Care Manager will forward referral to the Intensive Program for a clinical screening prior to authorization;

4.4. The Contractor shall first screen all referrals prior to TMRSN authorization to ensure that client is appropriate for this level of intensive services, chooses/agrees to participate, and could be expected to benefit from Intensive Outpatient Services.

4.5. Referrals should be accompanied by current clinical documentation that justifies the level of intensive services requested. Documentation should reflect current services being provided, history of multiple hospitalizations, frequency of crisis and/or ER utilization, and other alternative services that have been provided or offered in a less restrictive setting.

4.6. Contractor shall submit all screened and clinically appropriate referrals to TMRSN for pre-authorization by fax and include all required documentation. Faxes shall be addressed to:

TMRSN Care Management Staff
Fax: (360) 867-2601

4.7. **For Inquiries or to discuss potential referrals: (360) 867-2561.** TMRSN will review the referral and documentation, and authorize the client for services. A written authorization decision will be faxed back to the Contractor. If an authorization request is denied, TMRSN will provide reasons for the denial decision.

4.8. Contractor shall monitor program capacity, and if space is available, coordinate the screening process directly with the client and/or referent, and arrange for the initial assessment.

4.9. The Contractor will maintain a wait list when necessary for pre-approved clients and engage the client in Intensive Program services at the first opportunity.

5. PROGRAM COMPONENTS

5.1. All Intensive Program services shall be documented for each client's assessment, treatment plan and goals, services provided, and discharge plan and summary.

5.2. Services shall be provided primarily by or under the supervision of credentialed Mental Health Professionals with appropriate training and current licensure in good standing.

5.3. Psychiatric consultations shall be made available when necessary and applicable to the program or treatment goals.

5.4. Services shall include evaluation of current medications and possible side effects, and management strategies including peer to peer consultations and/or referrals for medication adjustments as necessary.

5.5. Weekly After-Care group that reinforces learning and behavioral changes that support treatment goals.

5.6. Provision of culturally and linguistically competent services, with services that meet special needs as indicated.

5.7. Treatment and discharge planning and coordination with case managers or other providers, to include provision of a transition/discharge summary upon program completion or discharge.

5.8. Referrals, linkage, and cross system coordination with other community supports and resources as necessary, to include families and other natural supports.

5.9. During the client's program enrollment, staff will provide crisis support and be available for other client contact and support as needed.

6. PROGRAM CAPACITY and COMPENSATION

6.1. TMRSN will fund Intensive Program Services for an average of (two) 2 eligible and pre-approved Medicaid individuals per treatment episode.

6.2. Reimbursement for services will be based on encounters submitted and for actual services provided in accordance with the TMRSN Intensive Program Reporting Guidelines. Services will be reimbursed at the group rate of $46.80 per hour and $150 per hour for individual services as specified in Exhibit B.

6.3. To maximize encounters and reimbursement, every effort should be made to provide Intensive Program services efficiently in group or individual modality, for a maximum of six (6) hours per treatment day.

6.3.1. Group services can be no more than three (3) hours per group component, but a client can participate in more than one group per day within the allowable six (6) hour treatment day.

6.4. Additional supportive services for medication management, crisis contacts, or other individual supportive services, must be documented and invoiced accordingly, with all encounters supported by appropriate clinical documentation in accordance with the TMRSN Reporting Guidelines for Intensive Program services.

6.5. Each program participant/graduate shall also have access to the After-Care weekly group upon completion of the Program for up to 12 months. Those services will be reimbursed at the group rate of $46.80 per hour and must follow the group guidelines of no more than three (3) hours per group.

6.6. Program expenditures shall not exceed an average of $5,000 per month for up to two (2) individuals per treatment episode (with an average length of stay of 12 program days).

6.7. TMRSN may adjust the capacity and compensation depending on the overall utilization of program services, the average monthly cost of service encounters submitted, and the available resources.

7. PROGRAM UTILIZATION and MARKETING

7.1. The Contractor shall;

7.1.1. Develop a marketing plan to educate and inform TMRSN Network Providers and eligible

clients about the availability of the Intensive Outpatient Program in an effort to effectively increase utilization of this service.

7.1.2. Publish marketing materials which describe the Intensive Outpatient Program including program and service description, eligibility requirements, access, referral and screening criteria, expected time commitment, and who could be expected to benefit from these services. Materials should include a minimum of two (2) types of materials/media; brochure, flyer, presentations/handouts, or website capable of responding to inquiries.

7.1.3. Distribute marketing materials to locations including, but not limited to; TMRSN, TMRSN Network Providers, and other service locations such as jails, crisis response services, and community inpatient facilities.

7.1.4. Assure that materials are available in easily understood language for both consumers and potential referents, and do not mislead or confuse the client or public.

7.1.5. Collaborate with TMRSN to identify target population, program measures and outcomes that demonstrate the effectiveness of Program services in facilitating completion of individual treatment goals and reducing utilization of more restrictive levels of care for clients.

7.1.6. Collaborate with TMRSN in a periodic quality and utilization review of program outcomes and effectiveness, and adjust marketing strategies as needed, especially if program is underutilized.

EXHIBIT B

Older Adult Outpatient Services

COMPENSATION

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1. COMPENSATION

1.1. Program funding is based on the services as set forth in the Program Contract.

1.1. Contractor shall bill for services based on the number of service hours performed per month to active enrolled TMRSN authorized clients.

1.2. The Contractor shall be funded based on a fee for service (FFS) model. The FFS is based on the number of service hours provided per month to active enrolled TMRSN authorized clients. Compensation is based on: $150.00 per hour for an individual service and $46.80 per hour for a group service.

1.2. All services provided or purchased for mental health benefit eligible Medicaid enrollees must be those identified in the "State plan" or waiver approved 1915 (b) services. All other services provided must have demonstrable and equivalent funding sources.

1.3. A service hour will only be funded if there is corresponding and accurate data in the Contractor and TMRSN MIS databases for the service provided. The service event also requires that corresponding and accurate written documentation is noted in the client records and the service provided accurately corresponds to the level of care and treatment plan. If the data is inaccurate or missing, and not corrected within an agreed upon time limit, compensation shall be reconciled and adjusted as necessary within the contract period.

1.4. Compensation rate may be adjusted based on actual costs and service productivity.

1.5. State funding can only fund services to those clients who are authorized for mental health benefits by TMRSN. All services provided or purchased for authorized clients must be those identified in the benefit section of this contract.

1.6. TMRSN shall compensate the Contractor for providing outpatient and intensive outpatient services as specified in Program Contract, Statement of Work, for this Contract. Required services provided to Medicaid eligible individuals that are not an allowable Medicaid benefit shall be funded under the state portion of this contract, as resources are available.

1.3. Each month, TMRSN shall establish the total number of eligible clients seen and service hours performed. An eligible service hour meets all of the following conditions:

- 1.3.1. Is provided by a registered counselor or higher credential in Washington State;
- 1.3.2. Meets all federal and state staff credential requirements for service provided;
- 1.3.3. With the exception of doctors and nurses, is supervised by an mental health professional (MHP);
- 1.3.4. Is an RSN allowable service as described in Appendix E3, Service Activity Codes (SAC) table of the *TMRSN Data Dictionary* or any successors, incorporated herein by reference;
- 1.3.5. Follows DBHR reporting guidelines with respect to provision of services, reporting of services, and Medicaid or State funding stipulations;
- 1.3.6. Client is defined as eligible in this Program Contract;
- 1.3.7. Client has a current authorization and is enrolled in services as described in the Program Contract, or has received an allowable pre-intake service;
- 1.6.1. Has not exceeded the LOC authorization period. (unless under a grievance/appeal).

1.7. Payment shall be based on the following table. It is the responsibility of the Contractor to monitor their monthly expenses and ensure that they do not go over the annual contract lid for each fund source.

Payment Period: January 01, 2015 through December 31, 2015				
Service Designation	**Rate Method**	**Fund Source**	**Project Code**	**Not to Exceed 12 Month Total**
Core Outpatient	Individual hr: $150.00 Group hr: $46.80	Medicaid	41408	$216,000
Core Outpatient		Reserves	41499	$41,856
Core Outpatient		State	41409	$7,200
Attachment 1: Intensive Outpatient Program		Medicaid	41408	$28,800
ITA Court Costs	Case Rate: $410	Reserves	41499	$80,000
			Total Annual Lid:	$373,856

1.8. A service event will only be funded if:

1.8.1. There is complete and accurate data in the Contractor and TMRSN MIS databases for all service encounters;

1.8.2. The service encounter data matches the documentation in the clinical record; and

1.8.3. The service provided accurately corresponds to the level of care and treatment plan as authorized by TMRSN.

1.9. Any monitoring process, including TMRSN encounter validation audits that show encounter invalidation will result in corrective action and funding reconciliation. Funding will be reconciled if the service event data: does not comply with the DBHR Encounter Instructions, does not comply with TMRSN reporting guidelines, or does not match or is missing from the clinical record.

1.9.1. Corrective action and funding reconciliation will occur for any missing or inaccurate encounters received from the Contractor. Reconciliation for outstanding invalid encounters will occur fifteen days (15) after the Contractor has received notification of errors. Overall encounter validation accuracy outcome expectation is 100% after necessary corrections.

2. OTHER FUNDING SOURCES

2.1. The Contractor shall make all effort to collect from Third Party Insurers when available. The Contractor shall be able to show by individual, those clients eligible for third party benefits, including which services, how much was billed by service, and how much was collected. This information shall be provided to TMRSN on a monthly basis prior to the invoicing date for that month (see Section 6 – Billing Procedure/Invoice Schedule).

3. FISCAL MANAGEMENT

3.1. The Contractor shall provide services in the most effective, efficient and economical manner possible to establish a prudent financial management system. This shall include, but not be limited to:

3.1.1. Establishing a sliding fee scale per licensing requirements. The sliding fee scale schedule shall be posted and accessible to staff and clients and may not require payment from clients with income levels equal to or below the grant standards for the general assistance program.

3.1.2. In accordance with Federal and State regulations and statutes, ensuring Medicaid or other RSN funds are not utilized to support administrative and/or direct services to non-Medicaid TMRSN authorized clients.

3.2. The Contractor shall maintain records in such a manner so as to reasonably ensure that all third-party resources available to clients are identified and pursued, in accordance with Medicaid being the payer of last resort. This information must be reported in the Financial Statement, see Section 7 of this exhibit. Third party revenue received by the Contractor for TMRSN funded services will be deducted from the RSN payment for same services.

3.3. The Contractor shall ensure that Medicaid enrollees are not charged or held liable for any of the

following:

3.3.1. Medicaid services covered under the terms of this Contract (42CFR447.15);

3.3.2. Contractor's debts in the event of insolvency;

3.3.3. Covered services provided to the enrollee for which DSHS does not pay TMRSN;

3.3.4. Services for which DSHS or TMRSN does not pay the individual or health care provider that furnishes the services under a contractual, referral or other arrangement;

3.3.5. Any service provided under contract, on referral, or other arrangement, which exceeds what TMRSN would cover if TMRSN provided the services directly.

4. PRODUCTIVITY

4.1. The Contractor's staff providing direct care services under this contract are expected to function at a target productivity level of 50%.

5. ACCOUNTING AND REPORTING REQUIREMENTS

5.1. The Contractor will submit service event encounters through the MIS system per the TMRSN Invoice and Data Send Calendar. All data will be certified as accurate per this contract.

5.2. The Contractor shall apply the TMRSN Reporting Guidelines, as set forth in TMRSN Policy. These guidelines are required to be utilized to determine allowable services that includes, but is not limited to the following: applicable funding source, appropriate service modality and service, location of service, and appropriate staff credentials. TMRSN will monitor for billing and data accuracy to these reporting requirements.

5.3. Funding for this program is only to be used to provide the services, as depicted in the Program Contract, and may not supplement any other programs or fund sources.

5.4. A minimum of 85 percent of the amount paid for outpatient funding to the Contractor shall be used for direct mental health services; the Contractor shall fully cooperate to assure compliance with this requirement.

6. BILLING PROCEDURE AND INVOICE SCHEDULE

6.1. TMRSN shall prepare an invoice each month based on encounter data entered in the RSN MIS for services provided. Payment shall not exceed the total amount of this Contract.

6.2. The Contractor will certify and verify for accuracy each and all batch submissions to TMRSN. Before any event send, the Contractor will perform checks to verify for accuracy. The Contractor will use the appropriate TMRSN Data Certification form according to policy (see the Manual) and provide a copy of the signed form to the TMRSN MIS Coordinator via Email or by fax to certify each batch submission. The Contractor will maintain a copy of the signed original certification form for at least one year from the end of this contracting period.

6.3. TMRSN reserves the rights to amend, delete, or add to the billing or reporting forms required in this Exhibit.

6.4. TMRSN shall not release payment until the Contractor provides required reports identified in this Contract.

6.5. Payment for outpatient services will be made based on all claims/encounters (services) accepted by TMRSN for a given month, per the TMRSN MCO Invoice Deadline and Payment Schedule for CY2014, attached herein or as otherwise stated according to 100.01 TMRSN Invoice and Data Send Calendar.

7. DELIVERABLES

7.1. The Contractor shall submit a budget vs actual report with each monthly invoice. Invoices submitted without the report will not be processed until the report is received.

7.2. The Contractor will submit Certification that the Administrative Costs incurred by the Contractor are no more than ten percent (10%) of the annual revenue under this contract. Certification must be submitted to the TMRSN by August 14, 2015.

PSPH ITA Court
INVOICE FORM

From:	Providence St. Peter Hospital 413 Lilly Rd NE Olympia WA 98506	Submit To:	Public Health & Social Services Fiscal Department 412 Lilly Rd NE Olympia WA 98506 P: 360.867.2530 | F: 360.867.2601 wagnerf@co.thurston.wa.us

Invoice Number:	#	**Submitted Date:**		**Vendor #:**	**20109**
For Service Dates:					

Item	Org	Object	Project	Source	# of Cases (x $410)	Amount
ITA Court Costs	1500D441	541000	41499	Reserves		
					Total:	

I attest that the information contained on this invoice is complete and accurate and all required reports or deliverables have been submitted.

______________________________ __________________
Providence St. Peter Authorized Signature Date

______________________________ __________________
TMRSN Authorized Signature Date

TMRSN MCO Invoice Deadline and Payment Schedule for CY2015

Revised 12-14 (lk)

			Month of Payment (Paid 2 days before Last Day of Month):												
			2015												2016
	Svs Dates	Payment Type:	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
Inclusive Service Dates	12/1/14-12/31/14	For svs approved by Jan 9th - DEC Svs Actual:													
	1/1/15-1/31/15	For svs approved by Feb 6th - JAN Svs Actual:													
	*1/1/14-12/31/14	*Semi-Annual Reconciliation to begin Feb 6th:													
	2/1/15-2/28/15	For svs approved by Mar 6th - FEB Svs Actual:													
	3/1/15-3/31/15	For svs approved by Apr 3rd - MAR Svs Actual:													
	4/1/1-4/30/15	For svs approved by May 8th - APR Svs Actual:													
	5/1/15-5/31/15	For svs approved by Jun 5th - MAY Svs Actual:													
	6/1/15-6/30/15	For svs approved by Jul 10th - JUN Svs Actual:													
	7/1/15-7/31/15	For svs approved by Aug 7th - JUL Svs Actual:													
	*1/1/15-6/30/15	*Semi-Annual Reconciliation to begin Aug 7th:													
	8/1/15-8/31/15	For svs approved by Sep 4th - AUG Svs Actual:													
	9/1/15-9/30/15	For svs approved by Oct 9th - SEP Svs Actual:													
	10/1/15-10/31/15	For svs approved by Nov 6th - OCT Svs Actual:													
	11/1/15-11/30/15	For svs approved by Dec 4th - NOV Svs Actual:													
	12/1/15-12/31/15	For svs approved by Jan 8th (TBD) - DEC Svs Actual:													

Semi-Annual Reconciliation Schedule

TMRSN's semi-annual (twice/year) reconciliation schedule for 2015 is as follows.
This reconciliation schedule is subject to change.

Reconciliation Due Date	Service Months Reconciled
February 6, 2015	January 1, 2014 - December 31, 2014
August 7, 2015	January 1, 2015 - June 30, 2015
February 2016 (TBD)	January 1, 2015 - December 31, 2015

EXHIBIT D

DATA SECURITY REQUIREMENTS

1. **Data Transport.** When transporting Protected Health Information (PHI) electronically, including via email, the data will be protected by:
   1.1. Transporting the data within the (State Governmental Network) SGN or contractor's internal network, or;
   1.2. Encrypting any data that will be in transit outside the SGN or contractor's internal network. This includes transit over the public Internet.
2. **Protection of Data.** The contractor agrees to store data on one or more of the following media and protect the data as described:
   2.1. **Hard disk drives.** Data stored on local workstation hard disks. Access to the data will be restricted to authorized users by requiring logon to the local workstation using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards.
   2.2. **Network server disks.** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the data will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
   2.3. **Optical discs (CDs or DVDs) in local workstation optical disc drives.** Data provided by the contractor on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a secure area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access PHI data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
   2.4. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers.** Data provided by the contractor on optical discs which will be attached to network servers and which will not be transported out of a secure area. Access to data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
   2.5. **Paper documents.** Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

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

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

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

2.8.1. PHI data shall not be stored by the Contractor on portable devices or media unless specifically authorized within the Special Terms and Conditions of the contract. If so authorized, the data shall be given the following protections:

2.8.1.1. Encrypt the data with a key length of at least 128 bits

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

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

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

2.8.2.1. Keeping them in locked storage when not in use

2.8.2.2. Using check-in/check-out procedures when they are shared, and

2.8.2.3. Taking frequent inventories

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

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

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

3. Data Segregation.

3.1. PHI data must be segregated or otherwise distinguishable from non-PHI data. This is to ensure that when no longer needed by the contractor, all PHI data can be identified for return or destruction. It also aids in determining whether PHI data has or may have been compromised in the event of a security breach.

3.2. PHI data will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no non-PHI data. Or,

3.3. PHI data will be stored in a logical container on electronic media, such as a partition or folder dedicated to PHI data. Or,

3.4. PHI data will be stored in a database which will contain no non-PHI data. Or,

3.5. PHI data will be stored within a database and will be distinguishable from non-PHI data by the value of a specific field or fields within database records. Or,

3.6. When stored as physical paper documents, PHI data will be physically segregated from non-PHI data in a drawer, folder, or other container.

3.7. When it is not feasible or practical to segregate PHI data from non-PHI data, then both the PHI data and the non-PHI data with which it is commingled must be protected as described in this exhibit.

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

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

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

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

EXHIBIT E

STATE PLAN MODALITY DEFINITIONS

Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid Enrollee's Individual Service Plan must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the Enrollee's current level of functioning and assistance with self care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

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

Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid Enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a Mental Health Professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

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

Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-

hospital/non-IMD) facilities licensed by the Department of Health and certified by DBHR to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care. This service does not include cost for room and board.

DBHR must authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

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

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

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

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

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

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

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

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

Medication Monitoring: Face-to-face, one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional. Time spent with the Enrollee is the only direct service billable component of this modality.

Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for

other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

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

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

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

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

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

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

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

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

needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

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

Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increase knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc. Services are provided at locations convenient to the consumer, by or under the supervision of a Mental Health Professional. Classroom style teaching, family treatment and individual treatment are not billable components of this service.

EXHIBIT F

ACCESS TO CARE STANDARDS

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

*** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of a mental illness.**	* **Must demonstrate moderate functional impairment in at least one life domain requiring assistance in order to meet the identified need AND-** * **Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least one life domain requiring assistance in order to meet the identified need AND-** * **Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders. * The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. * The individual is expected to benefit from the intervention. * The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. In addition to the modalities listed in Level of Care One, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

** = Descriptive Only*

	Level One - Brief Intervention	Level Two - Community Support
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least one life domain requiring assistance in order to meet the identified need AND-** * **Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least one life domain requiring assistance in order to meet identified need AND-** * **Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

** = Descriptive Only*

	Level One - Brief Intervention	Level Two - Community Support
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. In addition to the modalities listed in Level of Care One, individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... *(Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to... *(Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia *(refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS DEPRESSIVE DISORDERS	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive	B

	Type	
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A

	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	A

300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

<u>Additional Criteria for Diagnosis B</u>

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
* At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
* <u>Child is under six years of age</u> and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

EXHIBIT G

WA STATE CHILDREN'S MENTAL HEALTH SYSTEM PRINCIPLES AND CORE PRACTICE MODEL

- **Family and Youth Voice and Choice:** Family and child voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and child-centered from the first contact with or about the family or child.
- **Team based:** Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.
- **Natural Supports:** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration:** The system responds effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based:** Children are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant:** Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the child/youth and family and their community.
- **Individualized:** Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each child and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths Based:** Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
- **Outcome-based:** Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional:** A child and family team's commitment to achieving its goals persists regardless of the child's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

CORE PRACTICE MODEL

A. PURPOSE

The Washington State Division of Behavioral Health and Recovery core practice model is an overarching framework for providing comprehensive behavioral health services and supports for children and youth with complex emotional and behavioral issues. The practice model provides the broad principles that inform and guide the management and delivery of mental health services and supports; describes the treatment and support activities that providers undertake; governs how services are coordinated among systems and providers; prescribes the means to measure and account for outcomes; provides relevant feedback to managers and clinicians so as to continuously improve system and services quality; and ensures cost-effective use of resources.

B. PRACTICE MODEL COMPONENTS

Practice components embrace wraparound principles employed within a statewide System of Care to the fullest extent feasible. Each individual case affords the child and family all of components 1-6 (below) over the course of treatment and transition.

1. **Engagement:** Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
2. **Assessing:** Information gathering and assessing needs is the practice of gathering and evaluating information about the child and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children.
3. **Service Planning and Implementation:** Service planning is the practice of tailoring supports and services unique to each child and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child, family, and caregivers.
4. **Teaming:** Teaming is a process that brings together individuals agreed upon by the family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.
5. **Monitoring and Adapting:** Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
6. **Transition:** The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

EXHIBIT H

TMRSN OP Invoice Schedule 2015

Month	Date Invoice Data to Alice	Date Invoice for Review by Thurston County & Providers	Date Invoice to A/P for Payment
Jan	9	12	16
Feb	6	9	13
Mar	6	13	17
Apr	3	10	13
May	8	14	15
June	5	12	15
Jul	10	17	20
Aug	7	14	17
Sep	4	11	14
Oct	9	16	19
Nov	6	13	16
Dec	4	11	14

BUSINESS ASSOCIATE AGREEMENT ADDENDUM

THIS BUSINESS ASSOCIATE AGREEMENT (the "Addendum") is effective this 1st day of June 2014 (the "Effective Date") between Thurston County ("Covered Entity"), and Providence Health & Services – WA d/b/a Providence St. Peter Hospital ("Business Associate").

RECITALS

WHEREAS, Covered Entity and Business Associate are parties entering into Thurston Mason RSN General Terms & Conditions, Program Contracts, and all accompanying documents dated on, or after, January 01, 2012 and incorporated herein by reference (the "Underlying Agreement") pursuant to which Business Associate will deliver mental health services and such services involve the use and disclosure of Individually Identifiable Health Information that is subject to protection under HIPAA and the HIPAA Rules (all as hereinafter defined); and

WHEREAS, Business Associate has created and maintains security safeguards for the protection from unlawful disclosure of Protected Health Information (as hereinafter defined); and

WHEREAS, Covered Entity and Business Associate desire compliance with the Standards for Privacy of Individually Identifiable Health Information set forth under the HIPAA and the HIPAA Privacy Rule;

NOW, THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions herein contained, Covered Entity and Business Associate enter into the following Addendum to provide a full statement of their respective responsibilities as more fully described below:

ARTICLE 1 DEFINITIONS

Definitions. Unless otherwise provided herein terms used shall have the same meaning as set forth in HIPAA and the HIPAA Rules.

1.1 **"Addendum"** means this Business Associate Agreement Addendum.

1.2 **"Business Associate"** as used in this Addendum means the Business Associate named in this Addendum and generally has the same meaning as the term "business associate" at 45 C.F.R. § 160.103. Any reference to Business Associate in this Addendum includes Business Associate's employees, agents, officers, subcontractors, volunteers, or directors.

1.3 **"C.F.R."** means and refers to the Code of Federal Regulations.

1.4 **"Covered Entity"** means Thurston County, a Covered Entity as defined at 45 C.F.R. § 160.103, in its conduct of covered functions by its health care components.

1.5 **"Designated Record Set"** means a group of records maintained by or for a Covered Entity that is: the medical records and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used, in whole or in part, by or for the Covered Entity to make decisions about Individuals.

1.6 **"Electronic Protected Health Information" or "EPHI"** means Protected Health Information that is transmitted by electronic media or maintained in electronic media.

1.7 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, Pub.L. No. 104-191, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act,

enacted as Title XIII of The American Recovery and Reinvestment Act of 2009, H.R. 1, Pub.L. 111-5 (February 17, 2009), as amended or superseded, and any current and future regulations promulgated under HIPAA.

1.8 **"HIPAA Rules"** means the Privacy, Security, Enforcement, and Breach Notification Rules at 45 C.F.R. Part 160 and Part 164, in effect or as amended.

1.9 **"Individual"** means the person who is the subject of Protected Health Information and includes a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 **"Material Alteration"** means any addition, deletion or change to the PHI of any subject other than the addition of indexing, coding and other administrative identifiers for the purpose of facilitating the identification or processing of such information.

1.11 **"Privacy Rule"** means the Privacy Standards at 45 C.F.R. Part 164, Subpart E, in effect or as amended.

1.12 **"Protected Health Information" or "PHI"** means individually identifiable health information created, received, maintained or transmitted by Business Associate on behalf of a health care component of the Covered Entity that relates to the provision of health care to an Individual; the past, present, or future physical or mental health or condition of an Individual; or the past, present, or future payment for provision of health care to an Individual. 45 C.F.R. § 160.103. PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe can be used to identify the Individual. 45 C.F.R. § 160.103. PHI is information transmitted or held in any form or medium and includes Electronic Protected Health Information. 45 C.F.R. § 160.103. PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USCA 1232g (a)(4)(B)(iv) or employment records held by a Covered Entity in its role as employer.

1.13 **"Security Rule"** means the Security Standards at 45 C.F.R. Part 164, Subparts A and C, in effect or as amended.

1.14 **"Subcontractor"** as used in this Addendum means a Business Associate that creates, receives, maintains, or transmits Protected Health Information on behalf of another Business Associate.

1.15 **"Underlying Agreement"** means Thurston Mason RSN General Terms & Conditions, Program Contracts, and all accompanying documents.

ARTICLE 2
SCOPE OF USE OF PHI

2.1 **Services.** Except as otherwise specified herein, the Business Associate may use PHI solely to perform its duties as set forth in the Underlying Agreement. Except as otherwise limited in this Addendum, Business Associate may use and disclose PHI for the proper management and administration of the Business Associate, to carry out the legal responsibilities of the Business Associate and to provide any data aggregation services pursuant to the Underlying Agreement.

2.1.1 Business Associate may disclose PHI for the purposes pursuant to the Underlying Agreement only to its employees, subcontractors and agents, in accordance with Section 2.3.4 as directed by the Covered Entity.

2.1.2 Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that such disclosures are required by law or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which the PHI was disclosed to the person, the person implements reasonable and appropriate security measures to protect the PHI, and the

person notifies the Business Associate of any instances of which it is aware where the confidentiality of the PHI has been breached.

2.2 **Breach or Misuse of PHI.** Business Associate recognizes that any breach of confidentiality or misuse of information found in and/or obtained from records may result in the termination of the Underlying Agreement and this Addendum and/or legal action. Unauthorized disclosure of PHI may give rise to irreparable injury to the Individual or to the owner of such information, and the Individual or owner of such information may seek legal remedies against Business Associate.

2.3 **Responsibilities of Business Associate**. With regard to its use and/or disclosure of PHI, the Business Associate hereby agrees to do the following:

2.3.1 Use and/or disclose PHI only as permitted or required by this Addendum, HIPAA and HIPAA Rules, or as otherwise permitted or required by law. Business Associate agrees that it will not use or disclose PHI in any manner that violates federal law, including but not limited to HIPAA and any regulations enacted pursuant to its provisions, or applicable provisions of Washington State law. The Business Associate agrees that it is subject to and directly responsible for full compliance with the Privacy Rule that applies to the Business Associate to the same extent as the Covered Entity.

2.3.2 Use commercially reasonable efforts to maintain the security of the PHI and to prevent unauthorized use and/or disclosure of such PHI, including, but not limited to the following:

Any files on location at the agency must be kept in locked cabinets. Any client information transported must be kept from unauthorized access at all times.

In addition, the Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of all Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity in accordance with 45 C.F.R. Part 164, subpart C for as long as the PHI is within its possession and control, even after the termination or expiration of this Addendum. The Business Associate agrees that it is subject to and directly responsible for full compliance with the HIPAA Security Rule that applies to Business Associates, including sections 164.308, 164.310, 164.312, and 164.316 of title 45 C.F.R., to the same extent as the Covered Entity.

2.3.3 Business Associate shall apply the HIPAA Minimum Necessary standard to any use or disclosure of PHI necessary to achieve the purposes of the Underlying Agreement. See 45 C.F.R. 164.514(d)(2) through (d)(5).

2.3.4 Require all of its employees, representatives, subcontractors and agents that create, receive, maintain, or transmit PHI or use or have access to PHI under the Underlying Agreement to agree in writing to adhere to the same restrictions and conditions on the use and/or disclosure of PHI that apply herein, including the obligation to return or destroy the PHI if feasible, as provided under Sections 5.4 and 5.5 of this Addendum.

2.3.5 Promptly report to the designated privacy officer of the Covered Entity, any use and/or disclosure of the PHI that is not permitted or required by this Addendum by telephoning the privacy officer within twenty-four (24) hours of becoming aware of it, and providing a written report of the unauthorized disclosure within five (5) business days.

The name and contact information for the Covered Entity's privacy officer is as follows:

Contact Officer: Tammy Devlin
Telephone: (360) 786-5498

E-mail: devlint@co.thurston.wa.us
Address: 929 Lakeridge Drive SW, Building 4, Room 202
Olympia, WA 98502

2.3.6 Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum or the law.

2.3.7 Within five (5) business days of the discovery of a breach as defined at 45 C.F.R. § 164.402 notify the Covered Entity's privacy officer of any breach of unsecured PHI and take actions as may be necessary to identify, mitigate and remediate the cause of the breach. A breach shall be treated as discovered by the Business Associate in accordance with the terms of 45 C.F.R. § 164.410. The notification shall include the following information which shall be updated promptly and provided to the Covered Entity as requested by the Covered Entity:

a. the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during such breach;

b. a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

c. a description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

d. any steps individuals should take to protect themselves from potential harm resulting from the breach;

e. a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches;

f. contact procedures of the Business Associate for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address; and

g. any other information required to be provided to the individual by the Covered Entity pursuant to 45 C.F.R. § 164.404, as amended.

To the extent the Covered Entity deems warranted, the Covered Entity may provide notice or may require Business Associate to provide notice at Business Associate's expense to any or all individuals whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used, or disclosed as a result of such breach. In such case, the Business Associate shall consult with the Covered Entity regarding appropriate steps required to notify third parties. The Business Associate shall reimburse the Covered Entity, without limitation, for all costs of investigation, dispute resolution, notification of individuals, the media, and the government, and expenses incurred in responding to any audits or other investigation relating to or arising out of a breach of unsecured PHI by the Business Associate.

2.4 **Covered Entity Obligations.** With regard to the use and/or disclosure of PHI by the Business Associate, the Covered Entity hereby agrees to:

2.4.1 Provide the Business Associate a copy of the notice of privacy practices that the Covered Entity provides to Individuals pursuant to 45 C.F.R. § 164.520 by attaching it to this Addendum (Attachment A), and inform the Business Associate of any changes in the form of the notice;

2.4.2 Inform the Business Associate of any changes in, or withdrawal of, the authorization provided to the Covered Entity by Individuals whose PHI may be used and/or disclosed by Business Associate under the Underlying Agreement pursuant to 45 C.F.R. § 164.508; and

2.4.3 Notify the Business Associate, in writing and in a timely manner, of any restrictions on the use and/or disclosure of PHI agreed to by the Covered Entity in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

ARTICLE 3
AMENDMENT OF PHI

3.1 **Amendments by Business Associate.** Should Business Associate make any Material Alteration to PHI, Business Associate shall provide Covered Entity with notice of each Material Alteration to any PHI and shall promptly cooperate with Covered Entity in responding to any request made by any subject of such information to Covered Entity to inspect and/or copy such information. Business Associate shall not deny Covered Entity access to any such information if, in Covered Entity's sole discretion, such information must be made available to the subject seeking access to it. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 within twenty (20) days of the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

3.2 **Amendments Requested by Covered Entity.** Business Associate shall promptly incorporate all amendments or corrections to PHI when notified by Covered Entity that such information is inaccurate or incomplete.

ARTICLE 4
AVAILABILITY, ACCOUNTING OF DISCLOSURES, AUDITS AND INSPECTIONS

4.1 **Availability of PHI.** To the extent Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make PHI available to Covered Entity or, as directed by Covered Entity, to an Individual, within twenty (20) days of the request of the Covered Entity and in the manner designated by Covered Entity in accordance with 45 C.F.R. § 164.524.

4.2 **Accounting of Disclosures.** Business Associate agrees to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528. Business Associate will provide such accounting of disclosures to Covered Entity as soon as possible, but at least twenty (20) days from request by Covered Entity. Each accounting shall provide (i) the date of each disclosure; (ii) the name and address of the organization or person who received the PHI; (iii) a brief description of the PHI disclosed; and (iv) the purpose for which the PHI was disclosed, including the basis for such disclosure, or a copy of a written request for disclosure under §§ 164.502(a)(2)(ii) or 164.512. Business Associate shall maintain a process to provide the accounting of disclosures for as long as Business Associate maintains PHI received from or on behalf of Covered Entity.

4.3 **Access to Department of Health and Human Services.** Business Associate shall make its facilities, internal practices, books, records, documents, electronic data and all other business information relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity available to the Secretary of the Department of Health and Human Services, governmental officers and agencies within five (5) business days of written request by the Covered Entity for the purpose of determining compliance with HIPAA .

4.4 **Access to Covered Entity.** Upon written request, Business Associate agrees to make its facilities, internal practices, books, records, documents, electronic data and all other business information available

to Covered Entity within five (5) business days during normal business hours so that Covered Entity can monitor compliance with this Addendum.

ARTICLE 5
TERM AND TERMINATION

5.1 **Term.** This Addendum is valid as of the Effective Date and remains effective for the entire term of the Underlying Agreement, or until terminated as set forth herein.

5.2 **Termination.** This Addendum may be terminated by Covered Entity for convenience upon the same number of days prior written notice to the Business Associate as set out in the Underlying Agreement, otherwise upon thirty (30) days prior written notice. The notice will specify the date of termination.

5.3 **Termination for Cause.** Covered Entity may immediately terminate this Addendum and the Underlying Agreement without penalty if Covered Entity, in its sole discretion, determines that Business Associate has: (a) improperly used or disclosed PHI in breach of this Addendum; or (b) violated a material provision of this Addendum. Alternatively, the Covered Entity may choose to provide the Business Associate with written notice of the existence of an alleged material breach and a period of fifteen (15) days in which to cure the alleged material breach upon mutually agreeable terms. Failure to cure in the manner set forth in this paragraph is grounds for the immediate termination of this Addendum and the Underlying Agreement.

5.4 **Alternative to Termination.** If termination is not feasible, the Covered Entity shall report the breach to the Secretary of the Department of Health and Human Services.

5.5 **Return/Destruction of PHI.** Business Associate agrees that, upon termination of the Underlying Agreement, for whatever reason, it will return or destroy all PHI, if feasible, received from, or created or received by it on behalf of Covered Entity which Business Associate maintains in any form, and retain no copies of such information. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. An authorized representative of Business Associate shall certify in writing to Covered Entity, within five (5) days from the date of termination or other expiration of the Underlying Agreement, that all PHI has been returned or disposed of as provided above and that Business Associate no longer retains any such PHI in any form.

5.6 **No Feasible Return/Destruction of PHI.** If the return or destruction of PHI is not feasible, Business Associate shall notify Covered Entity of the conditions that make return or destruction infeasible. To the extent that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to the PHI retained and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. Business Associate shall remain bound by the provisions of this Addendum notwithstanding termination of the Underlying Agreement, until such time as all PHI has been returned or otherwise destroyed as provided in this section.

ARTICLE 6
INDEMNIFICATION/INSURANCE

6.1 **Defense and Indemnification.** Business Associate shall defend, indemnify and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including, without limitation attorney's fees, expert witness fees, and costs of investigation, litigation, or dispute resolution, relating to or arising out of any breach of this Addendum by Business Associate, its employees, officers, agents, or subcontractors.

6.1.1 Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with the Addendum or HIPAA or the HIPAA Rules will be adequate or satisfactory for Business Associate's own purposes or that any information in the possession of Business

Associate or Business Associate's control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure; nor shall Covered Entity be liable to Business Associate for any claim, loss or damage relating to the unauthorized use or disclosure of any information received by Business Associate from Covered Entity or from any other source. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

6.2 **Insurance.** If Covered Entity requires, Business Associate shall obtain and maintain insurance coverage against improper uses and disclosures of PHI by Business Associate naming Covered Entity as an additional named insured. Promptly following a request by Covered Entity for the maintenance of such insurance coverage, Business Associate shall provide a certificate evidencing such insurance coverage.

ARTICLE 7
MISCELLANEOUS

7.1 **Construction.** This Addendum shall be construed as broadly as necessary to implement and comply with HIPAA and the HIPAA Rules. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules.

7.2 **Notice.** All notices and other communications required or permitted pursuant to this Addendum shall be in writing, addressed to the party at the address set forth in the Underlying Agreement, or to such other address as either party may designate from time to time. All notices and other communications shall be mailed by registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or telegram. All notices shall be effective as of the date of delivery of personal notice or on the date of receipt, whichever is applicable.

7.3 **Modification of Addendum.** The parties agree to take such action as is necessary to modify this Addendum to ensure consistency with amendments to and changes in the applicable federal and state laws and regulations, including, but not limited to, HIPAA and the HIPAA Rules. This Addendum shall not be waived or altered, in whole or in part, except in writing signed by the parties.

7.4 **Invalid Terms.** In the event that any provision of the terms and conditions are held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Addendum will remain in full force and effect.

7.5 **Transferability.** Covered Entity has entered into this Addendum in specific reliance on the expertise and qualifications of Business Associate. Consequently, Business Associate's interest under this Addendum may not be transferred or assigned or assumed by any other person, in whole or part, without the prior written consent of Covered Entity.

7.6 **Governing Law and Venue.** This Addendum shall be governed by, and interpreted in accordance with the laws of the State of Washington in accordance with HIPAA and the HIPAA Rules without giving effect to the conflict of laws provisions. Thurston County, Washington, shall be the sole and exclusive venue for any litigation, special proceeding or other proceeding as between the parties that may be brought under, or arise out of, this Addendum.

7.7 **No Third Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor anything herein shall confer, upon any person other than the parties hereto any rights, remedies, obligations or liabilities whatsoever.

7.8 **Binding Effect.** This Addendum shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective permitted successors and assigns.

7.9 **Execution.** This Addendum may be executed in multiple counterparts, each of which shall constitute an original, all of which shall constitute but one agreement.

7.10 **<u>Gender and Number</u>.** The use of the masculine, feminine or neuter genders, and the use of the singular and plural, shall not be given an effect of any exclusion or limitation herein. The use of the word "person" or "party" shall mean and include any individual, trust, corporation, partnership or other entity.

7.11 **<u>Priority of Agreements</u>.** If any portion of the Addendum is inconsistent with the terms of the Underlying Agreement, the terms of this Addendum shall prevail. Except as set forth above, the remaining provisions of the Underlying Agreement are ratified in their entirety.

7.12 **<u>Survival</u>.** The obligations of Business Associate shall survive the termination of this Addendum and the Underlying Agreement.

7.13 **<u>Recitals</u>.** The preamble to this Addendum is not a mere recital of facts, but consists of binding agreed upon statements that form the basis of this Addendum.

IN WITNESS WHEREOF, the parties hereto have signed this Addendum effective the day and year first above written.

BUSINESS ASSOCIATE:	**COVERED ENTITY:** **THURSTON COUNTY**
______________________ *Signature (Authorized Representative)* ______________________ *Printed Name* ______________________ *Title* ______________________ *Date*	______________________ *Signature* Don Sloma *Printed Name* Director *Title* ______________________ *Date*

ATTACHMENT A
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

Thurston County is required by law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are required to notify you following a breach of your unsecured protected health information. We must follow the privacy practices that are described in this Notice currently in effect.

Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. We reserve the right to change our privacy practices and the terms of this Notice at any time. Changes will be available from the County office that provides your service. Any changes in our privacy practices and the new terms of our Notice will be effective for all protected health information that we maintain, including protected health information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your health information:

For treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. For example, if we refer you to a physician for a service that we cannot provide, your health information will be disclosed to that office.

For payment: We may use and disclose your health information to obtain payment for services we provide to you or to coordinate your medical benefits. For example, if an insurance company pays for your service, it may be necessary to disclose your health information to that company.

For healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To provide appointment reminders: We may disclose limited health information to provide you with appointment reminders such as voicemail messages, postcards, or letters.

To persons involved in your care: We may use or disclose health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, then we will provide you with an opportunity to object to such uses or disclosures before they are made. In the event of your incapacity or emergency circumstances, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

As required by law: We may disclose your health information when we are required to do so by federal, state or local law.

Business Associates: We may disclose health information to third party "business associates" who perform various activities involving your health information (e.g., claims payment or case management services) for the County. The County will implement written contracts to ensure the business associates will appropriately safeguard the information and to limit the use or disclosure of health information.

For public health activities: We may use and disclose medical information about you for public health activities, including to report births and deaths, and notify appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other crimes.

For public safety: We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

For health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law.

For judicial and administrative proceedings: We may disclose health information about you in response to a court or administrative order. We may disclose health information in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

For law enforcement purposes: We may disclose health information to law enforcement officials when certain conditions are met.

To coroners, medical examiners and funeral directors: We may disclose health information to coroners, medical examiners and funeral directors as authorized by law.

For workers' compensation: We may release health information about you for workers' compensation or similar programs.

For national security and similar government functions: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities.

To correctional institutions or law enforcement officials: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose information about you to the institution or official under certain circumstances.

For organ and tissue donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research protocol and determined that adequate safeguards exist to ensure the privacy of your health information.

With your authorization: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. Unless otherwise allowed by law, your written authorization is required before use or disclosure of psychotherapy notes or use or disclosure of protected health information for marketing purposes or disclosure for the sale of health information. (Thurston County does not market or sell health information in any event.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Specially Protected Types of Health Information: Some types of health information have greater protection under Washington State or federal laws. When required by law we will obtain your authorization before releasing HIV-related and sexually transmitted disease information that is protected by Washington State laws; alcohol and substance abuse treatment information that is protected under both Washington State and federal laws; and mental health treatment information that is protected under both Washington State and federal laws.

YOUR RIGHTS

Access: You have the right to look at and get copies of your protected health information, with limited exceptions. You may make your request for access to your medical records orally or in writing by using forms we provide or sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page plus postage if you want the copies mailed to you. We may deny your request in certain very

limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed. Another licensed health care professional not directly involved in the decision to deny your request will review your request and the denial. We will abide by the outcome of the review.

Disclosure accounting: You have the right to receive a list of disclosures we or our business associates made of your protected health information for purposes other than treatment, payment, healthcare operations and certain other activities for a period of time up to six years prior to the date of the accounting request, but not including dates before April 14, 2003. You must make this request in writing to our Contact Officer. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for providing the list.

Request restrictions: You have the right to request that we restrict how we use or disclose your protected health information for treatment, payment, or health care operations or the disclosures we make to someone who is involved in your care or the payment for your care, such as a family member, other relative, or friend. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operations and the information you seek to restrict pertains solely to a health care item or service for which you have paid the health care provider out-of-pocket in full.

Confidential communication: You have the right to request that we communicate with you about your protected health information by alternative means or at alternative locations. You must make your request in writing to the Contact Officer and may use forms we provide. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must give a reason for your request. We may deny your request if you ask us to amend information that was not created by us, is not part of the information kept by the County, is not part of the information you would be permitted to inspect and copy, or is accurate and complete. Any denial will be in writing and state the reason for the denial.

Paper Copy: You have the right to get a paper copy of this Notice if you request it, even if you have agreed to receive the Notice electronically.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or if you disagree with a decision we made about use or disclosure of your protected health information, you may complain to us using the contact information listed here. You also may submit a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Contact Officer: Tammy Devlin
Telephone: (360)786-5498
E-mail: devlint@co.thurston.wa.us
Address: 929 Lakeridge Drive SW, Building 4, Room 202
Olympia, WA 98502

Attachment 11

Attachment 11: ProtoCall Services.2015

PROFESSIONAL SERVICES CONTRACT

THURSTON COUNTY DEPARTMENT: THURSTON MASON RSN

THIS CONTRACT is entered into in duplicate originals between **THURSTON COUNTY**, a municipal corporation, with its principal offices at 412 Lilly Rd NE, Olympia, Washington 98506, hereinafter **"COUNTY,"** and **ProtoCall Services, Inc.**, with its principal offices at 621 SW Alder Ste 400, Portland OR 97205 hereinafter **"CONTRACTOR."**

In consideration of the mutual benefits and covenants contained herein, the parties agree as follows:

1. **DURATION OF CONTRACT**

   The term of this Contract shall begin March 01, 2015, and shall terminate on December 31, 2015.

2. **SERVICES PROVIDED BY THE CONTRACTOR**

   The CONTRACTOR represents that it is qualified and possesses the necessary expertise, knowledge, training, and skills, and has the necessary licenses and/or certification to perform the services set forth in this Contract.

   The CONTRACTOR shall perform the following services:

   - **Utilization Management Services**

     a. A detailed description of the services to be performed by the CONTRACTOR is set forth in Exhibit A, which is attached hereto and incorporated herein by reference.

     b. The CONTRACTOR agrees to provide its own labor and materials. Unless otherwise provided for in the Contract, no material, labor, or facilities will be furnished by the COUNTY.

     c. The CONTRACTOR shall perform according to standard industry practice of the work specified by this Contract.

     d. The CONTRACTOR shall complete its work in a timely manner and in accordance with the schedule agreed to by the parties.

     e. The CONTRACTOR shall, from time to time, during the progress of the work, confer with the COUNTY. At the COUNTY'S request, the CONTRACTOR shall prepare and present status reports on its work.

     f. A statement of the CONTRACTOR'S and the COUNTY'S responsibilities with respect to protected health information (the "Business Associate Addendum") is attached hereto and incorporated herein by reference.

3. **SERVICES PROVIDED BY THE COUNTY**

   In order to assist the CONTRACTOR in fulfilling its duties under this Contract, the COUNTY shall provide the following:

   a. Relevant information as exists to assist the CONTRACTOR with the performance of the CONTRACTOR'S services.

   b. Coordination with other County Departments or other Consultants as necessary for the performance of the CONTRACTOR'S services.

   c. Services documents, or other information identified in Exhibit A.

4. **CONTRACT REPRESENTATIVES**

   Each party to this Contract shall have a contract representative. Each party may change its representative upon providing written notice to the other party. The parties' representatives are as follows:

a. For CONTRACTOR:

Name of Representative: Philip Evans

Title: CEO

Mailing Address: 621 SW Alder Ste 400

City, State and Zip Code: Portland OR 97205

Telephone Number: 800-435-297

Fax Number: 503.499.6250

E-mail Address: phil.evans@protocallservices.com

b. For COUNTY:

Name of Representative: Mark Meyer

Title: Care Manager

Mailing Address: 412 Lilly Road NE

City, State and Zip Code: Olympia WA 98506

Telephone Number: 360.867.2561

Fax Number: 360.867.2601

E-mail Address: meyerm@co.thurston.wa.us

5. **COMPENSATION**

a. For the services performed hereunder, the CONTRACTOR shall be paid based upon mutually agreed rates contained in Exhibit B, which is attached hereto and incorporated herein by reference. The maximum total amount payable by the COUNTY to the CONTRACTOR under this Contract shall not exceed $70,000.00.

b. No payment shall be made for any work performed by the CONTRACTOR, except for work identified and set forth in this Contract or supporting exhibits or attachments incorporated by reference into this Contract.

c. The CONTRACTOR may, in accordance with Exhibit B, submit invoices to the COUNTY not more often than once per month during the progress of the work for partial payment of work completed to date. Invoices shall cover the time CONTRACTOR performed work for the COUNTY during the billing period. The COUNTY shall pay the CONTRACTOR for services rendered in the month following the actual delivery of the work and will remit payment within thirty (30) days from the date of receipt of billing.

d. The CONTRACTOR shall not be paid for services rendered under the CONTRACT unless and until they have been performed to the satisfaction of the COUNTY.

e. In the event the CONTRACTOR has failed to perform any substantial obligation to be performed by the CONTRACTOR under this Contract and such failure has not been cured within ten (10) days following notice from the COUNTY, then the COUNTY may, in its sole discretion, upon written notice to the CONTRACTOR, withhold any and all monies due and payable to the CONTRACTOR, without penalty until such failure to perform is cured or otherwise adjudicated. "Substantial" for purposes of this Contract means faithfully fulfilling the terms of the contract with variances only for technical or minor omissions or defects.

f. Unless otherwise provided for in this Contract or any exhibits or attachments hereto, the CONTRACTOR will not be paid for any billings or invoices presented for payment prior to the execution of the Contract or after its termination.

6. SAFEGUARDING PERSONAL INFORMATION

a. Personal information collected, used or acquired in connection with this Contract shall be used solely for the purposes of this Contract. The CONTRACTOR agrees not to release, divulge, publish, transfer, sell or otherwise make known personal information without the express written consent of the entity or as provided by law.

b. The CONTRACTOR agrees to implement physical, electronic and managerial safeguards to prevent unauthorized access to personal information. The COUNTY reserves the right to monitor, audit, or investigate the use of personal information collected, used or acquired by the CONTRACTOR through this Contract. To the extent required by law, the CONTRACTOR shall certify the return or destruction of all personal information upon expiration of this Contract.

c. Any breach of this Section may result in termination of the Contract and the demand for return of all records in connection with this Contract. The CONTRACTOR agrees to indemnify and hold harmless the COUNTY for any damages related to the CONTRACTOR'S unauthorized use or disclosure of personal information.

d. The provisions of this Section shall be included in any CONTRACTOR'S subcontract(s) relating to the services provide under this Contract.

e. "Personal Information" shall mean information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers. Personal Information includes "Protected Health Information" as set forth in 45 CFR § 160.103 as currently drafted and subsequently amended or revised and other information that may be exempt from disclosure to the public or other unauthorized persons under either Chapter 42.17 RCW or other federal and state statutes and regulations including 42 CFR Part 2, Chapter 70.02 RCW, Chapter 70.24 RCW, Chapter 70.96A RCW and Chapter 71.05 RCW.

7. AMENDMENTS AND CHANGES IN WORK

a. In the event of any errors or omissions by the CONTRACTOR in the performance of any work required under this Contract, the CONTRACTOR shall make any and all necessary corrections without additional compensation. All work submitted by the CONTRACTOR shall be certified by the CONTRACTOR and checked for errors and omissions. The CONTRACTOR shall be responsible for the accuracy of the work, even if the work is accepted by the COUNTY.

b. No amendment, modification or renewal shall be made to this Contract unless set forth in a written Contract Amendment, signed by both parties and attached to this Contract. Work under a Contract Amendment shall not proceed until the Contract Amendment is duly executed by the COUNTY.

8. HOLD HARMLESS AND INDEMNIFICATION

a. The CONTRACTOR shall hold harmless, indemnify and defend the COUNTY, its officers, officials, employees and agents, from and against any and all claims, actions, suits, liability, losses, expenses, damages, and judgments of any nature whatsoever, including costs and attorneys fees in defense thereof, for injury, sickness, disability or death to persons or damage to property or business, caused by or arising out of the CONTRACTOR'S acts, errors or omissions or the acts, errors or omissions of its employees, agents, subcontractors or anyone for whose acts any of them may be liable, in the performance of this Contract. Claims shall include, but not be limited to, assertions that information supplied or used by the CONTRACTOR or subcontractor infringes any patent, copyright, trademark, trade name, or otherwise results in an unfair trade practice. PROVIDED HOWEVER, that the CONTRACTOR'S obligations hereunder shall not extend to injury, sickness, death or damage caused by or arising out of the sole negligence of the COUNTY, its officers, officials, employees or agents. PROVIDED FURTHER, that in the event of the concurrent negligence of the parties, the CONTRACTOR'S obligations hereunder shall

apply only to the percentage of fault attributable to the CONTRACTOR, its employees, agents or subcontractors.

b. In any and all claims against the COUNTY, its officers, officials, employees and agents by any employee of the CONTRACTOR, subcontractor, anyone directly or indirectly employed by any of them, or anyone for whose acts any of them may be liable, the indemnification obligation under this Section shall not be limited in any way by any limitation on the amount or type of damages, compensation, or benefits payable by or for the CONTRACTOR or subcontractor under Worker's Compensation acts, disability benefits acts, or other employee benefits acts, it being clearly agreed and understood by the parties hereto that the CONTRACTOR expressly waives any immunity the CONTRACTOR might have had under Title 51 RCW. By executing the Contract, the CONTRACTOR acknowledges that the foregoing waiver has been mutually negotiated by the parties and that the provisions of this Section shall be incorporated, as relevant, into any contract the CONTRACTOR makes with any subcontractor or agent performing work hereunder.

c. The CONTRACTOR'S obligations hereunder shall include, but are not limited to, investigating, adjusting and defending all claims alleging loss from action, error or omission, or breach of any common law, statutory or other delegated duty by the CONTRACTOR, the CONTRACTOR'S employees, agents or subcontractors.

9. <u>INSURANCE</u>

a. **Professional Legal Liability**: The CONTRACTOR, if he is a licensed professional, shall maintain Professional Legal Liability or Professional Errors and Omissions coverage appropriate to the CONTRACTOR'S profession and shall be written subject to limits of not less than $1,000,000 per loss.

   The coverage shall apply to liability for a professional error, act or omission arising out of the scope of the CONTRACTOR'S services defined in this Contract. Coverage shall not exclude bodily injury or property damage. Coverage shall not exclude hazards related to the work rendered as part of the Contract or within the scope of the CONTRACTOR'S services as defined by this Contract including testing, monitoring, measuring operations, or laboratory analysis where such services are rendered as part of the Contract.

b. **Workers' Compensation (Industrial Insurance):** The CONTRACTOR shall maintain workers' compensation insurance as required by Title 51 RCW, and shall provide evidence of coverage to the Thurston County Risk Management Division.

   The CONTRACTOR shall send to Thurston County at the end of each quarter written verification that premium has been paid to the Washington State Department of Labor and Industries for Industrial Insurance coverage. Alternatively, the CONTRACTOR shall provide certification of approval by the Washington State Department of Labor and Industries if self-insured for Workers Compensation.

c. **Commercial General Liability**: The CONTRACTOR shall maintain Commercial General Liability coverage for bodily injury, personal injury and property damage, subject to limits of not less than $1,000,000 per loss. The general aggregate limit shall apply separately to this Contract and be no less than $2,000,000.

   i. The CONTRACTOR shall provide Commercial General Liability coverage which does not exclude any activity to be performed in fulfillment of this Contract. Specialized forms specific to the industry of the CONTRACTOR will be deemed equivalent provided coverage is no more restrictive than would be provided under a standard Commercial General Liability policy, including contractual liability coverage.

   ii. The CONTRACTOR'S Commercial General Liability insurance shall include the COUNTY, its officers, officials, employees and agents with respect to performance of services, and shall contain no special limitations on the scope of protection afforded to the COUNTY as additional insured.

   iii. The CONTRACTOR shall furnish the COUNTY with evidence that the additional insured provision required above has been met. An acceptable form of evidence is the endorsement pages of the policy showing the COUNTY as an additional insured.

iv. If the CONTRACTOR'S liability coverage is written as a claims made policy, then the CONTRACTOR must evidence the purchase of an extended reporting period or "tail" coverage for a three-year period after project completion, or otherwise maintain the coverage for the three-year period.

v. If the Contract is over $50,000 then the CONTRACTOR shall also maintain Employers Liability Coverage with a limit of not less than $1,000,000.

d. **Other Insurance Provisions:**

i. The CONTRACTOR'S liability insurance provisions shall be primary with respect to any insurance or self-insurance programs covering the COUNTY, its elected and appointed officers, officials, employees and agents.

ii. Any failure to comply with reporting provisions of the policies shall not affect coverage provided to the COUNTY, its officers, officials, employees or agents.

iii. The CONTRACTOR'S insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

iv. The CONTRACTOR shall include all subcontractors as insureds under its policies or shall furnish separate certificates and endorsements for each subcontractor. All coverage for subcontractors shall be subject to all of the requirements stated herein.

v. The insurance limits mandated for any insurance coverage required by this Contract are not intended to be an indication of exposure nor are they limitations on indemnification.

vi. The CONTRACTOR shall maintain all required policies in force from the time services commence until services are completed. Certificates, policies, and endorsements expiring before completion of services shall be promptly replaced.

e. **Verification of Coverage and Acceptability of Insurers:** The CONTRACTOR shall place insurance with insurers licensed to do business in the State of Oregon and having A.M. Best Company ratings of no less than A-, 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 Oregon.

i. Certificates of Insurance shall show the Certificate Holder as Thurston County and include c/o of the Office or Department issuing the Contract. The address of the Certificate Holder shall be shown as the current address of the Office or Department.

ii. Written notice of cancellation or change shall be mailed to the COUNTY at the following address: **Attn: Kristy Lysell 412 Lilly Rd NE Olympia WA 98506**

iii. The CONTRACTOR shall furnish the COUNTY with properly executed certificated of insurance or a signed policy endorsement which shall clearly evidence all insurance required in this section prior to commencement of services. The certificate will, at a minimum, list limits of liability and coverage. The certificate will provide that the underlying insurance contract will not be canceled or allowed to expire except on thirty (30) days prior written notice to the COUNTY.

iv. The CONTRACTOR or its broker shall provide a copy of any and all insurance policies specified in this Contract upon request of the Thurston County Risk Management Division.

10. <u>TERMINATION</u>

a. The COUNTY may terminate this Contract for convenience in whole or in part whenever the COUNTY determines, in its sole discretion that such termination is in the best interests of the COUNTY. The COUNTY may terminate this Contract upon giving ten (10) days written notice by Certified Mail to the CONTRACTOR. In that event, the COUNTY shall pay the CONTRACTOR for all costs incurred by the CONTRACTOR in performing the Contract up to the date of such notice. Payment shall be made in accordance with Section 5 of this Contract.

b. The CONTRACTOR may terminate this Contract for convenience in whole or in part whenever the CONTRACTOR determines, in its sole discretion that such termination is in the best interests of the

CONTRACTOR. The CONTRACTOR may terminate this Contract upon giving ten (10) days written notice by Certified Mail to the COUNTY. In that event, the COUNTY shall pay the CONTRACTOR for all costs incurred by the CONTRACTOR in performing the Contract up to the date of termination of the contract. Payment shall be made in accordance with Section 5 of this Contract.

c. In the event that funding for this project is withdrawn, reduced or limited in any way after the effective date of this Contract, the COUNTY may summarily terminate this Contract notwithstanding any other termination provision of the Contract. Termination under this paragraph shall be effective upon the date specified in the written notice of termination sent by the COUNTY to the CONTRACTOR. After the effective date, no charges incurred under this Contract are allowable.

d. If the CONTRACTOR breaches any of its obligations hereunder, and fails to cure the breach within ten (10) days of written notice to do so by the COUNTY, the COUNTY may terminate this Contract, in which case the COUNTY shall pay the CONTRACTOR only for the costs of services accepted by the COUNTY, in accordance with Section 5 of this Contract. Upon such termination, the COUNTY, at its discretion, may obtain performance of the work elsewhere, and the CONTRACTOR shall bear all costs and expenses incurred by the COUNTY in completing the work and all damage sustained by the COUNTY by reason of the CONTRACTOR'S breach. If, subsequent to termination, it is determined for any reason that (1) the CONTRACTOR was not in default, or (2) the CONTRACTOR'S failure to perform was not its fault or its subcontractor's fault or negligence, the termination shall be deemed to be a termination under subsection a of this section.

11. <u>ASSIGNMENT, DELEGATION, AND SUBCONTRACTING</u>

a. The CONTRACTOR shall perform the terms of the Contract using only its bona fide employees or agents who have the qualifications to perform under this Contract. The obligations and duties of the CONTRACTOR under this Contract shall not be assigned, delegated, or subcontracted to any other person or firm without the prior express written consent of the COUNTY.

b. The CONTRACTOR warrants that it has not paid nor has it agreed to pay any company, person, partnership, or firm, other than a bona fide employee working exclusively for CONTRACTOR, any fee, commission, percentage, brokerage fee, gift, or other consideration contingent upon or resulting from the award or making of this Contract.

12. <u>NON-WAIVER OF RIGHTS</u>

a. The parties agree that the excuse or forgiveness of performance, or waiver of any provision(s) of this Contract does not constitute a waiver of such provision(s) or future performance, or prejudice the right of the waiving party to enforce any of the provisions of this Contract at a later time.

13. <u>INDEPENDENT CONTRACTOR</u>

a. The CONTRACTOR'S services shall be furnished by the CONTRACTOR as an Independent CONTRACTOR and not as an agent, employee or servant of the COUNTY. The CONTRACTOR specifically has the right to direct and control CONTRACTOR'S own activities in providing the agreed services in accordance with the specifications set out in this Contract.

b. The CONTRACTOR acknowledges that the entire compensation for this Contract is set forth in Section 5 of this Contract, and the CONTRACTOR is not entitled to any County benefits, including, but not limited to: vacation pay, holiday pay, sick leave pay, medical, dental, or other insurance benefits, fringe benefits, or any other rights or privileges afforded to Thurston County employees.

c. The CONTRACTOR shall have and maintain complete responsibility and control over all of its subcontractors, employees, agents, and representatives. No subcontractor, employee, agent or representative of the CONTRACTOR shall be or deem to be or act or purport to act as an employee, agent or representative of the COUNTY.

d. The CONTRACTOR shall assume full responsibility for the payment of all payroll taxes, use, sales, income or other form of taxes, fees, licenses, excises, or payments required by any city, county, federal or state legislation which is now or may during the term of this Contract be enacted as to all persons employed by the CONTRACTOR and as to all duties, activities and requirements by the CONTRACTOR

in performance of the work on this project and under this Contract and shall assume exclusive liability therefore, and meet all requirements thereunder pursuant to any rules or regulations.

e. The CONTRACTOR agrees to immediately remove any of its employees or agents from assignment to perform services under this Contract upon receipt of a written request to do so from the COUNTY'S contract representative or designee for reasonable cause.

14. COMPLIANCE WITH LAWS

a. The CONTRACTOR shall comply with all applicable federal, state and local laws, rules and regulations in performing this Contract.

b. The relationship contemplated by this Contract may implicate the Privacy Regulations under the Health Insurance Portability and Accountability Act of 1996, Pub.L. No. 104-191, 110 Stat. 1936 (1996) (HIPAA). The CONTRACTOR shall comply with HIPAA and applicable regulations contained in 45 CFR parts 160 and 164. The CONTRACTOR shall enter into a Business Associate Addendum with the COUNTY if the COUNTY determines that the CONTRACTOR will be acting as Business Associate as defined under HIPAA.

15. INSPECTION OF BOOKS AND RECORDS

a. The COUNTY may, at reasonable times, inspect the books and records of the CONTRACTOR relating to the performance of this Contract. The CONTRACTOR shall keep all records required by this Contract for six (6) years after termination of this Contract for audit purposes.

16. NONDISCRIMINATION

a. The CONTRACTOR, its assignees, delegatees or subcontractors shall not discriminate against any person in the performance of any of its obligations hereunder on the basis of race, color, creed, ethnicity, religion, national origin, age, sex, marital status, veteran or military status, sexual orientation or the presence of any disability. Implementation of this provision shall be consistent with RCW 49.60.400.

17. OWNERSHIP OF MATERIALS/WORK PRODUCED

a. Material produced in the performance of the work under this Contract shall be "works for hire" as defined by the U.S. Copyright Act of 1976 and shall be owned by the COUNTY. This material includes, but is not limited to, books, computer programs, plans, specifications, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes, and/or training materials. Ownership includes the right to copyright, patent, register, and the ability to transfer these rights. The COUNTY agrees that if it uses any materials prepared by the CONTRACTOR for purposes other than those intended by this Contract, it does so at its sole risk and it agrees to hold the CONTRACTOR harmless therefore to the extent such use is agreed to in writing by the CONTRACTOR.

b. An electronic copy of all or a portion of material produced shall be submitted to the COUNTY upon request or at the end of the job using the word processing program and version specified by the COUNTY.

18. DISPUTES

a. Differences between the CONTRACTOR and the COUNTY, arising under and by virtue of this Contract, shall be brought to the attention of the COUNTY at the earliest possible time in order that such matters may be settled or other appropriate action promptly taken. Any dispute relating to the quality or acceptability of performance and/or compensation due the CONTRACTOR shall be decided by the COUNTY'S Contract representative or designee. All rulings, orders, instructions and decisions of the COUNTY'S contract representative shall be final and conclusive, subject to the CONTRACTOR'S right to seek judicial relief pursuant to Section 18.

19. CHOICE OF LAW, JURISDICTION AND VENUE

a. This Contract has been and shall be construed as having been made and delivered within the State of Washington, and it is agreed by each party hereto that this Contract shall be governed by the laws of the State of Washington, both as to its interpretation and performance.

b. Any action at law, suit in equity, or judicial proceeding arising out of this Contract shall be instituted and maintained only in any of the courts of competent jurisdiction in Thurston County, Washington.

20. SEVERABILITY

a. If a court of competent jurisdiction holds any part, term or provision of this Contract to be illegal, or invalid in whole or in part, the validity of the remaining provisions shall not be affected, and the parties' rights and obligations shall be construed and enforced as if the Contract did not contain the particular provision held to be invalid.

b. If any provision of this Contract is in direct conflict with any statutory provision of the State of Washington, that provision which may conflict shall be deemed inoperative and null and void insofar as it may conflict, and shall be deemed modified to conform to such statutory provision.

c. Should the COUNTY determine that the severed portions substantially alter this Contract so that the original intent and purpose of the Contract no longer exists, the COUNTY may, in its sole discretion, terminate this Contract.

21. ENTIRE CONRACT

a. The parties agree that this Contract is the complete expression of its terms and conditions. Any oral or written representations or understandings not incorporated in this Contract are specifically excluded.

22. NOTICES

a. Any notices shall be effective if personally served upon the other party or if mailed by registered or certified mail, return receipt requested, to the addresses set out in Section 4. Notice may also be given by facsimile with the original to follow by regular mail. Notice shall be deemed to be given three days following the date of mailing or immediately if personally served. For service by facsimile, service shall be effective upon receipt during working hours. If a facsimile is sent after working hours, it shall be effective at the beginning of the next working day.

The parties hereto acknowledge that the waiver of immunity set out in Section 8.b. was mutually negotiated and specifically agreed to by the parties herein.

Contractor's Authorized Representative:	**For the Board of Thurston County Commissioners:**
[signature]	[signature]
Signature	*Signature*
Philip H. Evans	DON SLOMA
Printed Name	*Printed Name*
CEO	DIRECTOR
Title	*Title*
2/13/15	3/17/15
Date	*Date*

Approved as to Form by the Prosecuting Attorney's Office
Reviewed 1/5/05

Exhibit A
SCOPE OF SERVICES

A. The services to be performed by the CONTRACTOR under this Contract, which are identified in Section 2 of the Contract (SERVICES PROVIDED BY THE CONTRACTOR), are set forth as follows:

1. The CONTRACTOR shall provide limited Utilization Management services for Thurston Mason RSN. Services will include;

    a) Medical necessity certification and prior-authorization services for voluntary inpatient admission requests for eligible Medicaid and non-Medicaid individuals.

    b) Authorization services for involuntary inpatient admission (ITA) notifications for eligible Medicaid and non-Medicaid individuals.

    c) Documentation of hospital notifications to TMRSN of hospital inpatient admissions that do not require TMRSN prior-authorization or authorization (primarily when Medicaid is secondary to Medicare).

    d) Timely twenty four hour, seven day a week (24/7) telephone response to pre-authorization requests for eligible individuals.

        i) Requests for voluntary prior-authorizations and involuntary authorizations must be responded to by a credentialed Mental Health Professional (MHP), as defined in WAC 388-865-0150, promptly, but at least within 1 hour.

2. The CONTRACTOR shall follow TMRSN's written policies, procedures and protocols.

3. The CONTRACTOR shall be in compliance with Utilization Management requirements of the Centers for Medicare and Medicaid Services (CMS) for Medicaid managed care as found in 42 CFR Part 438.

4. The CONTRACTOR shall;

    a) Maintain a designated toll free (800) line for calls from TMRSN Network Providers, community hospitals providing voluntary hospitalization services, and outlying facilities (other than TMRSN's Evaluation and Treatment Facility) licensed to provide ITA services.

    b) Provide 24 hour per day, 7 day per week response to telephone requests for authorization of involuntary psychiatric inpatient admissions in accordance with State of Washington's Inpatient Hospital Psychiatric Admissions requirements and TMRSN protocols.

    c) Provide a "live answer" to calls within 30 seconds.

    d) Provide certification of medical necessity and prior authorization of voluntary hospital admission requests for all eligible consumers by a Mental Health Professional as defined in WAC 388-865-0150.

    e) Provide the initial prior-authorization for voluntary inpatient care once medical necessity is established and certified as soon as possible, but at least within 12 hours of request.

    f) Contact TMRSN's Medical Director for consultation or peer review when medical necessity for voluntary inpatient admission or continuing stay is questionable. Only TMRSN's Medical Director can determine a denial for TMRSN voluntary inpatient admission or continuing stay requests.

    g) Contact TMRSN or the TMRSN Medical Director for consultation before authorizing extension of voluntary hospitalization stay when the request seems based more on lack of discharge placement resources than on continuing medical necessity.

    h) Obtain by phone from requesting facility demographic and clinical information relative to each request for authorization or extension of stay.

    i) Maintain a TMRSN database system that captures Call Log details and the demographic and clinical information relative to each request and authorization record. (TMRSN uses this database for utilization management and as a basis for deliverables required of TMRSN.)

j) Enter information in Washington's ProviderOne (P1) database to establish an authorization number and a record of each voluntary and involuntary inpatient episode of care. (The P1 database is the official record of all Washington RSN inpatient authorizations and the basis for the payment process to hospitals and facilities providing inpatient care.)

k) Provide the P1-generated authorization number to the facility requesting TMRSN prior-authorization of voluntary admission or notifying TMRSN of involuntary admission.

l) Collaborate with crisis services staff, case managers, emergency department staff, Designated Mental Health Professionals (DMHPs), and other allied service providers regarding crisis intervention, diversions, inpatient care, and available community resources when requested.

m) Ensure denial procedures are implemented prior to any denial of certification or prior-authorization.

n) Transmit specified screening, clinical and certification/authorization information by the next business day in accordance with TMRSNs' protocols.

5. The CONTRACTOR shall establish and maintain a record-keeping system to track and monitor the services performed, and a method of data submission for the following:

a) Screening and other data collected for medical necessity determinations and prior authorization decisions by the next business day.

b) Response times, utilization management services reports, and provision of other specified data to the respective Partners upon request.

c) Provision of any additional information regarding Utilization Management services that may be required or requested by TMRSN, the Department of Social and Health Services (DSHS), and CMS.

6. Inpatient denials and appeals are made only by physicians and will be managed directly by TMRSN and is not part of this contract. The responsibility of the CONTRACTOR is limited to ensuring that communication between inpatient facilities and psychiatrists, so each is informed of the pending decision in a timely manner.

B. TMRSN reserves the right to revoke delegation, impose corrective action, or take other remedial actions if the Contractor's performance is not considered adequate based on the outcome of the annual review.

1. Adverse findings will be communicated in writing to the Contractor and may result in one of the following:

a) Corrective action or other remedial actions;

b) Contract revision and amendment;

c) · Termination of this contract.

2. The authority to perform the delegated function(s) shall be revoked with the contract expiration date.

C. The Contractor shall comply with the Excluded Providers requirements and perform monthly checks on all staff, board members, volunteers, and interns that provide services funded under this contract.

1. The Contractor shall submit a monthly report to TMRSN showing a check was performed against the OIG Excluded Provider Database. The Report shall be submitted electronically, by no later than the 10th of each month to lysellk@co.thurston.wa.us.

D. The services to be performed by the COUNTY under this Contract, which are identified in Section 3 of the Contract (SERVICES PROVIDED BY THE COUNTY), are set forth as follows:

1. COUNTY, Thurston Mason RSN, will:

a) Issue the authorizations for Thurston Mason RSN;

b) Provide a designated contact person or persons;

c) Provide written protocols, policies, and any other supporting documentation to support the inpatient authorization process; and

d) Perform periodic monitoring and oversight of delegated Utilization Management functions to assure compliance with the terms of this contract, protocols, and policies.

Exhibit B

COMPENSATION

A. The CONTRACTOR'S compensation under this Contract, which is described in Section 5 of the Contract (COMPENSATION), is set forth as follows:

1. The COUNTY shall reimburse the CONTRACTOR for services performed under this Contract no more than $70,000, payable in the following manner:
    a) The CONTRACTOR shall bill in advance each month $3,125.00 which includes up to 25 inpatient prior authorization requests. Additional inpatient prior authorization requests will be charged $125.00 per inpatient prior authorization request up to 50 per month.
        i. Should the volume of inpatient prior authorization requests exceed 50 per month, the COUNTY and the CONTRACTOR shall negotiate a revised rate and amend the current contract.
    b) The CONTRACTOR may use up to $7,500 of funding for interpreter services or other contract related expenses not included in the prior authorization process.
2. The CONTRACTOR shall bill the COUNTY for services using the specified invoice form in this Exhibit. The COUNTY reserves the right to amend, delete or add to the billing form as shown in this Exhibit.
3. Attached to this exhibit is an invoice form in Excel that must be completed for reimbursement. An original signed invoice must be received prior to dispersal of funds. Attach any data requested prior to submitting invoices.
    a) The Contractor shall complete the budget vs actual report with each monthly invoice.
4. All invoices must have an invoice number provided which must unique and not be repeated.
5. The CONTRACTOR must submit billings to arrive at the COUNTY'S Social Services Department no later than the tenth (10th) calendar day of the month in order to receive COUNTY reimbursement by the last working day of the month. Billings received after the tenth calendar day shall be reimbursed no later than the last working day of the following month. The CONTRACTOR agrees that receipt of any payment from the COUNTY is expressly conditioned on submission to the COUNTY of any, and all required reports and documentation prior to the COUNTY deadlines.
6. COUNTY shall not release reimbursement until the CONTRACTOR provides any reports identified in this Contract.

BUSINESS ASSOCIATE AGREEMENT
ADDENDUM

THIS BUSINESS ASSOCIATE AGREEMENT (the "Addendum") is effective this 1st day of March 2015 (the "Effective Date") between Thurston County ("Covered Entity"), and ProtoCall Services Inc. ("Business Associate").

RECITALS

WHEREAS, Covered Entity and Business Associate are parties entering into a Professional Service Contract, and all accompanying documents dated on, or after, March 01, 2015 and incorporated herein by reference (the "Underlying Agreement") pursuant to which Business Associate will provide Inpatient Utilization Management Services and such services involve the use and disclosure of Individually Identifiable Health Information that is subject to protection under HIPAA and the HIPAA Rules (all as hereinafter defined); and

WHEREAS, Business Associate has created and maintains security safeguards for the protection from unlawful disclosure of Protected Health Information (as hereinafter defined); and

WHEREAS, Covered Entity and Business Associate desire compliance with the Standards for Privacy of Individually Identifiable Health Information set forth under the HIPAA and the HIPAA Privacy Rule;

NOW, THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions herein contained, Covered Entity and Business Associate enter into the following Addendum to provide a full statement of their respective responsibilities as more fully described below:

ARTICLE 1
DEFINITIONS

Definitions. Unless otherwise provided herein terms used shall have the same meaning as set forth in HIPAA and the HIPAA Rules.

1.1 **"Addendum"** means this Business Associate Agreement Addendum.

1.2 **"Business Associate"** as used in this Addendum means the Business Associate named in this Addendum and generally has the same meaning as the term "business associate" at 45 C.F.R. § 160.103. Any reference to Business Associate in this Addendum includes Business Associate's employees, agents, officers, subcontractors, volunteers, or directors.

1.3 **"C.F.R."** means and refers to the Code of Federal Regulations.

1.4 **"Covered Entity"** means Thurston County, a Covered Entity as defined at 45 C.F.R. § 160.103, in its conduct of covered functions by its health care components.

1.5 **"Designated Record Set"** means a group of records maintained by or for a Covered Entity that is: the medical records and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used, in whole or in part, by or for the Covered Entity to make decisions about Individuals.

1.6 **"Electronic Protected Health Information" or "EPHI"** means Protected Health Information that is transmitted by electronic media or maintained in electronic media.

1.7 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, Pub.L. No. 104-191, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as Title XIII of The American Recovery and Reinvestment Act of 2009, H.R. 1, Pub.L. 111-5

(February 17, 2009), as amended or superseded, and any current and future regulations promulgated under HIPAA.

1.8 **"HIPAA Rules"** means the Privacy, Security, Enforcement, and Breach Notification Rules at 45 C.F.R. Part 160 and Part 164, in effect or as amended.

1.9 **"Individual"** means the person who is the subject of Protected Health Information and includes a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 **"Material Alteration"** means any addition, deletion or change to the PHI of any subject other than the addition of indexing, coding and other administrative identifiers for the purpose of facilitating the identification or processing of such information.

1.11 **"Privacy Rule"** means the Privacy Standards at 45 C.F.R. Part 164, Subpart E, in effect or as amended.

1.12 **"Protected Health Information" or "PHI"** means individually identifiable health information created, received, maintained or transmitted by Business Associate on behalf of a health care component of the Covered Entity that relates to the provision of health care to an Individual; the past, present, or future physical or mental health or condition of an Individual; or the past, present, or future payment for provision of health care to an Individual. 45 C.F.R. § 160.103. PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe can be used to identify the Individual. 45 C.F.R. § 160.103. PHI is information transmitted or held in any form or medium and includes Electronic Protected Health Information. 45 C.F.R. § 160.103. PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USCA 1232g (a)(4)(B)(iv) or employment records held by a Covered Entity in its role as employer.

1.13 **"Security Rule"** means the Security Standards at 45 C.F.R. Part 164, Subparts A and C, in effect or as amended.

1.14 **"Subcontractor"** as used in this Addendum means a Business Associate that creates, receives, maintains, or transmits Protected Health Information on behalf of another Business Associate.

1.15 **"Underlying Agreement"** means the Professional Service Contract and all accompanying documents.

ARTICLE 2
SCOPE OF USE OF PHI

2.1 **Services.** Except as otherwise specified herein, the Business Associate may use PHI solely to perform its duties as set forth in the Underlying Agreement. Except as otherwise limited in this Addendum, Business Associate may use and disclose PHI for the proper management and administration of the Business Associate, to carry out the legal responsibilities of the Business Associate and to provide any data aggregation services pursuant to the Underlying Agreement.

2.1.1 Business Associate may disclose PHI for the purposes pursuant to the Underlying Agreement only to its employees, subcontractors and agents, in accordance with Section 2.3.4 as directed by the Covered Entity.

2.1.2 Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that such disclosures are required by law or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which the PHI was disclosed to the person, the person implements reasonable and appropriate security measures to protect the PHI, and the person notifies the Business Associate of any instances of which it is aware where the confidentiality of the PHI has been breached.

2.2 Breach or Misuse of PHI. Business Associate recognizes that any breach of confidentiality or misuse of information found in and/or obtained from records may result in the termination of the Underlying Agreement and this Addendum and/or legal action. Unauthorized disclosure of PHI may give rise to irreparable injury to the Individual or to the owner of such information, and the Individual or owner of such information may seek legal remedies against Business Associate.

2.3 Responsibilities of Business Associate. With regard to its use and/or disclosure of PHI, the Business Associate hereby agrees to do the following:

2.3.1 Use and/or disclose PHI only as permitted or required by this Addendum, HIPAA and HIPAA Rules, or as otherwise permitted or required by law. Business Associate agrees that it will not use or disclose PHI in any manner that violates federal law, including but not limited to HIPAA and any regulations enacted pursuant to its provisions, or applicable provisions of Washington State law. The Business Associate agrees that it is subject to and directly responsible for full compliance with the Privacy Rule that applies to the Business Associate to the same extent as the Covered Entity.

2.3.2 Use commercially reasonable efforts to maintain the security of the PHI and to prevent unauthorized use and/or disclosure of such PHI, including, but not limited to the following:

Any files on location at the agency must be kept in locked cabinets. Any client information transported must be kept from unauthorized access at all times.

In addition, the Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of all Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity in accordance with 45 C.F.R. Part 164, subpart C for as long as the PHI is within its possession and control, even after the termination or expiration of this Addendum. The Business Associate agrees that it is subject to and directly responsible for full compliance with the HIPAA Security Rule that applies to Business Associates, including sections 164.308, 164.310, 164.312, and 164.316 of title 45 C.F.R., to the same extent as the Covered Entity.

2.3.3 Business Associate shall apply the HIPAA Minimum Necessary standard to any use or disclosure of PHI necessary to achieve the purposes of the Underlying Agreement. See 45 C.F.R. 164.514(d)(2) through (d)(5).

2.3.4 Require all of its employees, representatives, subcontractors and agents that create, receive, maintain, or transmit PHI or use or have access to PHI under the Underlying Agreement to agree in writing to adhere to the same restrictions and conditions on the use and/or disclosure of PHI that apply herein, including the obligation to return or destroy the PHI if feasible, as provided under Sections 5.4 and 5.5 of this Addendum.

2.3.5 Promptly report to the designated privacy officer of the Covered Entity, any use and/or disclosure of the PHI that is not permitted or required by this Addendum by telephoning the privacy officer within two (2) business days of becoming aware of it, and providing a written report of the unauthorized disclosure within five (5) business days.

The name and contact information for the Covered Entity's privacy officer is as follows:

Contact Officer:	Tammy Devlin
Telephone:	(360) 786-5498
E-mail:	devlint@co.thurston.wa.us
Address:	929 Lakeridge Drive SW, Building 4, Room 202 Olympia, WA 98502

2.3.6 Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum or the law.

2.3.7 Within two (2) business days of the discovery of a breach as defined at 45 C.F.R. § 164.402 notify the Covered Entity's privacy officer of any breach of unsecured PHI and take actions as may be necessary to identify, mitigate and remediate the cause of the breach. A breach shall be treated as discovered by the Business Associate in accordance with the terms of 45 C.F.R. § 164.410. The notification shall include the following information which shall be updated promptly and provided to the Covered Entity as requested by the Covered Entity:

a. the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during such breach;

b. a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

c. a description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

d. any steps individuals should take to protect themselves from potential harm resulting from the breach;

e. a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches;

f. contact procedures of the Business Associate for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address; and

g. any other information required to be provided to the individual by the Covered Entity pursuant to 45 C.F.R. § 164.404, as amended.

To the extent the Covered Entity deems warranted, the Covered Entity may provide notice or may require Business Associate to provide notice at Business Associate's expense to any or all individuals whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used, or disclosed as a result of such breach. In such case, the Business Associate shall consult with the Covered Entity regarding appropriate steps required to notify third parties. The Business Associate shall reimburse the Covered Entity, without limitation, for all costs of investigation, dispute resolution, notification of individuals, the media, and the government, and expenses incurred in responding to any audits or other investigation relating to or arising out of a breach of unsecured PHI by the Business Associate.

2.4 **Covered Entity Obligations.** With regard to the use and/or disclosure of PHI by the Business Associate, the Covered Entity hereby agrees to:

2.4.1 Provide the Business Associate a copy of the notice of privacy practices that the Covered Entity provides to Individuals pursuant to 45 C.F.R. § 164.520 by attaching it to this Addendum (Attachment A), and inform the Business Associate of any changes in the form of the notice;

2.4.2 Inform the Business Associate of any changes in, or withdrawal of, the authorization provided to the Covered Entity by Individuals whose PHI may be used and/or disclosed by Business Associate under the Underlying Agreement pursuant to 45 C.F.R. § 164.508; and

2.4.3 Notify the Business Associate, in writing and in a timely manner, of any restrictions on the use and/or disclosure of PHI agreed to by the Covered Entity in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

ARTICLE 3
AMENDMENT OF PHI

3.1 **Amendments by Business Associate.** Should Business Associate make any Material Alteration to PHI, Business Associate shall provide Covered Entity with notice of each Material Alteration to any PHI and shall promptly cooperate with Covered Entity in responding to any request made by any subject of such information to Covered Entity to inspect and/or copy such information. Business Associate shall not deny Covered Entity access to any such information if, in Covered Entity's sole discretion, such information must be made available to the subject seeking access to it. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 within twenty (20) days of the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

3.2 **Amendments Requested by Covered Entity.** Business Associate shall promptly incorporate all amendments or corrections to PHI when notified by Covered Entity that such information is inaccurate or incomplete.

ARTICLE 4
AVAILABILITY, ACCOUNTING OF DISCLOSURES, AUDITS AND INSPECTIONS

4.1 **Availability of PHI.** To the extent Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make PHI available to Covered Entity or, as directed by Covered Entity, to an Individual, within twenty (20) days of the request of the Covered Entity and in the manner designated by Covered Entity in accordance with 45 C.F.R. § 164.524.

4.2 **Accounting of Disclosures.** Business Associate agrees to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528. Business Associate will provide such accounting of disclosures to Covered Entity as soon as possible, but at least twenty (20) days from request by Covered Entity. Each accounting shall provide (i) the date of each disclosure; (ii) the name and address of the organization or person who received the PHI; (iii) a brief description of the PHI disclosed; and (iv) the purpose for which the PHI was disclosed, including the basis for such disclosure, or a copy of a written request for disclosure under §§ 164.502(a)(2)(ii) or 164.512. Business Associate shall maintain a process to provide the accounting of disclosures for as long as Business Associate maintains PHI received from or on behalf of Covered Entity.

4.3 **Access to Department of Health and Human Services.** Business Associate shall make its facilities, internal practices, books, records, documents, electronic data and all other business information relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity available to the Secretary of the Department of Health and Human Services, governmental officers and agencies within five (5) business days of written request by the Covered Entity for the purpose of determining compliance with HIPAA .

4.4 **Access to Covered Entity.** Upon written request, Business Associate agrees to make its facilities, internal practices, books, records, documents, electronic data and all other business information available

to Covered Entity within five (5) business days during normal business hours so that Covered Entity can monitor compliance with this Addendum.

ARTICLE 5
TERM AND TERMINATION

5.1 **Term.** This Addendum is valid as of the Effective Date and remains effective for the entire term of the Underlying Agreement, or until terminated as set forth herein.

5.2 **Termination.** This Addendum may be terminated by Covered Entity for convenience upon the same number of days prior written notice to the Business Associate as set out in the Underlying Agreement, otherwise upon thirty (30) days prior written notice. The notice will specify the date of termination.

5.3 **Termination for Cause.** Covered Entity may immediately terminate this Addendum and the Underlying Agreement without penalty if Covered Entity, in its sole discretion, determines that Business Associate has: (a) improperly used or disclosed PHI in breach of this Addendum; or (b) violated a material provision of this Addendum. Alternatively, the Covered Entity may choose to provide the Business Associate with written notice of the existence of an alleged material breach and a period of fifteen (15) days in which to cure the alleged material breach upon mutually agreeable terms. Failure to cure in the manner set forth in this paragraph is grounds for the immediate termination of this Addendum and the Underlying Agreement.

5.4 **Alternative to Termination.** If termination is not feasible, the Covered Entity shall report the breach to the Secretary of the Department of Health and Human Services.

5.5 **Return/Destruction of PHI.** Business Associate agrees that, upon termination of the Underlying Agreement, for whatever reason, it will return or destroy all PHI, if feasible, received from, or created or received by it on behalf of Covered Entity which Business Associate maintains in any form, and retain no copies of such information. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. An authorized representative of Business Associate shall certify in writing to Covered Entity, within five (5) days from the date of termination or other expiration of the Underlying Agreement, that all PHI has been returned or disposed of as provided above and that Business Associate no longer retains any such PHI in any form.

5.6 **No Feasible Return/Destruction of PHI.** If the return or destruction of PHI is not feasible, Business Associate shall notify Covered Entity of the conditions that make return or destruction infeasible. To the extent that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to the PHI retained and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. Business Associate shall remain bound by the provisions of this Addendum notwithstanding termination of the Underlying Agreement, until such time as all PHI has been returned or otherwise destroyed as provided in this section.

ARTICLE 6
INDEMNIFICATION/INSURANCE

6.1 **Defense and Indemnification.** Business Associate shall defend, indemnify and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including, without limitation attorney's fees, expert witness fees, and costs of investigation, litigation, or dispute resolution, relating to or arising out of any breach of this Addendum by Business Associate, its employees, officers, agents, or subcontractors.

6.1.1 Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with the Addendum or HIPAA or the HIPAA Rules will be adequate or satisfactory for Business Associate's own purposes or that any information in the possession of Business

Associate or Business Associate's control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure; nor shall Covered Entity be liable to Business Associate for any claim, loss or damage relating to the unauthorized use or disclosure of any information received by Business Associate from Covered Entity or from any other source. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

6.2 **Insurance.** If Covered Entity requires, Business Associate shall obtain and maintain insurance coverage against improper uses and disclosures of PHI by Business Associate naming Covered Entity as an additional named insured. Promptly following a request by Covered Entity for the maintenance of such insurance coverage, Business Associate shall provide a certificate evidencing such insurance coverage.

ARTICLE 7
MISCELLANEOUS

7.1 **Construction.** This Addendum shall be construed as broadly as necessary to implement and comply with HIPAA and the HIPAA Rules. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules.

7.2 **Notice.** All notices and other communications required or permitted pursuant to this Addendum shall be in writing, addressed to the party at the address set forth in the Underlying Agreement, or to such other address as either party may designate from time to time. All notices and other communications shall be mailed by registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or telegram. All notices shall be effective as of the date of delivery of personal notice or on the date of receipt, whichever is applicable.

7.3 **Modification of Addendum.** The parties agree to take such action as is necessary to modify this Addendum to ensure consistency with amendments to and changes in the applicable federal and state laws and regulations, including, but not limited to, HIPAA and the HIPAA Rules. This Addendum shall not be waived or altered, in whole or in part, except in writing signed by the parties.

7.4 **Invalid Terms.** In the event that any provision of the terms and conditions are held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Addendum will remain in full force and effect.

7.5 **Transferability.** Covered Entity has entered into this Addendum in specific reliance on the expertise and qualifications of Business Associate. Consequently, Business Associate's interest under this Addendum may not be transferred or assigned or assumed by any other person, in whole or part, without the prior written consent of Covered Entity.

7.6 **Governing Law and Venue.** This Addendum shall be governed by, and interpreted in accordance with the laws of the State of Washington in accordance with HIPAA and the HIPAA Rules without giving effect to the conflict of laws provisions. Thurston County, Washington, shall be the sole and exclusive venue for any litigation, special proceeding or other proceeding as between the parties that may be brought under, or arise out of, this Addendum.

7.7 **No Third Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor anything herein shall confer, upon any person other than the parties hereto any rights, remedies, obligations or liabilities whatsoever.

7.8 **Binding Effect.** This Addendum shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective permitted successors and assigns.

7.9 **Execution.** This Addendum may be executed in multiple counterparts, each of which shall constitute an original, all of which shall constitute but one agreement.

7.10 **Gender and Number.** The use of the masculine, feminine or neuter genders, and the use of the singular and plural, shall not be given an effect of any exclusion or limitation herein. The use of the word "person" or "party" shall mean and include any individual, trust, corporation, partnership or other entity.

7.11 **Priority of Agreements.** If any portion of the Addendum is inconsistent with the terms of the Underlying Agreement, the terms of this Addendum shall prevail. Except as set forth above, the remaining provisions of the Underlying Agreement are ratified in their entirety.

7.12 **Survival.** The obligations of Business Associate shall survive the termination of this Addendum and the Underlying Agreement.

7.13 **Recitals.** The preamble to this Addendum is not a mere recital of facts, but consists of binding agreed upon statements that form the basis of this Addendum.

IN WITNESS WHEREOF, the parties hereto have signed this Addendum effective the day and year first above written.

BUSINESS ASSOCIATE:	**COVERED ENTITY:** **THURSTON COUNTY**
[signature] *Signature (Authorized Representative)* Philip H. Evans *Printed Name* CEO *Title* 3/3/15 *Date*	[signature] *Signature* Don Sloma *Printed Name* Director *Title* 3/17/15 *Date*

ATTACHMENT A
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

Thurston County is required by law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are required to notify you following a breach of your unsecured protected health information. We must follow the privacy practices that are described in this Notice currently in effect.

Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. We reserve the right to change our privacy practices and the terms of this Notice at any time. Changes will be available from the County office that provides your service. Any changes in our privacy practices and the new terms of our Notice will be effective for all protected health information that we maintain, including protected health information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your health information:

For treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. For example, if we refer you to a physician for a service that we cannot provide, your health information will be disclosed to that office.

For payment: We may use and disclose your health information to obtain payment for services we provide to you or to coordinate your medical benefits. For example, if an insurance company pays for your service, it may be necessary to disclose your health information to that company.

For healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To provide appointment reminders: We may disclose limited health information to provide you with appointment reminders such as voicemail messages, postcards, or letters.

To persons involved in your care: We may use or disclose health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, then we will provide you with an opportunity to object to such uses or disclosures before they are made. In the event of your incapacity or emergency circumstances, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

As required by law: We may disclose your health information when we are required to do so by federal, state or local law.

Business Associates: We may disclose health information to third party "business associates" who perform various activities involving your health information (e.g., claims payment or case management services) for the County. The County will implement written contracts to ensure the business associates will appropriately safeguard the information and to limit the use or disclosure of health information.

For public health activities: We may use and disclose medical information about you for public health activities, including to report births and deaths, and notify appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other crimes.

For public safety: We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

For health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law.

For judicial and administrative proceedings: We may disclose health information about you in response to a court or administrative order. We may disclose health information in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

For law enforcement purposes: We may disclose health information to law enforcement officials when certain conditions are met.

To coroners, medical examiners and funeral directors: We may disclose health information to coroners, medical examiners and funeral directors as authorized by law.

For workers' compensation: We may release health information about you for workers' compensation or similar programs.

For national security and similar government functions: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities.

To correctional institutions or law enforcement officials: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose information about you to the institution or official under certain circumstances.

For organ and tissue donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research protocol and determined that adequate safeguards exist to ensure the privacy of your health information.

With your authorization: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. Unless otherwise allowed by law, your written authorization is required before use or disclosure of psychotherapy notes or use or disclosure of protected health information for marketing purposes or disclosure for the sale of health information. (Thurston County does not market or sell health information in any event.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Specially Protected Types of Health Information: Some types of health information have greater protection under Washington State or federal laws. When required by law we will obtain your authorization before releasing HIV-related and sexually transmitted disease information that is protected by Washington State laws; alcohol and substance abuse treatment information that is protected under both Washington State and federal laws; and mental health treatment information that is protected under both Washington State and federal laws.

YOUR RIGHTS

Access: You have the right to look at and get copies of your protected health information, with limited exceptions. You may make your request for access to your medical records orally or in writing by using forms we provide or sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page plus postage if you want the copies mailed to you. We may deny your request in certain very limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed. Another licensed health care professional not directly involved in the decision to deny your request will review your request and the denial. We will abide by the outcome of the review.

Disclosure accounting: You have the right to receive a list of disclosures we or our business associates made of your protected health information for purposes other than treatment, payment, healthcare operations and certain other activities for a period of time up to six years prior to the date of the accounting request, but not including dates before April 14, 2003. You must make this request in writing to our Contact Officer. If you request this

accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for providing the list.

Request restrictions: You have the right to request that we restrict how we use or disclose your protected health information for treatment, payment, or health care operations or the disclosures we make to someone who is involved in your care or the payment for your care, such as a family member, other relative, or friend. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operations and the information you seek to restrict pertains solely to a health care item or service for which you have paid the health care provider out-of-pocket in full.

Confidential communication: You have the right to request that we communicate with you about your protected health information by alternative means or at alternative locations. You must make your request in writing to the Contact Officer and may use forms we provide. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must give a reason for your request. We may deny your request if you ask us to amend information that was not created by us, is not part of the information kept by the County, is not part of the information you would be permitted to inspect and copy, or is accurate and complete. Any denial will be in writing and state the reason for the denial.

Paper Copy: You have the right to get a paper copy of this Notice if you request it, even if you have agreed to receive the Notice electronically.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or if you disagree with a decision we made about use or disclosure of your protected health information, you may complain to us using the contact information listed here. You also may submit a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Contact Officer: Tammy Devlin
Telephone: (360)786-5498
E-mail: devlint@co.thurston.wa.us
Address: 929 Lakeridge Drive SW, Building 4, Room 202
Olympia, WA 98502

Attachment 12

Attachment 12: BHR Acute Services.2015

Thurston Mason Regional Support Network Contract on General Terms and Conditions

<table>
<tr><td colspan="5">These General Terms and Conditions are entered into in duplicate originals between Thurston County by and through Thurston Mason Regional Support Network, hereinafter “TMRSN” and Behavioral Health Resources hereinafter “CONTRACTOR.” These General Terms and Conditions govern work to be performed under any TMRSN Program Contract between the parties, and supersede and replace any previously executed general terms and conditions as of the start date below.</td></tr>
<tr><td colspan="2">Thurston Mason RSN Contact:</td><td colspan="3">Kristy Lysell, Provider Network Coordinator</td></tr>
<tr><td>Address:</td><td colspan="4">412 Lilly Road NE Olympia WA 98506</td></tr>
<tr><td>Contact Information:</td><td>Phone:
360.867.2560</td><td colspan="3">Email:
lysellk@co.thurston.wa.us</td></tr>
<tr><td>Contractor:</td><td>Behavioral Health Resources</td><td>Contact:</td><td colspan="2">John Masterson, CEO</td></tr>
<tr><td>Address:</td><td colspan="4">3857 Martin Way East Olympia WA 98506</td></tr>
<tr><td>Contact Information:</td><td>Phone:
360.704.7170</td><td colspan="3">Email:
jmasterson@bhr.org</td></tr>
<tr><td colspan="5">The term of this Contract on General Terms and Conditions shall start and end on the following dates, unless terminated sooner as provided herein.</td></tr>
<tr><td colspan="2">Contract Start Date: January 01, 2012</td><td colspan="3">Contract End Date: June 30, 2017</td></tr>
<tr><td colspan="5">By their signatures below, the parties hereto agree to these General Terms and Conditions. FURTHER, THE PARTIES HEREBY SPECIFICALLY ACKNOWLEDGE THAT BY SIGNING THESE GENERAL TERMS AND CONDITIONS THE PARTIES HAVE MUTUALLY NEGOTIATED THE WAIVER PROVISION SET OUT IN SECTION 20.2 The individual signing below warrants that he/she has the authority to execute these General Terms and Conditions on behalf of the CONTRACTOR.</td></tr>
<tr><td colspan="2">Contractor Signature:</td><td colspan="2">Printed Name and Tile:
John Masterson, CEO</td><td>Date:</td></tr>
<tr><td colspan="2">Thurston County Signature:</td><td colspan="2">Printed Name and Title:
Sherri McDonald, Director</td><td>Date:</td></tr>
<tr><td colspan="2">Approved as to Form:</td><td colspan="3">Jon Tunheim Prosecuting Attorney:
By: Catherine Galvin, Deputy Prosecuting Attorney</td></tr>
</table>

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1. **DEFINITIONS –** The words and phrases listed below, as used in this Contract, shall each have the following definitions:

1.1. **CFR** means Code of Federal Regulations. All references in this Contract to CFR chapters or sections shall include any successor, amended, or replacement regulation. The CFR may be accessed at http://www.gpoaccess.gov/cfr/index.html

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

1.3. **Contract** means this Thurston Mason Regional Support Network Contract on General Terms and Conditions and Program Contracts Statement of Work, including any exhibits and other documents attached or incorporated by reference.

1.4. **CONTRACTOR** means the CONTRACTOR named above, its employees, agents and Subcontractors performing services pursuant to this Contract.

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

1.6. **DSHS or the department or the Department** means the Department of Social and Health Services of the State of Washington and its Secretary, officers, employees, and authorized agents.

1.7. **General Terms and Conditions** means the contractual provisions contained within this Thurston Mason Regional Support Network Contract on General Terms and Conditions, which govern the contractual relationship between TMRSN and the CONTRACTOR, under the Program Contracts subsidiary to and incorporating therein by reference this Thurston Mason Regional Support Network Contract on General Terms and Conditions

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

1.9. **Program Contract** means a written contract between TMRSN and the CONTRACTOR including a statement of work to be performed by the CONTRACTOR and payment to be made by TMRSN.

1.10. **RCW** means the Revised Code of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. The RCW may be accessed at http://apps.leg.**wa.gov/rcw.**

1.11. **RSN** means the Regional Support Network designated by the county authority, group of county authorities or nonprofit entity recognized by the secretary of DSHS, and has authority to establish and operate a community mental health program.

1.12. **Shall** indicates that which is mandatory.

1.13. **Subcontract** means a separate contract between the CONTRACTOR and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the CONTRACTOR shall perform pursuant to this Contract.

1.14. **Subcontractor** means any person, partnership, corporation, association or organization, not in the employment of TMRSN or the CONTRACTOR, who is performing any part of this Contract under separate contract with the CONTRACTOR. The term "subcontractor(s)" mean subcontractor(s) in any tier.

1.15. **Subrecipient** means any person, government department, agency, or establishment that receives

federal financial assistance through the State to carry out a program for which it is accountable through an agreement, contract, subcontract, or award.

1.16. **TMRSN** means Thurston Mason Regional Support Network.

1.17. **USC** means United States Code. All references to USC chapters or sections in this Contract shall include any successor, amended, or replacement statute. The USC may be accessed at http://www.gpoaccess.gov/uscode/

1.18. **WAC** means the Washington Administrative Code. All references to WAC chapters or sections in this Contract shall include any successor, amended, or replacement regulation. The WAC may be accessed at http://apps.leg.wa.gov/wac.

2. RECAPTURE PROVISIONS

2.1. In the event that the CONTRACTOR fails to comply with any of the terms and conditions of this Contract and that failure results in an overpayment, or CONTRACTOR fails to expend funds under this Contract in accordance with state and federal laws and/or provisions of this Contract, TMRSN reserves the right to recapture funds in an amount equivalent to the overpayment or extent of the noncompliance. Such right of recapture shall exist for a period not to exceed three (3) years following Contract termination or Contract completion. Repayment by the CONTRACTOR of funds under this recapture provision shall occur within 30 calendar days of demand. If repayment is not made within the specified time frame, TMRSN may secure repayment, plus interest, if any, utilizing available remedies.

3. COMPLIANCE WITH APPLICABLE LAW & TMRSN PRACTICES

3.1. The CONTRACTOR shall comply with all applicable local, State, and federal laws, rules, regulations, and ordinances, including but not limited to nondiscrimination laws, rules, and regulations, all as now existing or as later adopted or amended. The CONTRACTOR shall also comply with Title XIX and Title XXI of the Social Security Act and Title 42 of the CFR regardless of whether a specific citation is identified in various sections of this Contract.

3.2. The CONTRACTOR shall comply with applicable federal, State and local professional and facility licensing and accreditation requirements/standards that apply to services performed under this Contract regardless of whether a specific citation is identified in various sections of this Contract.

3.3. The CONTRACTOR shall comply with these General Terms and Conditions, the Program Contract Statement of Work, Exhibits, Attachments, TMRSN and/or the Department Reporting Guidelines, TMRSN Data Dictionary, TMRSN Policies and Procedures, TMRSN Protocols, TMRSN and/or the Department required forms and policies, and any other documents attached hereto or incorporated herein by reference.

3.4. The CONTRACTOR shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC § 1320(d) et.seq., and all applicable regulations contained in 45 CFR parts 160, 162, 164 issued by the U.S. Department of Health and Human Services, as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5). The CONTRACTOR shall enter into a Business Associate Addendum with TMRSN if TMRSN determines that the CONTRACTOR will be acting as a Business Associate as defined under HIPAA.

3.5. The CONTRACTOR shall have policies, procedures, and practices that ensure a drug free workplace.

3.6. The CONTRACTOR shall comply with the Americans with Disabilities Act. The

CONTRACTOR shall provide reasonable accommodations for individuals with disabilities in accordance with the Americans with Disabilities Act for all covered services and will assure that physical and communication barriers will not inhibit individuals with disabilities from obtaining covered services.

4. DEBARMENT CERTIFICATION

4.1. The CONTRACTOR, by signature to this General Terms and Conditions, certifies that the CONTRACTOR is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Contract by any Federal department or agency. The CONTRACTOR also agrees to include the above requirement in all Subcontracts entered into.

4.2. The CONTRACTOR shall ensure that it neither employs any person nor contracts with any person or entity excluded from participation in federal health care programs under either 42 U.S.C.§1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Contract.

5. PROFESSIONAL CREDENTIALING

5.1. The CONTRACTOR must have a formal agency process to credential Mental Health Professionals and Mental Health Specialists, per WAC 388-865-0150, and written policies and procedures that require ongoing monitoring of individual provider credentials.

5.2. The CONTRACTOR shall require a criminal history background check through the Washington State Patrol for all employees, including contracted employees, interns, and volunteers. The CONTRACTOR will also require a similar criminal history background check of all Subcontractors.

6. PHYSICIAN INCENTIVE PLANS

6.1. The CONTRACTOR shall not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) contract with any Subcontractor operating such a plan.

7. EXCLUDED PROVIDERS

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

7.2. The CONTRACTOR shall screen potential employees through the OIG Excluded Provider Database prior to employment. If the individual is determined to be an excluded individual, the CONTRACTOR may not hire that individual to provide services under this Contract.

7.3. The CONTRACTOR shall monitor employees and individuals at a minimum of once a year through the OIG Excluded Provider Database. If an employee is found to be on the excluded provider list, the CONTRACTOR must notify TMRSN within five (5) business days. The CONTRACTOR will immediately terminate any employment, contractual, and control relationships with an excluded individual and entity that it discovers.

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

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

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

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

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

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

8. SUBCONTRACTING

8.1. The obligations and duties of the CONTRACTOR under this Contract shall not be subcontracted without the prior written consent of TMRSN.

8.2. All Subcontracts must be in writing and specify all duties, responsibilities and reports that are appropriate to the service or activity delegated under the Subcontract and require compliance with all applicable local, State and federal laws, rules and regulations. No Subcontract terminates the legal responsibility of the CONTRACTOR to TMRSN to perform the terms of this Contract. The CONTRACTOR shall be responsible for the acts and omissions of any Subcontractor, and the CONTRACTOR is responsible for all contractual obligations, financial or otherwise, to its Subcontractors. TMRSN has no contractual obligations to any Subcontractor under contract to the CONTRACTOR. Subcontractors must abide by the requirements of Section 1128A(b) of the Social Security Act prohibiting RSN'S and other providers from making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to recipients.

8.3. In accordance with Medicaid being the payer of last resort, Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Contract.

8.4. The Contractor must make available upon request copies of all Subcontracts and/or Subcontract amendments to TMRSN.

8.5. The CONTRACTOR shall not assign all or any portion of this Contract to a third party.

9. CONFIDENTIALITY

9.1. The CONTRACTOR shall protect all Personal Information, records and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307; RCWs chapters 70.02, 71.05 and 71.34; and, for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW chapter 70.96A. The CONTRACTOR shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services.

9.2. The CONTRACTOR shall comply with all confidentiality requirements of HIPAA under 45 CFR Parts 160-164 and confidentiality requirements under 42 CFR Parts 438.

9.3. Confidential Information collected, used or acquired in connection with this Contract shall be used solely for the purpose of this Contract. The CONTRACTOR shall not release, disclose, publish, transfer, sell or otherwise make known any such information to any other party, except: as provided by law; or, in the case of Personal Information, as provided by law or with the prior written consent of the person or personal representative of the person who is the subject of the Personal Information.

9.4. The CONTRACTOR shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss. This duty requires the CONTRACTOR to employ reasonable security measures, which include restricting access to the Confidential Information by: (a) allowing access only to staff that have an authorized business requirement to view the Confidential Information; and (b) physically securing any computers, documents, or other media containing the Confidential Information.

9.5. To the extent allowed by law, when the Contract term has ended or the Contract terminated, or when Confidential Information is no longer needed, the CONTRACTOR shall return the Confidential Information or certify in writing the destruction of Confidential Information upon written request by TMRSN.

9.6. The CONTRACTOR shall obtain written consent from an individual prior to the use of the individual's picture(s) or personal story.

9.7. The CONTRACTOR agrees to implement physical, electronic and managerial safeguards to prevent unauthorized access to Personal Information. TMRSN reserves the right to monitor, audit, or investigate the use of Personal Information collected, used or acquired by the CONTRACTOR through this Contract.

9.8. Paper documents with Confidential Information may be recycled through a contracted firm, provided the contract with the recycler specifies that the confidentiality of information will be protected, and the information destroyed through the recycling process. Paper documents with Confidential Information must be destroyed through shredding, pulping, or incineration.

9.9. The compromise or potential compromise of Confidential Information must be reported to TMRSN within three (3) business days of discovery for breaches of less than 500 persons' protected data, and within one (1) business day of discovery for breaches of over 500 persons' protected data. The parties must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law.

9.10. Any breach of this Section may result in termination of the Contract and the demand for return of all records in connection with this Contract. The CONTRACTOR agrees to indemnify and hold harmless Thurston County, Mason County, and TMRSN for any damages related to the CONTRACTOR's unauthorized use or disclosure of Confidential Information.

9.11. The provisions of this Section shall be included in any CONTRACTOR's Subcontract relating to the services provided under this Contract.

10. FRAUD AND ABUSE

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

10.1.1. Create and maintain a mandatory compliance plan that includes provisions to educate CONTRACTOR employees of the false claim act and whistle blower protections.

10.1.2. Develop written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable federal and State standards.

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

10.1.4. Provide effective ongoing training and education for the compliance officer, CONTRACTOR's employees, interns, volunteers, contracted employees, and any Subcontractors.

10.1.5. Facilitate effective communication between the compliance officer and the CONTRACTOR's employees, interns, volunteers, contracted employees, and any Subcontractors.

10.1.6. Enforce standards through well-publicized disciplinary guidelines.

10.1.7. Conduct self internal monitoring and auditing.

10.1.8. Respond promptly to detected offenses and develop corrective action initiatives.

10.1.9. Report fraud and/or abuse information to TMRSN as soon as it is discovered to include the source of the complaint, the involved individual, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

11. FUTURE SUPPORT

11.1. The TMRSN makes no commitment to future support and assumes no obligation for future support of the services contracted for, except as expressly set forth in this Contract.

12. RELATIONSHIP OF PARTIES

12.1. The parties intend that an independent contractor relationship between the CONTRACTOR and TMRSN shall be created by this Contract. The TMRSN is interested primarily in the results to be achieved. The conduct, control and implementation of services shall lie solely with the CONTRACTOR. No official, officer, agent, employee, servant or representative of the CONTRACTOR shall be or deem to be or act or purport to act as an official, officer, agent, employee, servant, or representative of Thurston County or TMRSN for any purpose, and the employees of the CONTRACTOR are not entitled to any of the benefits Thurston County provides for Thurston County employees. The CONTRACTOR shall indemnify and hold harmless Thurston County and TMRSN from all obligations to pay or withhold federal or state taxes or contributions on behalf of the CONTRACTOR or the CONTRACTOR's employees. The CONTRACTOR shall be solely and entirely responsible for its acts and for the acts of its officials, officers, agents, employees, servants, representatives, Subcontractors, or otherwise during the performance of this Contract.

12.2. The results of the work contemplated herein must meet the approval of TMRSN and shall be subject to TMRSN's general rights of inspection and review to secure the satisfactory completion thereof.

12.3. In the event that any of the CONTRACTOR's officials, officers, agents, employees, servants, representatives, Subcontractors, or otherwise, carry on activities or conduct themselves in any manner which may jeopardize the funding of this Contract, the CONTRACTOR shall be responsible for taking adequate measures to prevent said officials, officers, agents, employees, servants, representatives or Subcontractors from performing or providing any of the services contained in this Contract.

12.4. The Contractor and any Subcontractors must comply with 42-USC §1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or an employee, Subcontractor, or consultant who is significant or material to the provision of services under this Contract, who has been, or is affiliated with someone who has been debarred, suspended, or otherwise excluded by any federal agency.

13. POLITICAL ACTIVITY PROHIBITED

13.1. None of the funds, materials, property or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office.

14. INSPECTION; MAINTENANCE AND RETENTION OF RECORDS

14.1. The CONTRACTOR shall provide access to its records and place of business during the term of this Contract and for one (1) year following termination or expiration of this Contract for the purposes of monitoring, auditing, and evaluating CONTRACTOR's compliance with this Contract, and compliance with applicable State and federal laws, rules, and regulations as existing now or as later amended. CONTRACTOR shall allow access to its records and place of business to DSHS, the Department of Health and Human Services, External Quality Review Office, Centers for Medicare & Medicaid Services, the Comptroller, the Office of the State Auditor, and TMRSN or their authorized representatives. The CONTRACTOR and its Subcontractors shall cooperate in all reviews, including but not limited to, financial audits, contract monitoring, surveys, and research. Evaluations shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services performed under this Contract and to determine whether the CONTRACTOR and its Subcontractors are providing service to individuals in accordance with the requirements set forth in this Contract and applicable State and federal laws, rules, and regulations.

14.2. During the term of this Contract and for six (6) years following expiration or termination of this Contract, the CONTRACTOR shall retain all books, records, documents, and other material relevant to this Contract. All hospitals, clinics, or nursing facilities shall retain those records as prescribed in chapters 70.41 and 18.51 RCW. If any audit, claim, litigation, or other legal action involving this Contract is started before the expiration of the six (6) year period or the period set out in chapters 70.41 and 18.51 RCW (retention period), the records shall be retained until completion and resolution of all issues arising therefrom or until the end of the retention period, whichever is later.

14.3. The CONTRACTOR shall maintain books, records, documents and other material relevant to this Contract which sufficiently and properly reflects all direct and indirect costs expended in the performance of the services described herein and the performance of all acts required by the Contract and applicable laws, rules, and regulations. The CONTRACTOR shall maintain the content of all medical records in a manner consistent with utilization of control requirements of 42 CFR §456, 42 CFR §434.34 (a), 42 CFR §456.111, and 42 CFR §456.211. The CONTRACTOR shall maintain books, records, documents, and other materials relevant to this Contract which sufficiently and properly reflects all payments made, TMRSN rate setting activities related to the CONTRACTOR, or other actions taken in regard to the CONTRACTOR's performance of the services described in the Program Contracts.

14.4. Records will enable identification of all federal funds received and expended by Catalog of Federal Domestic Assistance Number (CFDA#), federal program, award number and year, name of federal, state and pass-through agency. Records will meet the requirements of OMB Circular A-102 Grants and Cooperative Contracts with state and local Governments, and also OMB Circular A-110 Uniform Administrative Requirements for Grants and Contracts with institutions of higher education, hospitals and other non-profit organizations.

14.5. The CONTRACTOR will include in their financial statements a schedule of expenditures of all federal awards. The schedule will include the name of the federal agency, the pass-through entity, the CFDA#, any other identification number, the amount of expenditures for the program, identification of any major programs, and any notes that pertain to the significant accounting policies used to account for the federal programs.

14.6. The CONTRACTOR's financial statements will also include a schedule of prior audit findings,

along with any corrective action taken or any corrective action planned with the anticipated completion date.

14.7. The provisions of this Section shall be included in any CONTRACTOR's Subcontracts relating to the services provided under this Contract.

15. SINGLE AUDIT ACT

15.1. If the CONTRACTOR is a Subrecipient and expends $500,000 or more in federal awards from all funding sources in any fiscal year, the CONTRACTOR shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the CONTRACTOR shall:

15.1.1. Submit to the TMRSN contact person, listed on the first page of this Contract, the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor. For purposes of "Subrecipient" status under the rules of OMB Circular A-133 205(i) Medicaid payments to a Subrecipient for providing patient care services to Medicaid eligible individuals are not considered federal awards expended under this part of the rule unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis; and

15.1.2. Follow-up and develop corrective action for all audit findings, in accordance with OMB Circular A-133, and prepare a "Summary Schedule of Prior Audit Findings."

16. SUBRECIPIENTS

16.1. If the CONTRACTOR is a Subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Contract, the CONTRACTOR shall:

16.1.1. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity;

16.1.2. Maintain internal controls that provide reasonable assurance that the CONTRACTOR is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant contracts that could have a material effect on each of its federal programs;

16.1.3. Prepare appropriate financial statements, including a schedule of expenditures of federal awards;

16.1.4. Incorporate OMB Circular A-133 audit requirements into all contracts between the CONTRACTOR and its Subcontractors who are Subrecipients;

16.1.5. Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation;

16.1.6. Comply with the applicable requirements of either 2 CFR Part 225 (OMB Circular A-87) or 2 CFR Part 230 (OMB Circular A-122), any future amendments, and any successor or replacement Circular or regulation; and

16.1.7. Comply with the Omnibus Crime Control and Safe streets Act of 1968, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and The Department of Justice Non-Discrimination Regulations at 28 CFR Part 42, Subparts C, D, E, and G, and 28 CFR

Parts 35 and 39. (See http://www.ojp.usdoj.gov/about/offices/ocr.htm for additional information and access to the aforementioned federal laws and regulations.)

17. TITLE TO PROPERTY

17.1. Except as otherwise provided in this Contract, title to all property purchased or furnished by TMRSN for use by the CONTRACTOR during the term of this Contract shall remain with TMRSN. Title to all property purchased or furnished by the CONTRACTOR for which the CONTRACTOR is entitled to reimbursement by TMRSN under this Contract shall pass to and vest in TMRSN. The term "reimbursement" as used in this paragraph means and is limited to reimbursement made by TMRSN to CONTRACTOR under cost-reimbursement program contracts in effect between TMRSN and CONTRACTOR during the term hereof; "reimbursement" as used in this paragraph does not mean and does not include compensation received or to be received by CONTRACTOR under fee-for-service (FFS) contracts in effect between TMRSN and CONTRACTOR during the term hereof, including without limitation the FFS components of any State or Medicaid funded Program Contracts in effect between TMRSN and CONTRACTOR during the term hereof. The CONTRACTOR shall take reasonable steps to protect and maintain all TMRSN property in its possession against loss or damage and shall return TMRSN property to TMRSN upon Contract termination or expiration, reasonable wear and tear excepted.

18. TREATMENT OF CLIENT PROPERTY

18.1. Except as otherwise provided by court order or this Contract, the CONTRACTOR shall ensure that any adult client for whom the CONTRACTOR is providing services under this Contract shall have unrestricted access to the client's personal property. The CONTRACTOR shall not interfere with any adult client's ownership, possession, or use of the client's personal property. The CONTRACTOR shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination or completion of this Contract, the CONTRACTOR shall promptly release to the client and/or the client's guardian or custodian the entire client's personal property. This Section does not prohibit the CONTRACTOR from implementing such lawful and reasonable policies, procedures and practices as the CONTRACTOR deems necessary for safe, appropriate, and effective service delivery.

19. NONDISCRIMINATION

19.1. The CONTRACTOR or its Subcontractors shall not discriminate against any employee in the performance of any of its obligations hereunder on the basis of race, color, creed, religion, national origin, ethnicity, age, sex, marital status, veteran or military status, sexual orientation, or the presence of any disability.

19.2. The CONTRACTOR or its Subcontractors shall not on the basis of race, color, creed, religion, national origin, ethnicity, age, sex, marital status, veteran or military status, sexual orientation, or the presence of any disability:

19.2.1. Deny an individual any services or other benefits provided under this Contract;

19.2.2. Provide any service(s) or other benefits to an individual which are different, or are provided in a different manner from those provided to others under this Contract;

19.2.3. Subject an individual to segregation or separate treatment in any manner related to his or her receipt of any service(s) or other benefits provided under this Contract; or

19.2.4. Deny any individual an opportunity to participate in any program provided by this Contract through the provision of services or otherwise or afford an opportunity to do so which is different from that afforded others under this Contract.

19.3. If subcontracting has been authorized, said Subcontract shall include appropriate safeguards against discrimination in client services binding upon each Subcontractor. The CONTRACTOR shall take such action as may be required to ensure full compliance with the provisions of this Section.

20. HOLD HARMLESS AND INDEMNIFICATION

20.1. The CONTRACTOR shall hold harmless, indemnify and defend THURSTON COUNTY, MASON COUNTY, TMRSN, its officers, officials, employees and agents, from and against any and all claims, actions, suits, liability, losses, expenses, damages, and judgments of any nature whatsoever, including costs and attorneys fees in defense thereof, for injury, sickness, disability or death to persons or damage to property or business, caused by or arising out of the CONTRACTOR'S acts, errors or omissions or the acts, errors or omissions of its employees, agents, Subcontractors or anyone for whose acts any of them may be liable, in the performance of this Contract. PROVIDED HOWEVER, that the CONTRACTOR'S obligations hereunder shall not extend to injury, sickness, disability, death or damage caused by or arising out of the sole negligence of THURSTON COUNTY, MASON COUNTY, TMRSN, its officers, officials, employees or agents. PROVIDED FURTHER, that in the event of the concurrent negligence of the parties, the CONTRACTOR'S obligations hereunder shall apply only to the percentage of fault attributable to the CONTRACTOR, its employees, agents or Subcontractors. Claims shall include, but not be limited to, assertions that information supplied or used by the CONTRACTOR or Subcontractor infringes any patent, copyright, trademark, trade name, or otherwise results in an unfair trade practice.

20.2. In any and all claims against THURSTON COUNTY, MASON COUNTY, TMRSN, its officers, officials, employees and agents by any employee of the CONTRACTOR, Subcontractor, anyone directly or indirectly employed by any of them, or anyone for whose acts any of them may be liable, the indemnification obligation under this Section shall not be limited in any way by any limitation on the amount or type of damages, compensation, or benefits payable by or for the CONTRACTOR or Subcontractor under Worker's Compensation acts, disability benefits acts, or other employee benefits acts, it being clearly agreed and understood by the parties hereto that the CONTRACTOR expressly waives any immunity the CONTRACTOR might have had under Title 51 RCW. By executing the Contract, the CONTRACTOR acknowledges that the foregoing waiver has been mutually negotiated by the parties and that the provisions of this Section shall be incorporated, as relevant, into any contract the CONTRACTOR makes with any Subcontractor or agent performing work hereunder.

20.3. The CONTRACTOR'S obligations hereunder shall include, but are not limited to, investigating, adjusting and defending all claims alleging loss from action, error or omission, or breach of any common law, statutory or other delegated duty by the CONTRACTOR, the CONTRACTOR'S employees, agents or Subcontractors.

21. INSURANCE

21.1. **Professional Legal Liability:** The CONTRACTOR, if a licensed professional, shall maintain Professional Legal Liability or Professional Errors and Omissions coverage appropriate to the CONTRACTOR's profession and shall be written subject to limits of not less than $2,000,000 per loss and a $5,000,000 aggregate.

21.2. The coverage shall apply to liability for a professional error, act or omission arising out of the scope of the CONTRACTOR's services defined in this Contract. Coverage shall not exclude bodily injury or property damage. Coverage shall not exclude hazards related to the work rendered as part of the Contract or within the scope of the CONTRACTOR's services as defined by this Contract including testing, monitoring, measuring operations, or laboratory analysis where such services are rendered as part of the Contract.

21.3. Workers' Compensation (Industrial Insurance): The CONTRACTOR shall maintain workers' compensation insurance as required by Title 51 RCW, and shall provide evidence of coverage to the Thurston County Risk Management Division.

21.4. The CONTRACTOR shall send to Thurston County at the end of each quarter written verification that premium has been paid to the Washington State Department of Labor and industries for Industrial Insurance coverage. Alternatively, the CONTRACTOR shall provide certification of approval by Washington State Department of Labor and Industries if self-insured for Workers Compensation.

21.5. **Commercial General Liability:** The CONTRACTOR shall maintain Commercial General Liability coverage for bodily injury, personal injury and property damage, subject to limits of not less than $1,000,000 per loss. The general aggregate limit shall apply separately to this Contract and be no less than $3,000,000.

21.6. The CONTRACTOR will provide Commercial General Liability coverage that does not exclude any activity to be performed in fulfillment of this Contract. Specialized forms specific to the industry of the CONTRACTOR will be deemed equivalent, provided coverage is no more restrictive than would be provided under a standard Commercial General Liability policy, including contractual liability coverage.

21.7. The CONTRACTOR shall secure employers' liability coverage with limits not less than $100,000 as part of their CGL policy or separately.

21.8. **Automobile Liability:** The CONTRACTOR shall maintain automobile liability insurance as follows:

21.8.1. The CONTRACTOR shall maintain Business Automobile Liability Insurance with a limit of not less than $1,000,000 each accident combined Bodily Injury and Property Damages. Coverage shall include owned, hired and non-owned automobiles.

21.9. **Other Insurance Provisions:**

21.9.1. The CONTRACTOR's liability insurance provisions shall be primary with respect to any insurance or self-insurance programs covering Thurston County, its elected and appointed officers, officials, employees and agents.

21.9.2. Where such coverage is required, the CONTRACTOR's Commercial General Liability insurance shall include Thurston County, its officers, officials, employees and agents with respect to performance of services.

21.9.3. Where such coverage is required, the CONTRACTOR's Commercial General Liability insurance shall contain no special limitations on the scope of protection afforded to Thurston County as additional insured.

21.9.4. Any failure to comply with reporting provisions of the policies shall not affect coverage provided to Thurston County, its officers, officials, employees or agents.

21.9.5. The CONTRACTOR's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

21.9.6. The CONTRACTOR shall include all Subcontractors as insured under its policies or shall furnish separate certificates and endorsements for each Subcontractor. All coverage for Subcontractors shall be subject to all of the requirements stated herein.

21.9.7. The insurance limits mandated for any insurance coverage, required by this Contract, are not intended to be an indication of exposure nor are they limitations on indemnification.

21.9.8. The CONTRACTOR shall maintain all required policies in force from the time services commence until services are completed. Certificates, policies, and endorsements expiring before completion of services shall be promptly replaced. If the CONTRACTOR's liability coverage is written as a claim made policy, then the CONTRACTOR must evidence the purchase of an extended reporting period or "tail" coverage for a three (3) year period after project completion.

21.9.9. Verification of Coverage and Acceptability of Insurers: The CONTRACTOR shall 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 minus 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.

21.9.10. The CONTRACTOR shall furnish Thurston County with properly executed Certificates of Insurance or a signed policy endorsement which shall clearly evidence all insurance required in this Section 22 prior to commencement of services. The certificates will, at a minimum, list limits of liability and coverage. The certificate will provide that the underlying insurance contract will not be canceled, allowed to expire, or be materially reduced in coverage except on 30 days prior written notice to Thurston County.

21.9.11. The CONTRACTOR shall furnish Thurston County with evidence that the additional insured provision required above is been met. Acceptable form of evidence is the endorsement page(s) of the policy showing Thurston County as an additional insured.

21.9.12. Written notice of cancellation or change shall be mailed to Thurston County at the following address:

Thurston County Public Health & Social Services
Attn: Kristy Lysell
412 Lilly Road NE
Olympia, WA 98506-5132

21.9.13. The CONTRACTOR or its broker shall provide a copy of any, and all insurance policies specified in this Contract upon request of the Thurston County Risk Management Division.

22. AMENDMENTS AND CHANGES IN WORK

22.1. In the event of any errors or omissions by the CONTRACTOR in the performance of any work required under this Contract, the CONTRACTOR shall make any and all necessary corrections without additional compensation. All work submitted by the CONTRACTOR shall be certified by the CONTRACTOR and checked for errors and omissions. The CONTRACTOR shall be responsible for the accuracy of the work, even if the work is accepted by TMRSN.

22.2. No amendment, modification or renewal shall be made to this Contract unless set forth in a written amendment to the General Terms and Conditions and/or Program Contract and signed by an authorized representative of each of the parties hereto. Work under a Program Contract amendment shall not proceed until the Program Contract amendment is duly executed on or before the start date by TMRSN.

22.3. The Contractor shall not make any changes to service delivery requirements under any Program Contract due to changes in federal or State law, rules or regulations applicable to said service delivery without TMRSN approval.

22.4. TMRSN may withhold the CONTRACTOR'S payment in part or whole, if there is a delay in the

timely execution of Program Contracts and/or Program Contract amendments.

23. DISPUTES

23.1. Differences between the CONTRACTOR and TMRSN, arising under and by virtue of this Contract, shall be brought to the attention of TMRSN at the earliest possible time in order that such matters may be settled or other appropriate action promptly taken. Any dispute relating to the quality or acceptability of performance and/or compensation due the CONTRACTOR shall be submitted to the appropriate TMRSN staff, representative, or designee. If the dispute cannot be resolved by CONTRACTOR and TMRSN's staff representative informally, then all entities have access to TMRSN formal dispute resolution process as follows:

23.1.1. The CONTRACTOR and TMRSN shall attempt to resolve the dispute through informal means between the CONTRACTOR and TMRSN.

23.1.2. If the CONTRACTOR is not satisfied with the outcome, the CONTRACTOR may submit the disputed issue, in writing to TMRSN Administrator Thurston County Public Health and Social Services, 412 Lilly Rd NE, Olympia, WA 98506, to be reviewed. The written submission must contain the following information:

23.1.2.1. The CONTRACTOR's Contact for the issue.

23.1.2.2. The Issue in dispute.

23.1.2.3. The CONTRACTOR's position on the issue.

23.2. The Administrator may request additional information from the CONTRACTOR. The Administrator shall issue a written review decision to the CONTRACTOR within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the CONTRACTOR.

23.3. If the CONTRACTOR disagrees with the written review decision of the Administrator, the CONTRACTOR may request the Public Health and Social Services Director to review all information supplied by both parties up to that point. The Public Health and Social Services Director may request any additional information necessary to make the final decision for TMRSN. Timelines for production of any such additional information will be clearly marked within the request. The Public Health and Social Services Director shall issue a final written decision to the CONTRACTOR within thirty (30) calendar days of receipt of all requested information.

23.4. Both parties agree to make their best efforts to resolve disputes arising under this Contract and agree that this dispute resolution process is the sole and final administrative relief available to the parties and shall precede any judicial action.

24. TERMINATION

24.1. This Contract may be terminated in whole or in part as follows:

24.1.1. **Termination for Convenience**

24.1.1.1. Except as otherwise provided in this Contract, either party may terminate any Program Contract for convenience upon thirty (30) calendar days written notification by certified mail to the other party as listed on the first page of the General Terms and Conditions. The effective date of termination shall be the 30th day after receipt of written notification to the other party or the last day of a calendar month in which the 30th day occurs, whichever is later.

24.1.2. **Termination for Default**

24.1.2.1. TMRSN may terminate this Contract for default in whole or in part, without limiting remedies, by written notice to the CONTRACTOR if TMRSN has a reasonable basis to believe that the CONTRACTOR has:

24.1.2.1.1. Failed to perform under any provision of this Contract;

24.1.2.1.2. Failed to take satisfactory action as directed by TMRSN or its authorized representative within the time specified by the same;

24.1.2.1.3. Failed to satisfactorily substantiate its compliance with the terms and conditions of this Contract within the time specified by TMRSN or its authorized representative;

24.1.2.1.4. Violated any law, regulation, rule or ordinance applicable to this Contract; and/or

24.1.2.1.5. Otherwise breached any provision or condition of this Contract.

24.1.2.2. If this Contract is terminated for default, TMRSN may withhold a sum from the final payment to the CONTRACTOR that TMRSN determines necessary to protect TMRSN against loss or additional liability.

24.1.2.3. If, subsequent to termination, it is determined for any reason that (1) the CONTRACTOR was not in default, or (2) the CONTRACTOR's failure to perform was not its fault or its Subcontractor's fault or negligence, the termination shall be deemed to be a "termination for convenience."

24.1.3. **Termination Due to Change in Funding**

24.1.3.1.1. Notwithstanding any other termination provisions of this Contract, in the event funding from State, federal, or other sources upon which TMRSN relied to establish any Program Contract is withdrawn, reduced, or limited in any way, or if additional or modified conditions are placed on such funding, TMRSN may terminate that Program Contract by providing at least fifteen (15) calendar days written notice to the CONTRACTOR. The termination shall be effective on the date specified in the notice of termination.

24.1.4. **Termination of Regional Support Networks**

24.1.4.1. In the event that TMRSN becomes a nonparticipating RSN or in the event that the Department terminates or does not renew its contract with TMRSN, TMRSN may terminate this Contract by providing at least 60 days written notice to the CONTRACTOR. In this event, the Termination Procedure of the General Terms and Conditions shall be followed.

24.1.5. **Termination Procedure**

24.1.5.1. The following provisions shall survive and be binding on the parties in

the event this General Terms and Conditions and/or Program Contract is terminated in whole or in part:

24.1.5.1.1. Each party shall be responsible only for its performance in accordance with the terms of this Contract rendered prior to the effective date of termination. The CONTRACTOR shall assist in the orderly transfer/transition of the service recipients served under this Contract. The CONTRACTOR shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

24.1.5.1.2. The CONTRACTOR shall cease to perform any services required by the Contract as of the effective date of termination and shall comply with all of the instructions contained in the notice of termination.

24.1.5.1.3. The TMRSN shall be responsible for payment only for those services authorized and provided in accordance with the terms of this Contract rendered up to the effective date of termination. TMRSN shall withhold 20% of the final payment under this Contract until all final Contract deliverables, reports, client data, and any mutual transition plans under this General Terms & Conditions and/or Program Contracts are received and accepted by TMRSN.

24.1.5.1.4. The CONTRACTOR shall submit, within thirty (30) calendar days after the effective date of termination of this Contract, all financial, performance, and other reports required by this Contract.

24.1.5.1.5. Should this Contract be terminated in part, the CONTRACTOR shall complete performance of such part of the work not terminated.

24.1.5.1.6. The rights and remedies of TMRSN provided in this Section are in addition to any other rights and remedies available at law, in equity, or under this Contract.

25. TERMINATION OF DEPARTMENT CONTRACT

25.1. In the event that TMRSN's contract with the Department is terminated in whole or in part due to the CONTRACTOR's breach of its duties as set out in this Contract, the CONTRACTOR shall be liable for any charges TMRSN incurs from the Department including, but not limited to, procurement of similar services.

26. CHOICE OF LAW, JURISDICTION AND VENUE

26.1. This Contract has been and shall be construed as having been made and delivered within the State of Washington, and it is agreed by each party hereto that this Contract shall be governed by laws of the State of Washington, both as to interpretation and performance.

26.2. Any action at law, suit in equity, or judicial proceeding arising out of this Contract shall be instituted and maintained only in any of the courts of competent jurisdiction in Thurston County, Washington.

27. SEVERABILITY

27.1. If a court of competent jurisdiction holds any part, term, or provision of this Contract to be illegal, or invalid in whole or part, the validity of the remaining provisions shall not be affected, and the parties' rights and obligations shall be construed and enforced as if the Contract did not contain the particular provision held to be invalid.

27.2. If any provision of this Contract is in direct conflict with any statutory provision of the State of Washington, or federal statutes, that provision which may conflict shall be deemed inoperative and null and void insofar as it may conflict, and shall be deemed modified to conform to such statutory provision. Such modification will be effective on the effective date of the statutes necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

27.3. Should TMRSN determine that the severed portions substantially alter this Contract so that the original intent and purpose of the Contract no longer exists, TMRSN may, in its sole discretion, terminate this Contract.

28. TIME OF THE ESSENCE

28.1. Both parties recognize that time is of the essence in the performance of the provisions of this Contract.

29. ENTIRE CONTRACT

29.1. The parties agree that this Contract, including all documents attached or incorporated by reference, is the complete expression of its terms and conditions. Any oral or written representations or understandings not incorporated in this Contract are specifically excluded.

30. ORDER OF PRECEDENCE

30.1. In the event of an inconsistency in the terms of this Contract, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:

30.1.1. Thurston Mason Regional Support Network Contract on General Terms and Conditions;

30.1.2. Program Contract(s) and any Exhibits or other documents attached or incorporated by reference.

30.2. Notwithstanding the order of precedence listed above, additional details and more stringent requirements contained in a lower priority document will control unless the requirements of the lower priority document present an actual conflict with the requirements of the higher level document.

31. OWNERSHIP OF MATERIAL

31.1. Material created by the CONTRACTOR and paid for by TMRSN as a part of this Contract shall be owned by TMRSN and shall be "work made for hire" as defined by Title 17 USC, Section 101 et seq. This material includes, but is not limited to: books, computer programs and code, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes, and/or training materials. Material that the CONTRACTOR uses to perform this Contract but is not created for or paid for by TMRSN is owned by the CONTRACTOR and is not “work made for hire”; however, TMRSN and the Department shall have a perpetual license to use this material for TMRSN and the Department internal purposes at no charge to TMRSN or the Department, provided that such license shall be limited to the extent that the CONTRACTOR has a right to grant such a license.

31.2. The TMRSN agrees that if it uses any materials prepared by the CONTRACTOR for purposes other than those intended by this Contract, it does so at its sole risk and it agrees to hold the CONTRACTOR harmless therefore.

32. HEADINGS

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

33. NON-WAIVER OF RIGHTS

33.1. The parties agree that the excuse or forgiveness of performance or waiver of any provision(s) of this Contract does not constitute a waiver of such provision(s) or future performance, or prejudice the right of the waiving party to enforce any of the provisions of this Contract at a later time.

34. SURVIVABILITY

34.1. The terms and conditions contained in this Contract that by their sense and context are intended to survive the expiration or termination of this Contract shall survive. Surviving terms include, but are not limited to: Recapture Provisions, Confidentiality, Relationship of Parties, Inspection/Maintenance and Retention of Records, Title to Property, Hold Harmless and Indemnification, Disputes, Termination for Default, Termination Procedure, Ownership of Material, and Choice of Law, Jurisdiction, and Venue.

35. OPERATION OF TMRSN CONTRACT ON GENERAL TERMS AND CONDITIONS

35.1. This Thurston Mason Regional Support Network Contract on General Terms and Conditions is incorporated by reference into each Program Contract between TMRSN and the CONTRACTOR in effect on or after the start date of this Thurston Mason Regional Support Network Contract on General Terms and Conditions. This Thurston Mason Regional Support Network Contract on General Terms and Conditions govern and apply only to work performed under Program Contracts between the parties.

EVALUATION & TREATMENT PROGRAM CONTRACT

Program Contract Number: 2015-62ET

This Program Contract is between the Thurston Mason Regional Support Network (TMRSN) and the Contractor identified below. This Program Contract, exhibits, and attachment(s) are valid only when the Contractor and the TMRSN have executed the Contract on General Terms and Conditions. The Contract on General Terms and Conditions is incorporated herein by reference as if fully set forth herein. The Contract on General Terms and Conditions, Program Contract, and all exhibits, attachment(s) and other documents attached or incorporated by reference contain all of the terms and conditions agreed to by the parties.

Thurston Mason RSN Contract Manager:	Kristy Lysell, Provider Network Coordinator	
Address:	412 Lilly Road NE, Olympia WA 98506	
Contact Information:	**Phone:** 360.867.2560	**Email:** lysellk@co.thurston.wa.us
Contractor:	Behavioral Health Resources	**Contact:** John Masterson, CEO
Address:	3857 Martin Way East Olympia WA 98506	
Contact Information:	**Phone:** 360.704.7170	**Email:** jmasterson@bhr.org

Is this contractor a Subrecipient for purposes of this contract? ☒ **Y** ☐ **N** | **CFDA #:** **93.958**

TOTAL FUNDING DURING CONTRACT PERIOD: **$7,995,738**

Fund Source:	☒ Federal	☒ Medicaid	☒ State	☒ TST	☒ Inter-Gov	☒ Proviso	☒ Reserves
Amount:	$45,738	$4,645,029	$2,561,643	$83,640	$16,140	$207,552	$435,996

Contract Start Date: **January 01, 2015** | **Contract End Date:** **December 31, 2015**

Exhibits:	**Attachments:**
A: Statement of Work	**1:** Community Integration Outreach
B: Compensation	**2:** Maintenance Responsibilities
C: Performance Measures	Invoices – E&T and CIO [Excel]
D: Data Security	Specialized Service Activity Log [Excel]
E: Modality Definitions	Quarterly Staffing Report [Excel]
F: Access to Care Standards	

This Program Contract, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties. No other understandings and representations, oral or otherwise, regarding the subject matter of this Contract shall be deemed to exist or bind the parties. The parties signing below warrant that they have read and understand this Contract, and have authority to enter into this Program Contract. By their signatures below, the parties hereto agree to this Program Contract and execute it in duplicate originals.

Contractor Signature:	**Printed Name and Tile:**	**Date:**
Thurston County Signature:	**Printed Name and Title:** Don Sloma, Director	**Date:**

EXHIBIT A

Evaluation and Treatment Facility
STATEMENT OF WORK

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1. PURPOSE OF CONTRACT

1.1. Operate the Evaluation and Treatment Facility to provide Crisis Stabilization, Inpatient, and ITA services to individuals experiencing acute symptoms of a mental illness or disorder within the Thurston Mason RSN service area. Services provided shall be age, linguistic and culturally competent, and be medically necessary and clinically appropriate and relevant pursuant to:

1.1.1. Federal 1915 (b) Mental Health Waiver and the Medicaid State plan or any successors;

1.1.2. Thurston Mason RSN's Contract on General Terms and Conditions;

1.1.3. Thurston Mason RSN's policies, procedures, protocols, guidelines, and instructions provided or referenced herein, and any successors, amended or replaced;

1.1.4. CFR 42 Part(s) 438, 206, 207 or any successors;

1.1.5. RCW 38.52, 70.02, 71.05, 71.24, and 71.34, or any successors;

1.1.6. WAC Chapter 388-865, 388-877, and 388-877A, or any successors; and

1.1.7. Other applicable state and federal laws and regulation, administrative policies, or any successors.

2. DEFINITIONS

2.1. **Access to Care Standards** are a set of standards published by DBHR that defines the eligibility requirements for initial authorization of outpatient services for Medicaid and Non-Medicaid adults, older adults, and children. The guidelines define the minimum eligibility criteria that can be applied, and are not intended to be applied as continuing stay criteria. The Standards provide guidelines on the goals and periods of authorization, a list of covered diagnoses, identifying functional impairments within life domains, supports and environment, and a minimum modality set for treatment services identified at two levels - brief intervention and community support. The most current Access to Care Standards is dated January 01, 2006.

2.2. **Action** in the context of PIHP services means

2.2.1. the denial or limited authorization of a requested service, including the type or level of service.

2.2.2. the reduction, suspension, or termination of a previously authorized service.

2.2.3. the denial, in whole or in part, of payment for a service.

2.2.4. the failure to provide services in a timely manner, as defined by the state.

2.2.5. the failure of a PIHP to act within the timeframes provided in section 42 CFR 408(b).

2.3. **Administrative Cost** means costs for the administration of this Contract for the general operation of the public mental health system. These activities cannot be identified with a specific direct services or direct services support function as defined in the BARS supplemental instructions and must be limited to no more than 10%.

2.4. **Advance Directive** A written instruction, such as a living shall or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care (including mental health care) when the individual is incapacitated.

2.5. **Annual Revenue** means all revenue received by the Contractor pursuant to the Contract for July of any year through June of the next year.

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

2.7. **Available Resources** means funds appropriated for the purpose of providing community MH programs: federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under RCW 71.24 or RCW 71.05 by the legislature during any biennium for the purpose of providing residential services, resource management services, community support

services, and other MH services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

2.8. **Clinical Management Team** A team of clinical professionals that includes the Evaluation and Treatment Facility Medical Director, Program Manager, and a Psychiatric Registered Nurse.

2.9. **Community Mental Health Agency ("CMHA")** means a Community Mental Health Agency that is licensed by the State of Washington to provide mental health services and Subcontracted to provide services covered under this Contract.

2.10. **Consumer** means a person and/or Enrollee who has applied for, is eligible for, or who has received mental health services.

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

2.12. **Day** for purposes of this Contract means calendar days unless otherwise indicated in the Contract.

2.13. **Deliverable** means items that are required for submission to TMRSN to satisfy the work requirements of this Contract and that are due by a particular date or on a regularly occurring schedule.

2.14. **Denial** means the decision by a Pre-paid Inpatient Health Plan (PIHP), or their formal designee, not to authorize a covered Medicaid mental health services that have been requested by a provider on behalf of an eligible Medicaid Client.

2.14.1. It is also a denial if an intake is not provided upon request by a Medicaid Enrollee.

2.15. **Designated Mental Health Professional (DMHP)** means a mental health professional designated by the appropriate Regional Support Network to perform the duties of the Involuntary Treatment Acts. RCW 71.05.020(11) and RCW 71.34.020(4)

2.16. **Elective Inpatient Admission** A clinically appropriate voluntary preplanned admission occurring prior to the need for an emergent admission.

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

2.18. **Emergent Inpatient Admission** A voluntary admission to inpatient psychiatric care when an individual meets the criteria of the Involuntary Treatment Act (RCW 71.05 or RCW 71.34) agree to care, or who have eligible diagnosis, and whose health and bodily functions are in serious and imminent jeopardy due to medication or chemical reactions.

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

2.20. **Enrollee** means a Medicaid recipient who is enrolled in an RSN.

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

2.22. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings (OAH).

2.23. **Family** means:

2.23.1. For adult Clients, family means those the Client defines as family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the Client.

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

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

2.25. **"High Risk"**

2.25.1. Persons who are not Medicaid eligible but are determined to meet the criteria for "state priority populations" as defined in RCW 71.05, 71.24. 71.34 or any successors,

2.25.2. Who meet the Federal Poverty Level, with special attention to children, older adults and minorities shall be served based on available state only funding.

2.25.3. The level of need, risk for inpatient and jail (due to mental illness) and severity of illness shall determine the order of precedence for utilizing available resources for serving those without Medicaid.

2.25.4. Those with the highest priority shall be at imminent risk of psychiatric hospitalization or jail due to their disorder or just released

2.25.5. Those individuals who are on a "spenddown", who can achieve Medicaid Client status within the first month of their spend down period, shall be served based on available resources through State Only funding to assist the individual prior to achieving their spenddown level.

2.26. **Indirect Costs** Costs incurred for activities other than those that qualify as direct costs. Indirect costs include, but are not limited to: activities, staff, tools, depreciation and equipment, transportation, education or training related to financial, facilities, or data management, quality management, resource management (except for direct costs incurred pursuant to RCW 71.24.025), and RSN/PIHP or subcontractor administration. Indirect costs do not include capital items or unexpended reserves.

2.27. **Involuntary Admission** An admission that occurs for initial detention and/or involuntary commitment in accordance with RCW 71.34 or RCW 71.05.

2.28. **Involuntary Treatment Act** was intended by the legislature to prevent inappropriate, indefinite commitment of mentally ill persons and to eliminate legal disabilities that arise from such commitment, provide prompt evaluation and timely treatment, to safeguard individual rights, protect public safety, and encourages stewardship when delivering services.

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

2.30. **Medical Necessity or Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.
Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve,

stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

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

2.32. **Mental Health Professional** means:

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

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

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

2.32.4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the regional support network and granted by the DSHS prior to July 1, 2001; or

2.32.5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the DBHR consistent with WAC 388-865-0265.

2.33. **Network Provider** means a Community Mental Health Agency, Professional Service, or other identified service that is contracted directly with Thurston Mason RSN for the delivery, or support of delivery, of mental health services in the Provider Network.

2.34. **Patient Days of Care** includes all voluntary patients and involuntarily committed patients under Chapter 71.05 RCW, regardless of where in the State Hospital they reside. Patients who are committed to the State Hospital under 10.77 RCW are not included in the Patient Days of Care. Patients who are committed under Chapter Ch. 375, Laws of 2007 (ESSB 5533), Section 5 (misdemeanor procedure) by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the Patient Days of Care until a petition for 90 days of civil commitment under Chapter 71.05 RCW has been filed in court. Patients who are committed under Chapter Ch. 375, Laws of 2007 (ESSB 5533), Section 4 (felony procedure) by a superior court after failed competency restoration and dismissal of felony charges are not counted in the Patient Days of Care until the patient is civilly committed under Chapter 71.05 RCW.

2.35. P**rovider Network** means all Thurston Mason RSN contracted Network Providers within the Thurston Mason service area.

2.36. **Provider One** means the Departments Medicaid Management Information Payment Processing System.

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

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

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

2.40. **Recovery** means the process in which people are able to live, work, learn, and participate fully in their communities.

2.41. **Regional Support Network ("RSN")** means a county authority or group of county authorities or other entity recognized by the secretary of DSHS to administer mental health services in a defined region.

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

2.43. **Service Area** means the geographic area covered by this Contract for which the Contractor is responsible.

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

3. PROGRAM OBJECTIVES

3.1. This Contract is designed to prescribe specific functions and to define expected outcomes. These are considered minimum requirements.

3.2. The Contractor shall provide the following program services in Thurston and Mason Counties or for Thurston and Mason County residents:

3.2.1. **Telephone / Face-to-Face Screening.** Determine appropriate level of, and location for, full continuum of care as available through the TMRSN mental health system of care. Facilitate an intake for outpatient services as necessary.

3.2.2. **Crisis Resolution Services.** Evaluate mental health condition, both on-site and in the community, to determine acuity and level of care needed and take initial steps to stabilize. Provide crisis intervention services both on-site and in the community. These services shall be provided in concert with the Crisis Stabilization and Transitional Unit. These are not discreet and separate programs but rather extensions of program services. Services include the facilitation of intakes for outpatient services as necessary. These services may be provided under Medicaid or State funding. Crisis services include co-occurring screening per Section 7.3.

3.2.3. **Involuntary Treatment Act Services (ITA).** Provide all necessary services, administrative and court functions required for the evaluation for involuntary detention or involuntary treatment determination. These services are always provided under state funding. Clinical services are primarily those provided by Designated Mental Health Professionals in the evaluation and commitment process.

3.2.4. **Crisis Stabilization Services.** Alleviate acute symptoms and avert decompensation or re-escalation on site or in the community. Provide a least restrictive, step-down from or alternative to inpatient care that includes a range of integrated treatment modalities, primarily group therapy and psycho-education. These services shall include respite care, jail diversion, hospital diversion, and state hospital (WSH) step-down services to be a continuum of care.

3.2.5. **Freestanding Evaluation and Treatment Services.** Provide evaluation and inpatient level treatment to individuals who would otherwise meet psychiatric hospital admission criteria. Maintain Involuntary Treatment Act certified treatment beds to meet the statutory requirements of RCW 71.24.300(6)(c).

3.2.6. **Transition/Residential Services.** When stabilization services extend beyond 14 days, Transition/Residential services to further stabilize and supervise the client shall be provided. These services are utilized for WSH or other inpatient setting step down, PACT program, or

diversion prior to or from community based and jail based services.

4. FACILITY REQUIREMENTS

4.1. The Contractor shall:

4.1.1. Maintain policies and procedures designed to direct personnel in the care and protection of buildings, furnishings, appliances and equipment used in the provision of services described herein.

4.1.2. Report any and all building or County-owned equipment damage, breach of grounds integrity, infrastructure systems failures or any safety issue to TMRSN or as appropriate to Central Services for Thurston County immediately, or, if non-emergent, by the next business day.

4.1.3. Provide for janitorial / custodial and light maintenance services. Attachment 1, describes Thurston County maintenance responsibilities.

4.1.4. Provide connectivity, installation, and maintenance of telephone, and computer systems.

4.1.5. Provide and replace necessary office furnishings and equipment.

4.1.6. Ensure that the building, equipment and furnishings are safe, sanitary, and maintained in good repair.

4.1.7. Per Attachment 1, ensure that the building structure, exterior grounds and component parts are safe, clean, and maintained in good repair. This also includes safety during inclement weather, including snow and ice, by clearing and/or de-icing the parking lot, sidewalks, and building entrances if the service is not provided by Thurston County.

4.1.8. Ensure laundry facilities and equipment is clean, in good repair and adequate to meet the needs of clients.

5. PROGRAM OPERATIONS

5.1. The Contractor shall maintain an organizational structure that includes, who the Contractor's legal responsible authority is, clear lines of authority for management and clinical supervision, as evidenced by a single, non-duplicated line of authority for overall program management and operations. A printed organizational chart illustrating this structure shall be submitted to TMRSN within thirty (30) days upon execution of this contract and then as revised.

5.2. The Contractor shall maintain written policies and procedures that shall implement all applicable rules. Such policies and procedures are to be reviewed by the legally responsible authority or designed, kept current, located together, are made available at all times to all personnel who are responsible to carry out these policies, and are in compliance with WAC 246-337, 388-865, and 388-877.

5.3. The Contractor shall adopt, periodically review and update written policies, written procedures and written position descriptions that include, at a minimum:

5.3.1. Program description and scope of services, including population served.

5.3.2. Description of resources that are provided to meet client needs as per WAC 246-337-045.

5.3.3. Description of essential functions and credentials required for specific jobs.

5.3.4. Plan for communication and conflict resolution for clients and employees as per WAC 246-337-045.

5.3.5. Medical and nursing procedures.

5.3.6. Policy regarding possession of weapons in Evaluation & Treatment Facility.

5.3.7. Procedures for assessment, admission, discharge, and transfer of clients, both voluntary and involuntary.

5.3.8. Description of treatment modalities utilized.

5.3.9. Plan for addressing needs of children, adolescents, and elders (when applicable).

5.3.10. Procedures and training plan for managing disruptive, violent, suicidal and self-destructive behaviors.

5.3.11. Policy regarding smoking.

5.3.12. Plan for responding to emergency situations.

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

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

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

5.4.3. The second individual may be a law enforcement officer, a mental health professional, a mental health paraprofessional who has received training as described in RCW 49.19.030, or other first responder, such as fire or ambulance personnel.

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

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

5.4.6. Every DMHP, mental health professional, or crisis worker that is dispatched on a crisis visit, as described above, shall have access to all information through the MIS including any history of dangerousness or potential dangerousness on the client 24/7 they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

5.4.7. Every mental health professional including DMHP's and crisis outreach workers, who engage in home visits to Clients or potential Clients shall have access to the use of a cellular telephone or comparable devise provided by the Contractor for the purpose of emergency communication.

5.5. **Seclusion and restraint.** The Contractor shall protect client rights and safety with regard to the use of seclusion and restraint, and shall comply with all requirements of WAC 246-337-110, WAC 388-865-0545 and 0546 and shall:

5.5.1. Maintain a written policy that meets all applicable state and federal laws, rules and regulations pertaining to seclusion and restraint.

5.5.2. Ensure that restraint or seclusion is performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, the client's chronological and developmental age, size, gender, physical, medical and psychiatric condition and personal history.

5.5.3. Only use seclusion and restraint in case of emergency when treatment methods have failed.

5.5.4. Collect and keep data and provide reports regarding use of seclusion and restraint, and efforts to reduce use.

5.5.5. Demonstrate efforts to keep staff current with national trends in use of physically restrictive containment methods.

5.5.6. The Contractor shall maintain working relationships with local law enforcement, 911 services, and emergency medical transportation systems.

5.5.7. The Contractor shall maintain service relationships with local hospitals, emergency rooms, and outpatient mental health providers.

5.5.8. The Contractor shall develop service relationships for the purpose of coordinated care plans with any County that has an established Contract or contract with TMRSN for ITA services.

5.6. **Food and Nutrition Services.** The Contractor shall have a policy and procedure per WAC 246-337-090 to ensure that nutritionally adequate and appetizing meals that meet the client needs are acquired, stored, prepared and served in accordance with chapter 246-215 WAC, or any successor.

5.7. **Infection Control.** Contractor shall have written policies and procedures per WAC 246-337-060 to ensure client's care is provided in an environment that prevents the transmission of communicable diseases among clients, staff, and visitors.

5.8. **Medication Management.** Contractor shall be responsible for the control and use of all medications used by clients within the Evaluation & Treatment Facility whether administered or self-administered. The Contractor shall have written policies and procedures for medication acquisition, storage, administration and documentation that are developed, approved, and reviewed by medical and nursing staff, administration and pharmacist (as needed) per WAC 246-337-105 and WAC 388-865-0570.

5.9. **Medical Records.** Contractor shall have a policy and procedure per WAC 246-337-095 to ensure medical records that document the client's psychiatric care are maintained.

5.10. **Plan of Care/Treatment.** The Contractor shall have a policy and procedure per WAC 246-337-100 and WAC 388-865-0547 that ensures an individual plan of care/treatment is developed and implemented for each client based on assessment of the client's health care needs upon admission and updated as additional needs are identified during treatment.

5.11. **Health and Safety.** The Contractor shall have a policy and procedures per WAC 246-337-065 that protect the client's health and safety.

6. SERVICES

6.1. **Required Services.** The Contractor is required to provide all of the following services as described in the Crisis Mental Health and Inpatient sections, unless otherwise specified in this Contract. These services must be prioritized for the use of funds provided under this Contract. The Contractor shall ensure access to and availability of mental health services for any individual with acute or emergent mental health needs in any geographic area of Thurston and Mason Counties, residents of any County that has an ITA Contract or contract with TMRSN, and any other state residents in accordance with State law, rules, and regulations.

6.1.1. Crisis Mental Health Services. The Contractor must provide 24-hour, 7 day a week crisis mental health services to individuals who are within the Contractor's service area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the individual's ability to pay. Crisis services provided at the E&T are not a replacement or substitute for crisis services provided in an outpatient setting. Crisis mental health services must include each of the following:

6.1.1.1. Crisis Services. Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, the outcome of which decides whether possible bad consequences shall follow. Crisis services must be available on a

24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services must be provided by or under the supervision of a mental health professional.

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

6.1.1.3. Involuntary Treatment Act Services. Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 RCW 71.24. 300 and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional (DMHP) determines an individual must be evaluated for involuntary treatment. The decision making authority of the DMHP must be independent of the RSN administration. ITA services continue until the end of the involuntary commitment.

6.1.1.4. Ancillary Crisis Services. Includes costs associated with providing medically necessary crisis services not included in the Medicaid State Plan. Costs include but are not limited to the cost of room and board in hospital diversion settings or in freestanding Evaluation and Treatment facilities (per State Only Funding).

6.1.1.5. Freestanding Evaluation and Treatment Services. Provided in freestanding inpatient residential (non-hospital) facilities licensed by the Department of Health and certified by DBHR to provide medically necessary evaluation and treatment to the individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

6.1.2. Crisis mental health services may be provided prior to an intake evaluation or screening process. The Contractor must provide:

6.1.2.1. Emergent care within 2-hours of the request received from any source for crisis mental health services.

6.1.2.2. Urgent care within 24-hours of the request received from any source for crisis mental health services.

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

6.1.4. The Contractor must incorporate and train all Designated Mental Health Professionals (DMHP) on the most current statewide DMHP Protocols. The protocols can be accessed on the DBHR internet website and copies can be provided upon request.

6.1.4.1. DMHP's will be credentialed per *TMRSN Policy SD231 Designated Mental Health Professional*.

6.1.5. Maintain Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.

6.2. **Mental Health Services provided in Residential Settings.** A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours (minimum of 8 hours per day, 7 days per week) to provide direct mental health care to a Medicaid Client. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs from other services in the terms of location and duration.

7. ACCESS, ELIGIBILITY AND CLINICAL SERVICES

7.1. Telephone Screening and Crisis Intervention

7.1.1. Evaluation & Treatment Facility personnel shall accept phone calls from any person directly. Initial telephone calls shall be answered within 30 seconds or five (5) rings.

7.1.2. If caller is currently enrolled in public mental health services, assistance of the case manager may be requested.

7.1.3. Callers with non-urgent requests for service shall be routed to or scheduled with an outpatient provider.

7.1.4. A mental health crisis worker shall speak with an individual requesting care for symptoms of a mental illness within 15 minutes.

7.1.5. Screening includes nature of request, demographic data, financial data, eligibility determination and direction toward appropriate services.

7.2. Face to face crisis assessment and initial crisis intervention

7.2.1. Initial services shall be made available to the community for emergent and urgent care. There shall be a seamless flow of services between Crisis Resolution Services (CRS), Crisis Stabilization and Transitional Unit (CSTU) and the Evaluation and Treatment Unit (ETU). Assessment is intended for initial crisis response and determine of other services that may be needed.

7.2.2. Eligibility for mental health assessment includes adults or children who:

7.2.2.1. Believe they are having a mental health crisis.

7.2.2.2. Are reported by others to have acute symptoms of a mental disorder that may lead to deterioration in function if there is no intervention.

7.2.3. Unless there is an apparent major medical problem, individuals who are referred or requesting crisis services shall not be diverted to a hospital Emergency Room prior to being seen. Services shall be coordinated with hospital emergency departments and medical centers.

7.2.4. Initial face to face assessment and crisis intervention may include, depending on individual need and location:

7.2.4.1. Mental health assessment.

7.2.4.2. Nursing Health screen;

7.2.4.3. Consultation with psychiatrist or psychiatric ARNP;

7.2.4.4. Admission, transfer or referral to appropriate care;

7.2.4.5. Arrangement of suitable transportation; and

7.2.4.6. Specialists available for evaluation and consultation as indicated, e.g., children, elders, physically or sensory disabled, non-English speaking or any other specialist required for adequate evaluation.

7.2.4.7. Stabilization of symptoms

7.2.4.8. Crisis Intervention

7.2.4.9. ITA Evaluation

7.3. Co-Occurring Disorder Screening and Assessment: The Contractor must maintain the implementation of the integrated, comprehensive screening and assessment process for chemical dependency and mental disorders as required by RCW 70.96C. Failure to maintain the Screening and Assessment process shall result in remedial actions up to and including financial penalties as described in Section 23, Remedial Actions, of this Contract.

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

7.3.1.1. New intakes, as applicable.

7.3.1.2. The provision of each crisis episode of care including ITA investigation services, except when:

7.3.1.2.1. The service results in a referral for an intake assessment.

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

7.3.1.2.3. The contact is by telephone only.

7.3.1.2.4. The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous 12 months.

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

7.3.3. The results of the GAIN-SS screening, including refusals and unable-to-completes, must be reported to TMRSN through the MIS system.

7.3.4. Staff utilizing the tool must attend ongoing DBHR trainings on the use of the screening and assessment process that includes use of the tool and quadrant placement.

7.3.5. The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by DBHR and outlined in the *SAMHSA Treatment Protocol 42*, to determine a quadrant placement for the individual when the individual scores a 2 or higher on either of the first two scales (ID Screen & ED Screen) and a 2 or higher on the third (SD Screen).

7.3.6. The HRSA-GAIN-SS screening form, along with the quadrant score, must be placed within the Enrollee's clinical chart even if the Enrollee refused or was unable to complete it.

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

7.3.7.1. Less severe mental health disorder/less severe substance disorder.

7.3.7.2. More severe mental health disorder/less severe substance disorder.

7.3.7.3. Less severe mental health disorder/more severe substance disorder.

7.3.7.4. More severe mental health disorder/more severe substance disorder.

7.3.8. The quadrant placement must be reported to TMRSN through the MIS system.

8. CRISIS OUTREACH SERVICES

8.1. Eligibility shall include adults youth and children regardless of ability to pay or enrollment who:

8.1.1. Believe they are experiencing a mental health crisis, or

8.1.2. Demonstrate acute symptoms of a mental disorder; or

8.1.3. Have had an initial screen, assessment, or are directly routed to a mental health professional.

8.2. Crisis Services shall be provided per the following:

8.2.1. Off-site crisis outreach or on-site crisis intervention available 24 hours a day, 7 days a week.

8.2.2. The region of services is defined as Thurston and Mason Counties. The Contractor shall responds to requests for services throughout the service region.

8.2.3. Community intervention services provided within two (2) hours of initial contact. Any exceptions are clearly documented and are subject to review.

8.2.3.1. The mental health professional determines whether law enforcement, backup staff, or evaluation for involuntary treatment is needed per Section 5.4.

8.2.4. Crisis outreach services shall be provided at the level of intensity and duration necessary until the crisis is mitigated.

8.2.5. The mental health professional determines whether conditions are safe for outreach activities. If considered unsafe, arrangements may be made to have the client transported to a facility capable of containment or responded to with additional clinical staff or police.

8.2.6. Outreach requests for mental health assessment and crisis intervention from the following shall not be declined:

8.2.6.1. Law enforcement;

8.2.6.2. Jail / juvenile court or detention staff;

8.2.6.3. Hospital emergency staff;

8.2.6.4. Attending physician for a person in a medical unit at a local hospital;

8.2.6.5. Residential providers; and

8.2.6.6. Schools.

8.2.7. Requests from Police or other law enforcement for crisis intervention shall be responded to, whether or not an ITA evaluation is requested.

8.2.8. Mental health professionals shall have access to crisis plans 24 hours a day, 7 days a week.

8.2.9. Mutual development of a plan with the client that supports client stability and safety.

8.2.9.1. Involvement of client's natural support system.

8.2.9.2. Assistance with appropriate referral, including next business day appointments.

8.2.10. Crisis intervention or initial brief treatment shall be available 24 hours a day, 7 days a week, and may occur in the field or on-site.

8.2.11. Follow up brief treatment up to five (5) sessions by appointment.

8.2.12. Staffing assistance with voluntary admission to hospital, Crisis Stabilization Transition Unit (CSTU) or Evaluation and Treatment Unit (ETU), as needed.

8.2.13. Linkage to natural and professional supports.

8.2.14. Evaluation for involuntary treatment according to chapter 71.05 RCW by DMHP if initial intervention is unsuccessful in providing safety and client refuses services.

8.2.15. Evaluations for involuntary treatment occur within the boundaries of Thurston and Mason Counties.

8.2.16. Coordination of client transportation to the Evaluation & Treatment Facility and Providence St. Peter Hospital as necessary.

8.2.17. If a crisis may be resolved by providing food, transportation, medication, or lodging, the Contractor may provide these on a short-term basis, as resources are available. This may be provided ONLY for those who are experiencing acute mental health symptoms exacerbated by lack of food, medication, or shelter and who are not enrolled in TMRSN mental health services.

8.2.18. The Contractor shall provide direct monitoring for non-enrolled individuals discharged to Thurston or Mason counties who are on a Least Restrictive Alternative (LRA) or Conditional Release (CR).

9. CRISIS STABILIZATION AND TANSITION UNIT (CSTU)

9.1. CSTU services shall be seamless in providing continuum of care with Crisis Resolution Services and the ETU. CSTU is intended to provide a setting to monitor a client, even for an hour as part of their initial crisis response. CSTU services are designed to allow any crisis client a chance to stabilize when an initial crisis intervention in the community is insufficient.

9.2. The CSTU is also intended as a diversion and step down program from inpatient and jail. In particular, the CSTU is to be utilized for moving clients out of WSH prior to placement in the community. The CSTU shall work with outpatient programs, especially the Program for Assertiveness Community Treatment (PACT), to facilitate community placement.

9.3. Eligibility for admission includes:

9.3.1. Client has acute symptoms of a mental illness or mental disorder;

9.3.2. Client requires additional crisis services on a short term basis to stabilize;

9.3.2.1. CSTU "beds" may be utilized for brief periods to provide an individual time to stabilize. Procedures such as extensive medical clearance should not present as a barrier to providing these short term crisis services.

9.3.3. Client presents risk or imminent risk of danger to self or others, or an inability to care for basic needs as a result of symptoms;

9.3.4. Community resources and outpatient services are insufficient to provide client safety or stabilization;

9.3.5. It is likely that services offered shall be beneficial;

9.3.6. Client is voluntary or on a Lesser Restricted Order or Conditional Release Order from WSH;

9.3.7. Clients are residents of Thurston or Mason Counties, or, if out of county, admission is by prior TMRSN authorization;

9.3.8. Client is need of transition treatment services from WSH, or other Inpatient or Jail settings;

9.3.9. Client is in need of stabilization and transition to divert from inpatient care or jail due to a mental illness.

9.4. Initial authorization for stabilization admission shall be retrospective based on Access to Care Standards and WAC definition of acuity. If the length of stay is less than 23 hours then this service shall constitute a crisis intervention and requires no authorization. If the stay is 24 hours or more up to 14 days, then the service is Crisis Stabilization and shall be authorized retrospectively by the RSN. If the length of stay is more than 14 days, then the service is residential, requires prior authorization for Outpatient Level of Care, Residential Treatment and enrollment into outpatient services. This residential service is only available for individuals who have Medicaid.

9.5. Any denial of access to CSTU shall be documented and reported to TMRSN with 24 business hours.

9.6. The need for medication shall not be a reason for denial of admittance to CSTU.

9.7. Crisis stabilization in the CSTU is provided in a short-term, professionally staffed residential environment that includes:

9.7.1. Individually assigned room within a secure environment, supervision, protection of privacy, and behavior monitoring.

9.7.2. Meals and food service in accordance with WAC 246-337-090.

9.7.3. Provision of basic health needs that may include, though is not limited to, a combination of rest, sleep, hygiene, nutrition, activity, personal privacy, social contact, fresh air, education and recreation as needed.

9.7.4. Individualized plan of care in accordance with WAC 246-337-100 and WAC 388-865-0547.

9.7.5. Coordination with Outpatient Services for Medication assessment, administration, education and monitoring when necessary. Mental health-related laboratory services.

9.7.6. Routine medical services within the limits of medical resources available.

9.7.7. Facilitation of ongoing support post discharge including post discharge phone consult based on written discharge instructions. Discharge instructions shall be available to consult staff for 90 days.

9.8. The Contractor shall ensure entry and submission of MIS reporting at minimum; billing or stabilization services, other services when appropriate, admission transaction data, demographic data, utilization data, discharge data and other data requirements as set forth in this Contract.

9.9. Crisis Stabilization shall include Respite Care and function as a step down and diversion for Western State Hospital.

10. INPATIENT SERVICES

10.1. Evaluation and Treatment Unit (ETU)

10.1.1. Eligibility for admission includes, for clients detained or committed in accordance with chapters 71.05 or 71.34 RCW:

10.1.1.1. Thurston County DMHP or other Washington DMHP has performed probable cause evaluation; and

10.1.1.2. Detention is for adolescents age 13 to17 and adults age 18 and older detained for a 72 hour evaluation period; or

10.1.1.3. Adolescents age 13 to 17 and adults age 18 and older committed by Thurston County Superior Court for a 14 - day evaluation and treatment period; or

10.1.1.4. Adolescents age 13 to 17 and adults age 18 and older, whose least restrictive Court Order has been revoked.

10.1.2. Eligibility for voluntary admission to the ETU includes, at a minimum:

10.1.2.1. Client has acute symptoms of a mental illness or mental disorder;

10.1.2.2. Client presents risk or imminent risk of danger to self or others, or an inability to care for basic needs as a result of acute symptoms as defined under RCW 71.05;

10.1.2.3. Community resources and outpatient services are insufficient to provide client safety;

10.1.2.4. There is a likelihood that services offered shall be beneficial; and

10.1.2.5. Clients are residents of Thurston or Mason Counties, or, if out of county, admission is by prior authorization by TMRSN.

10.1.3. The TMRSN Medical Director shall review determination of clinical appropriateness for clients if denied a request for inpatient admission.

10.2. Inpatient services are made available through 15 Evaluation & Treatment Facility certified treatment beds in a professionally staffed, short-term residential setting and shall include but are not limited to:

10.2.1. Individually assigned room within a secure environment with a locked perimeter, supervision, protection of privacy, and behavior monitoring.

10.2.2. Meals and food service in accordance with WAC 246-337-090.

10.2.3. Provision of basic health needs that may include, though is not limited to a combination of: rest, sleep, hygiene, nutrition, activity, personal privacy, social contact, fresh air, education and recreation as needed.

10.2.4. Daily monitoring of vital signs.

10.2.5. Comprehensive evaluation including physical examination, psychosocial assessment and mental status examination within 24-hours of initial contact.

10.2.6. A structured daily program of activities and services to include:

10.2.6.1. Basic health care as described in Exhibit E: Modalities;

10.2.6.1.1. Individual therapy;

10.2.6.1.2. Group therapies;

10.2.6.1.3. When appropriate, family therapy;

10.2.6.1.4. Medication assessment, administration, education and monitoring.

10.2.6.2. Flexible structure to accommodate and/or closely match individual client’s acuity and home activity schedule.

10.2.6.3. Mental health-related laboratory services.

10.2.6.4. Routine medical services within the limits of medical resources available.

10.2.6.5. Individualized plan of care in accordance with WAC 246-337-100 and WAC 388-865-0547.

10.2.6.6. Arrangement for appropriate transportation at discharge.

10.2.6.7. Facilitation of ongoing support post discharge including post discharge phone consult by Evaluation & Treatment Facility staff. Consult shall be available for 90 days post discharge.

10.2.7. The Contractor shall ensure entry and submission of MIS reporting including but not limited to; bed days, individual services when appropriate, admission transaction data, demographic data, utilization data, discharge data and other data requirements as set forth in Section 18 for voluntary and involuntary services.

10.2.8. Request for voluntary admission requires pre-authorization through TMRSN inpatient authorization process.

10.2.8.1. First phase of authorization shall be for initial admission to the Evaluation & Treatment Facility. Initial authorization shall include number of bed days to be authorized.

10.2.8.2. Second phase of authorization shall be for continued stay if requested. Second phase authorization shall require same written request to be faxed to TMRSN prior to approval. Response from TMRSN shall include number of additional bed days to be authorized.

10.3. Hospital Liaison

10.3.1. The Contractor shall identify and designate 1 FTE as a Hospital Liaison to provide Rehabilitation Case Management services conducted in or with an inpatient facility for the direct benefit of an individual in or eligible for TMRSN mental health services.

10.3.2. The Liaison shall provide case management services at WSH to include monitoring of client status, regular documentation and updates, collaboration with WSH staff, and discharge planning and residential placement for all TMRSN eligible clients.

10.3.2.1. The hospital liaison shall be responsible for providing services to the total number of TMRSN allocated Western State Hospital beds. Current number of beds is 30.

10.3.2.2. The Hospital Liaison shall provide direct services to a minimum of twenty (20) clients per month to be eligible for full MHBG funding per Exhibit B.

10.3.2.2.1. To be eligible for full funding, the Contractor must also satisfy the 1 FTE requirement in section 10.3.1. Should the FTE be less than 1, the funding amount will be reduced per Exhibit B.

10.3.2.3. The Contractor shall submit a monthly deliverable report to include:

10.3.2.3.1. Staff name

10.3.2.3.2. Portion of the 1 FTE each staff represents, if more than one staff equates the 1 FTE.

10.3.2.3.3. Number of clients (each) staff has served in the month.

10.3.3. Contractors' WSH Hospital Liaison shall co-facilitate a monthly meeting with TMRSN Care Management staff; the PACT designated care coordinator, the Contractor's Housing Coordinator, and identified case managers as needed for care coordination and planning.

10.3.4. The TMRSN WSH Liaison shall facilitate all discharge planning, residential placement and linkages to services for all WSH clients considered TMRSN responsibility, regardless of enrollment status. The WSH Liaison shall obtain client information as necessary from other

Network Providers in order to coordinate discharge planning and placement activities for clients enrolled with providers other than BHR.

10.3.5. Rehabilitation Case Management activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services and primary care, and collaborative development of individualized services that promote continuity of care. Services are provided by or under the supervision of a Mental Health Professional.

10.3.6. The Contractor shall ensure that contact with the inpatient facility occurs within three (3) working days of an authorized voluntary or involuntary admission. The Contractor's liaison must participate throughout the admission in treatment and discharge planning with the inpatient treatment team.

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

10.3.8. The Hospital Liaison shall collaborate with outpatient providers to facilitate transition of an enrollee from the inpatient level of care to less restrictive and alternative services once the client is stabilized. Continuity of care must be provided to maintain the stability gained by the provision of services at the higher level of care.

10.3.9. The Contractor's Hospital Liaison shall facilitate appropriate and timely discharge for Medicaid eligible individuals regardless of enrollment status. This may include providing assistance with developing treatment plans, facilitating benefit applications or reinstatement of benefits, coordinating with H&CS for CARE assessments and residential placement, negotiating residential rates, and requesting TMRSN authorization for residential placement/Pathway.

10.3.9.1. The Contractor shall coordinate with TMRSN and the HCS regional office to support the placement of persons discharged or diverted from state hospitals into HCS placements. In order to accomplish this, the Contractor will, whenever possible, prior to referring a person with a diagnosis of dementia for a 90 day commitment to a state hospital:

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

10.3.9.1.2. Request and coordinate with HCS, a scheduled CARE assessment for such persons. If the assessment indicates functional and financial eligibility for long- term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the state hospital.

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

- The Contractor will coordinate with HCS placement activities with one entity designated as being responsible for those activities. This designation will be documented in writing and agreed upon by TMRSN, the Contractor, and HCS. Where such designation is not made the

responsibility shall be the Contractor's.

- The responsible entity will establish and coordinate a placement or discharge planning team that includes Contractor staff, HCS assessors, and other community partners, as necessary, to develop a plan of action for finding a safe, sustainable placement.
- The Contractor will ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.

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

10.3.9.1.5. When individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor will:

- Coordinate with HCS and any residential provider to develop a crisis plan to support the placement.
- When the individual meets access to care criteria, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement

10.3.10. The Contractor must provide or arrange for, a follow–up outpatient service within at least seven (7) calendar days from discharge for Medicaid eligible individuals who have been authorized for a voluntary or involuntary inpatient admission. If the individual is not Medicaid eligible, they may be referred to the E&T CRS for a follow-up visit as needed, including monitoring of LRA's.

10.3.11. Upon TMRSN request, the Hospital Liaison shall participate with TMRSN Care Managers in case reviews for high utilizers of inpatient and Emergency Department services, to develop team strategies for alternative treatments and less restrictive and costly levels of care.

11. ADDITIONAL ACCESS CONDITIONS

11.1. The Contractor shall maintain policies that address physical, developmental, and medical conditions. Regarding the Crisis Stabilization and Transitional Unit and the Evaluation and Treatment Unit:

11.1.1. Clients with physical disabilities must have the disability stabilized prior to admission.

11.1.2. Clients with serious or complex medical conditions shall require medical clearance prior to admission.

11.1.3. Clients demonstrating substance abuse may be treated with the following exceptions:

11.1.3.1. Clients demonstrating acute substance abuse symptoms without symptoms of a mental disorder shall be referred to a chemical dependency program.

11.1.3.2. Clients demonstrating acute toxicity or acute withdrawal from alcohol or other substances shall be transferred to a hospital or other facility equipped to medically monitor or medically manage the client depending on the level of the disorder.

11.1.4. For those individuals with a pending (not dismissed or otherwise disposed) felony charge, the Contractor shall develop procedures for evaluating admission on a case- by- case basis.

11.2. The Contractor shall maintain policies for serving sexual predators detained pursuant to chapter 71.09 RCW or high-risk sex offenders as classified by law enforcement:

11.2.1. Level III sex offenders (highest risk) shall be excluded from admission to the Evaluation & Treatment Facility.

11.2.2. Level II individuals may be considered on a case-by-case basis prior to admission.

11.3. The Contractor shall maintain policies for evaluation and referral of individuals whose level of violence and/or destructive behaviors cannot be contained within the Evaluation & Treatment Facility. The decision to exclude an individual based solely on violent behavior shall be made by the clinical management team.

11.4. The Contractor shall arrange for the appropriate level of transportation to and from the Evaluation & Treatment Facility, as clinically appropriate, to facilitate client and family access. The Contractor shall assure that Medical Administration Assistance (MAA) is billed for the transportation costs when an enrolled individual is transported to the Evaluation & Treatment Facility and when appropriate, away from the Evaluation & Treatment Facility.

11.5. Aside from the limitations above, the Evaluation & Treatment Facility shall have a "no decline" policy for referrals within the TMRSN service area provided the individual meets admission criteria described herein.

11.6. The Contractor shall admit clients to voluntary inpatient care after hours based on pre-authorization criteria established by TMRSN. Authorization and denial procedures shall follow the same "Hospital Instructions" as for community inpatient care. The TMRSN designated Inpatient Care Coordinator, Community Network for Behavioral Healthcare, Inc. (CommCare), can be contacted 24 hours a day, 7 days a week for authorization at (877) 468-9313.

12. ITA FUNCTIONS AND SUPERIOR COURT

12.1. Superior court judicial proceedings shall occur at the Evaluation & Treatment Facility; these proceedings shall have priority over all other uses of the Court Conference/Hearing room in the Evaluation & Treatment Facility.

12.2. With regard to ITA court functions Contractor shall:

12.2.1. Provide coordination of involved parties;

12.2.2. Notify parties of hearing dates, times and locations;

12.2.3. Adhere to timelines as determined by Washington State Law;

12.2.4. Arrange client transportation to Western State Hospital;

12.2.5. Recommend conditions for least restrictive alternatives (LRAs) in conjunction with case manager of record or DMHP;

12.2.6. Ensure that DMHPs are available for testimony when required;

12.2.7. Provide all necessary paperwork including but not limited to chapters 71.05 and 71.34 RCW.

12.3. With regard to ITA Court Hearings the Contractor shall:

12.3.1. Ensure court testimony by professional staff at probable cause hearings or trials;

12.3.2. Provide reports of client history, circumstances of admission and course of treatment;

12.3.3. Accompany and provide care of clients during court proceedings within and away from the Evaluation & Treatment Facility;

12.3.4. Monitor court process;

12.3.5. Assess court milieu for safety and intervene when there are disruptions;

12.3.6. Provide support to the County Prosecutor's office, Assigned Counsel office and State Attorney General's office in the form of consultation, live and telephonic testimony, records and reports, where required, at ITA proceedings for specific individuals;

12.3.7. Provide or arrange for expert witness testimony by a licensed physician, psychiatrist or licensed psychologist.

12.4. With regard to education the Contractor shall:

12.4.1. Assess learning needs of patient and family and provide information regarding ITA status and process;

12.4.2. Provide education and training regarding ITA and Court functions to the community, including but not limited to: emergency transportation services, hospitals and clinics, emergency departments and law enforcement.

12.5. With regard to documentation the Contractor shall:

12.5.1. Provide legal documents pertaining to the involuntary detention of persons at the Evaluation & Treatment Facility as required by the Thurston County Superior Court;

12.5.2. Ensure completion and filing of all ITA related court orders or accompanied documents including but not limited to Least Restrictive Orders and involuntary detention orders;

12.5.3. When necessary for judicial proceedings, Contractor shall promptly supply a certified copy of all medical and psychological records and make available, if necessary, a records custodian capable of testifying;

12.5.4. The Contractor shall ensure entry and submission of ITA investigations, detentions, revocations and hearing events and data as set forth in Section 18 of this Contract.

13. CLINICAL PRACTICE

13.1. The Contractor shall provide the necessary number of staff with the appropriate professional backgrounds and licensure needed to assure compliance with state and federal laws, rules and regulations and the terms set forth in this Contract.

13.1.1. A Medical Director, responsible for decisions regarding client care, quality management, safety issues, review of critical incidents and policy.

13.1.2. A Registered Nurse, an Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) shall perform healthcare assessments.

13.1.3. Comprehensive psychiatric evaluations shall be performed by a psychiatric ARNP, board certified or board eligible psychiatrist.

13.1.4. An ARNP, physician, or licensed Physician's Assistant (PA) shall perform comprehensive physical examinations.

13.1.5. A Registered Nurse with psychiatric experience shall perform medication administration, education, and monitoring. The Contractor shall ensure that a Registered Nurse certified, or meeting the certification competencies, as established by American Nurses Association Psychiatric or Mental Health Nurse, or greater credential, shall be on site at all times. Licensed Practical Nurses (LPN's) may perform some of these functions within their credentials.

13.1.6. Mental health assessments shall be performed a staff person who meets at minimum mental health professional (MHP) credentials.

13.1.7. Crisis / brief services shall be performed by mental health professionals with training and experience in crisis intervention.

13.1.8. A DMHP shall perform all evaluations for involuntary treatment pursuant to chapters 71.05 and 71.34 RCW and the DBHR DMHP Protocols.

13.1.9. Support for activities of daily living, basic health activities and vital signs measurement may be provided by any mental health clinician demonstrating competence and delegated by a Registered Nurse.

13.1.10. Clients with special needs shall have access to appropriately trained professionals for evaluation and consultation, e.g., children, elders, physically or sensory disabled, foreign language speaking, culturally relevant or any specialist required for adequate evaluation.

13.1.11. Sufficient numbers of clinical staff and professional mix shall be available at all times to ensure safety, quality of care, and regulatory requirements.

13.1.12. Employees trained in cardiopulmonary resuscitation and emergency first-aid shall be present in client treatment areas at all times.

14. INCIDENT REPORTING

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

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

14.1.2. The Contractor must report and follow-up on all incidents involving Enrollees, listed below.

14.1.3. The Contractor must report incidents to TMRSN by phone, fax, or an approved electronic incident reporting system. The report must contain:

14.1.3.1. A description of the incident;

14.1.3.2. The date and time of the incident;

14.1.3.3. Incident location;

14.1.3.4. Incident type;

14.1.3.5. Names and ages, if known, of all individuals involved in the incident;

14.1.3.6. The nature of each individual's involvement in the incident;

14.1.3.7. The service history with the Contractor, if any, of individuals involved;

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

14.1.3.9. Any legally required notifications made by the Contractor.

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

14.1.4.1. Category One Incidents: the Contractor must report and also notify the TMRSN Incident Manager by telephone or email immediately upon becoming aware of the occurrence of any of the following Category One incidents involving any individual that was served within 365 days of the incident.

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

14.1.4.1.2. Unauthorized leave of a mentally ill offender or a sexual violent offender from a mental health facility or a Secure Community Transition Facility. This includes ETU, CSTU, and Triage Facilities that accept involuntary clients.

14.1.4.1.3. Any violent act to include rape or sexual assault, as defined in RCW 71.05.020 and RCW 9.94A.030, or any homicide or

attempted homicide committed by a client.

14.1.4.1.4. Any event involving an individual or staff that has attracted media attention.

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

14.1.4.2.1. Alleged client abuse or client neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another client.

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

14.1.4.2.3. Any breach or loss of client data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of client personal information. In addition to the standard elements of an incident report, the Contractor shall document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.

14.1.4.2.4. Any allegation of financial exploitation as defined in RCW 74.34.020.

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

14.1.4.2.6. Any event involving a client or staff, likely to attract media attention in the professional judgment of the Incident Manager.

14.1.4.2.7. Any event involving: a credible threat towards a staff member that occurs at a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. A credible threat towards staff is defined as "A communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan.

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

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

14.2. Comprehensive Review: TMRSN or DSHS may require the Contractor to initiate a comprehensive review of an incident.

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

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

14.2.3. DSHS may request medication management information.

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

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

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

14.3.2. Whether the person is in custody (jail), in the hospital, or in the community, and if in the community whether the person is receiving services. If the client cannot be located, the Contractor will document in the Incident reporting system the steps that the Contractor took to attempt to locate the client by using available local resources;

14.3.3. Documentation of whether the client is receiving or not receiving mental health services from the Contractor at the time the incident is being closed.

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

14.3.5. In the case of a telephonic verification, the Contractor will document the date of the contact and both the name and official duty title of the person verifying the information.

14.3.6. If this information is unavailable, the attempt to retrieve it will be documented.

15. INFORMATION REQUIREMENTS

15.1. The Contractor must provide information to enrollees that complies with the requirements of 42 CFR §438.100, §438.10, §438.6(i)(3) or any successor.

15.2. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall;

15.2.1. Ensure equal access to mental health services for enrollees with communication barriers or sensory impairments.

15.2.2. Ensure that Mental Health Professionals and MHCPs have an effective mechanism to communicate with Enrollees with sensory impairments.

15.2.3. Provide interpreter services if necessary for enrollees with a primary language other than English for all interactions between the enrollee and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a concern or grievance.

15.2.3.1. The Contractor and affiliated service providers must maintain a log of all enrollee requests for interpreter services, or translated written material.

15.2.3.2. Provide written translations of generally available materials including, at minimum, applications for services, consent forms and *Benefits Booklets*, in each of the DSHS prevalent languages that are spoken by five percent (5%) or more of the population of the State of Washington based on the most recent US census. Currently, Spanish is the language requiring written translations.

15.2.3.3. The other DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. The Mental Health Benefits booklet which includes client rights has been provided to the Contractor by DBHR. The expectation is that this material is readily available to enrollees at all times from the Contractor.

15.2.3.4. These materials may be provided in English if the enrollee's primary language

is other than English but the enrollee can understand English and is willing to receive the materials in English. The enrollee's consent to receiving information and materials in English must be documented in the enrollee's chart.

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

15.2.3.6. The Contractor and affiliated service providers shall post a multilingual notice in each of the DSHS prevalent languages, which advises consumers that information is available in other languages and how to access this information.

15.2.3.7. The Contractor and affiliated service providers shall post a translated copy of the consumer rights as listed in the Mental Health Benefits Booklet in each of the DSHS prevalent languages.

15.3. Upon an enrollee's request, the Contractor shall make available and provide:

15.3.1. Oral interpretation service free of charge to the enrollee;

15.3.2. Information regarding benefits and authorization requirements;

15.3.3. Identification of individual Mental Health Care Providers (MHCP) who are accepting new enrollees;

15.3.4. Community Mental Health Agency (CMHA) licensure, certification and accreditation status; and

15.3.5. Information that includes but is not limited to, education, licensure, and Board certification and/or re-certification of mental health professionals and MHCPs.

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

15.4.1. The Contractor shall inform every Enrollee at the time of an intake evaluation that the Benefits Booklet produced by DBHR and the Benefits Booklet produced by TMRSN are available anytime upon request. Booklets may be downloaded from: http://www.co.thurston.wa.us/health/ssrsn and http://www1.dshs.wa.gov/Mentalhealth/benefits.shtml.

15.4.2. The Contractor shall provide interpreter services for Enrollee's who speak a primary language other than English and shall use a DSHS authorized vendor, which may include CTS Language link; http://hca.ctslanguagelink.com/.

15.4.2.1. The Contractor shall maintain a log of all requests for interpreter services or written translated materials. Logs must be made available to TMRSN upon request.

15.5. Customer Service

15.5.1. The Contractor shall provide Customer Service that is customer friendly, flexible, proactive, and responsive to Consumers, families, and stakeholders. The Contractor shall provide a local calling area telephone number and a toll free number.

15.5.2. At a minimum, Customer Services shall include:

15.5.2.1. Prompt answering of telephone calls with minimum wait time, from Consumers, family members and stakeholders from 8 a.m. until 5:00 p.m.

Monday through Friday, holidays excluded.

15.5.2.2. Maintenance of an after hours and holiday telephone answering system that informs callers of hours of operation, scheduled closings, and options for reaching on call staff after hours.

15.5.2.3. Responding to Consumers, family members and stakeholders in a manner that resolves their inquiry. Staff must have the ability to respond to those with limited English proficiency or hearing loss.

15.5.2.4. Staff that is trained to route calls to the appropriate staff or department with minimal redialing.

16. QUALITY MANAGEMENT

16.1. All performance measures, reviews, and audits included under this contract shall meet the minimum standard of 90% to be considered compliant. For any measure that has a varying percentage, TMRSN will identify that measure separately. Measures that fall below 90% are subject to corrective and/or remedial actions per Section 23.

16.2. The Contractor shall maintain an ongoing, planned and systematic organization-wide quality management process to measure, asses, analyze and improve its performance. At minimum, the Contractor shall monitor their internal quality management systems and provide monitoring results/outcomes to TMRSN upon request. Monitoring shall include;

16.2.1. Bed utilization of the ETU and CSTU **targeted** at 95% occupancy.

16.2.2. Quality Improvement activities including Performance Improvement Projects.

16.2.3. Implementation of Practice Guidelines and Evidence Based Practices.

16.2.4. Staff productivity which is driven by the most current actuarial performed by DSHS. Productivity levels shall meet or exceed a minimum of 50% towards direct care services.

16.2.5. Staff training requirements per Section 19.

16.2.6. Data accuracy, integrity, and encounter validation

16.2.7. Coordination efforts with primary medical care.

16.3. The Contractor shall monitor and provide quarterly reports per Section 24 on the following performance measures:

16.3.1. Data for each seclusion and restraint event, including;

16.3.1.1. Causes of seclusion/restraint use;

16.3.1.2. Alternatives attempted;

16.3.1.3. Frequency and duration of use;

16.3.1.4. Regulatory compliance;

16.3.1.5. Documentation;

16.3.1.6. Results and/or adverse outcomes;

16.3.1.7. Staff training;

16.3.1.8. Seclusion and restraint reduction measures.

16.4. The Contractor shall conduct internal chart reviews and submit results to TMRSN upon request. Review shall include the quality and timeliness of clinical record requirements, including, but not limited to;

16.4.1. Individualized Service/Treatment Plans;

16.4.2. Consumer Rights;

16.4.3. Efforts to create and support mental health services that are driven by and incorporate the voice of the Client and those they identify as family;

16.4.4. The degree to which mental health services delivered are age, culturally and linguistically competent;

16.4.5. Efforts to create and support services that promote Enrollee recovery and resiliency;

16.4.6. Monitoring activities to ensure that services are offered and provided in the most appropriate and least restrictive environment.

16.4.7. Efforts to provide services that are integrated and coordinated with other formal/informal allied service delivery systems.

16.5. The Contractor shall also monitor additional quality activities and submit results to TMRSN upon request. Activities shall include;

16.5.1. Service utilization, with particular attention to outliers (over and under utilization of services).

16.5.2. Cumulative responses to Enrollee surveys and how they are included into overall quality improvement.

16.5.2.1. Surveys included may be those solicited by the Contractor, DSHS, and TMRSN QRT.

16.5.3. Enrollee Concerns and Grievances and how they are included into overall quality improvement.

16.5.4. The Contractor shall provide quality improvement feedback to staff and other interested parties. The Contractor shall maintain documentation of the activities and provide the documentation to TMRSN upon request.

16.6. Quality Review Activities

16.6.1. Thurston Mason RSN will engage in ongoing quality improvement activities throughout the year. This includes conducting clinical, program, and utilization reviews. Ongoing quality improvement reviews are announced and the Contractor is expected to participate by:

16.6.1.1. Ensuring that clinical records are available for review;

16.6.1.2. Ensuring that staff are present for interviews during program reviews;

16.6.1.3. Creating Program Improvement Plans (PIPs) in response to any TMRSN findings as a result of the quality improvement review; and

16.6.1.4. Enacting recommended programmatic and clinical changes once the PIP has become finalized.

16.6.2. Thurston Mason RSN and Thurston County or any of their duly-authorized representatives, may conduct announced and unannounced:

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

16.6.2.2. Contract, chart, and data quality compliance;

16.6.2.3. Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Contract; and

16.6.2.4. Inspections and/or audits of financial records.

16.6.3. The Contractor shall notify TMRSN when an entity other than TMRSN performs any audit or review described above related to any activity contained in this Contract.

16.6.4. The Contractor shall submit to working with TMRSN annually for the EQRO monitoring review and schedule a time for the monitoring review that works for both parties.

16.6.5. The Contractor shall participate with TMRSN and DSHS in completing the annual Mental Health Statistics Improvement Project (MHSIP) surveys. Participation must include at a minimum:

16.6.5.1. Provision of accurate enrollee contact information to TMRSN.
16.6.5.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis.
16.6.5.3. Incorporation of the results into specific quality improvement activities.

16.7. Agency Licensing and Credentialing

16.7.1. Maintain DSHS and Department of Health (DOH) licensure and certification necessary as "Residential Treatment Facility", "Mental Health Adult Residential Treatment Facility" for the whole facility, and "Mental Health Inpatient Evaluation and Treatment Facility" for the services and space where Evaluation and Treatment Services voluntary and involuntary are to be provided.

16.7.2. Maintain certification as "Inpatient Evaluation and Treatment Facility" and "Community Support Service Provider" in accordance with chapter 388-865 WAC.

16.7.3. Maintain certification as an "Inpatient Evaluation and Treatment Facility" in accordance with Chapter 388-865 WAC and its revisions for the facility space and Evaluation and treatment services to be provided. Maintain all other necessary certifications per WAC 388-865 for the facility space and all other program services.

16.7.4. The Contractor shall meet licensing requirements for a community mental health agency as defined in WAC 388-877 and 388-877A, as they now exist or are hereinafter amended. The Contractor shall ensure that appropriately licensed and certified staff is employed when required by State and Federal regulations and statutes.

16.7.5. All services to adults, older adults, children, and special populations shall include those requirements as described in State WACs 388-865 and 388-877 and any successor. The Contractor shall submit copies to TMRSN of agency licenses, certifications, and proof of insurance annually when renewed.

16.7.6. The Contractor must participate in an agency credentialing process at least every two years. Type of credentialing application, either a complete or recredential, as well as the date of the application process, shall be determined by TMRSN.

16.7.7. The Contractor shall notify TMRSN immediately if there is any change in licensing status or in the event a license or certification is revoked or not renewed.

16.7.8. The Contractor shall submit copies of agency licenses and DSHS and DOH certifications annually when renewed.

17. CLIENT RIGHTS AND PROTECTIONS

17.1. The Contractor and affiliated service providers shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff takes those rights into account when furnishing services to enrollees. Any changes to applicable law must be implemented with 90 days of the effective date of change.

17.2. The Contractor shall maintain written policies and procedures addressing all requirements under this section. Polices must comply with all regulations, laws, contract, and documents as listed under Section 1 of this contract.

17.3. The Contractor must ensure that each enrollee is free to exercise his or her rights, and that the exercising of those rights does not adversely affect the way the Contractor and its providers treat the enrollee.

17.4. The Contractor shall require that mental health professionals and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to:

17.4.1. The enrollee's mental health status;

17.4.2. Receiving all information regarding mental health treatment options including any

alternative or self-administered treatment, in a culturally-competent manner;

17.4.3. Any information the enrollee needs in order to decide among all relevant mental health treatment options;

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

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

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

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

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

17.5. Enrollee's Rights

17.5.1. The Contractor shall ensure enrollee's, prospective enrollee's and legally responsible others are informed, in prevalent non-English languages as described in under this section, of their rights per 42 CFR Part 438.100 and WAC 388-877-0600 or any successors.

17.5.2. Post a written statement of enrollee rights in public areas with a copy available to enrollees on request.

17.5.3. Ensure the statement of enrollee rights incorporates DBHR enrollee's rights listed in the DBHR Handbook.

17.5.4. The Contractor shall ensure that all enrollees on LRAs are informed as to their rights pertaining to Chapter 71.05 RCW, or any successor, and provided all applicable services.

17.6. Additional Rights for Consumers on Less Restrictive Alternative:

17.6.1. To have access to an attorney, the court and other legal redress

17.6.2. To be told statements the consumer makes may be used in the involuntary proceedings

17.6.3. To be advised of rights if detained or committed under RCW 71.05 including, but not limited to:

17.6.3.1. To wear his or her own clothes and to keep and use his or her own personal possessions, except when deprivation of same is essential to protect the safety of the resident or other person;

17.6.3.2. To keep and be allowed to spend a reasonable sum of his or her money for canteen expenses and small purchases;

17.6.3.3. To have access to individual storage space for his or her private use;

17.6.3.4. To have visitors at reasonable times;

17.6.3.5. To have reasonable access to a telephone, both to make and receive confidential calls;

17.6.3.6. To have ready access to letter writing materials, including stamps, and to send and receive uncensored correspondence through the mail;

17.6.3.7. Not to consent to the administration of antipsychotic medications beyond the hearing conducted pursuant to RCW 71.05.320(2) or the performance of electro-convulsant therapy or surgery, except emergency life-saving surgery, unless ordered by a court of competent jurisdiction pursuant to the standards and procedures;

17.6.3.8. To dispose of property and sign contracts unless such person has been adjudicated an incompetent in a court proceeding directed to that particular issue;

17.6.3.9. Not to have psychosurgery performed on him or her under any circumstances;

17.6.3.10. Be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;

17.6.4. Any person who leaves a public or private agency following evaluation or treatment for mental disorder shall be given a written statement setting forth the substance of Section 450 of RCW 71.05 and WAC 388-865-0566.

17.6.5. To have the DMHP or Peace Officer take reasonable precautions to safeguard personal property, including locking the home or other property as soon as possible after being detained.

17.7. Additional Rights for Consumers in Long-term Care Facilities:

17.7.1. To receive appropriate services

17.7.2. To be treated with courtesy

17.7.3. To continue to enjoy their basic rights

17.7.4. To have the opportunity to exercise reasonable control over life decisions, including but not limited to:

17.7.4.1. Choice, participation, privacy, and the opportunity to engage in religious, political, civic, recreational, and other social activities foster a sense of self-worth and enhance the quality of life for long-term care residents.

17.7.4.2. To receive care in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life, including but not limited to:

17.7.4.2.1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

17.7.4.2.2. The right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes, but is not limited to:

- Accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.

17.8. Enrollee Voice in Treatment and Decision Making

17.8.1. The Contractor shall ensure informed consent to treatment and enrollee access to his or her medical records in accordance with WAC 388-877-0650 or any successor.

17.8.2. For enrollee’s under the age of 13 or adults with a legal guardian, appropriate documentation of the informed consent of the guardian must be in the enrollee’s medical record chart.

17.8.3. Every enrollee, and their family, and/or other natural supports, if appropriate and authorized by the enrollee, have a voice in the ongoing process of treatment planning and decision-making. Enrollee voice shall be demonstrated through:

17.8.3.1. Enrollee signature, if age 13 or older;

17.8.3.2. Enrollee’s parent or guardian or legal representative, if age 12 or under;

17.8.3.3. Enrollee quotes and input on treatment plans and 180-treatment plan reviews.

17.8.4. Enrollee quotes and input during the discharge planning process, to include the discharge

summary.

17.8.5. Every enrollee has a choice of contracted CMHA (if more than one is available) within his/her county of residence from which to receive mental health services.

17.8.6. An enrollee may change providers and/or direct service staff based on need and fit of service.

17.9. Individual Service Plans must be developed in compliance with WAC 388-877-0620 and 388-877A-0135.

17.9.1. In addition, the Contractor shall require that enrollees are actively included in the development of their individualized service plans, periodic (every 180 days) service plan reviews, advance directives for psychiatric care, and crisis plans (Section 17.10).

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

17.9.2. At a minimum, individual service plans must include:

17.9.2.1. A problem or needs statement that is in the words of the enrollee to be best extent possible;

17.9.2.2. Services mutually agreed upon by both the individual and provider for this treatment episode;

17.9.2.3. At least one goal that is in the words of the enrollee to the best extent possible, and that directly relates to the problem or needs statement, and to identified needs from the intake assessment;

17.9.2.4. Measurable outcomes and strategies. These are measurable steps the enrollee agrees to attempt in order to meet his/her overarching goal. These are sometimes referred to as objectives or benchmarks;

17.9.2.5. Service modalities; and

17.9.2.6. Discharge criteria, agreed upon between the Contractor and the enrollee, that clearly specifies when the treatment goal has been reached and the enrollee can either be discharged, or a new service plan developed.

17.9.3. Individualized service plans must be reviewed upon re-authorization requests, per the TMRSN LOC Guidelines, or at a minimum every six (6) months, and must include the following elements:

17.9.3.1. An evaluation of service modality effectiveness towards treatment progress;

17.9.3.2. A review of unmet treatment goals and needs;

17.9.3.3. The enrollee's voice in describing personal progress towards their stated goals and measurable outcomes; and

17.9.3.4. A method of determining if the enrollee has met discharge criteria or if further treatment is warranted.

17.9.4. The Individual Service Plan shall address the overall identified needs of the enrollee, including those that may be best met by another service delivery system, such as education, primary medical care, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections and juvenile justice as appropriate. If the treatment plan identifies one of those services, the Contractor shall ensure coordination with the other service delivery systems that shall be responsible for meeting those identified needs.

17.9.5. An individual peer support plan may be incorporated into the Individual Service Plan.

17.10. Risk Assessment and Crisis Plans

17.10.1. The Contractor shall adopt a standardized risk assessment instrument that will assist the mental health professional (MHP) in determining future crisis prevention services.

17.10.2. The Contractor shall perform a risk assessment when it is clinically indicated and in the best interest of the enrollee.

17.10.2.1. At the time of the initial intake assessment the enrollee presents with current and significant risk of harm to self or others.

17.10.2.2. At the time of the initial intake assessment the enrollee presents with a history of significant self-injurious or suicidal behaviors within the past six (6) months from the date of the intake.

17.10.2.3. Any time during the episode of care the enrollee presents with self-injurious or suicidal behaviors, or presents a risk to others.

17.10.3. The Contractor shall utilize the risk assessment tool as a guide to evaluate the level of risk of the enrollee and to determine if the level of risk requires a crisis plan. If it is determined a crisis plan is required, the plan:

17.10.3.1. Shall be written with the enrollee and other natural supports, as available.

17.10.3.2. Can be written in the form of an advance directive.

17.10.3.3. Shall be entered into the MIS within thirty (30) days.

17.10.3.4. Shall include the following elements:

17.10.3.4.1. Date completed;

17.10.3.4.2. Dependent record , to include information on persons and pets;

17.10.3.4.3. Prescriber name;

17.10.3.4.4. Prescriber phone number;

17.10.3.4.5. Current substance abuse/chemical dependency issues;

17.10.3.4.6. High risk and de-compensation patterns; and

17.10.3.4.7. Plan for care providers, emergency personnel and others who might be responding to the actual crisis.

17.10.4. The Contractor shall ensure that the enrollee is provided with a copy of their crisis plan upon completion.

17.10.5. The Contractor shall re-evaluate the enrollee's risk to self or others as determined by the risk assessment score and will complete a new risk assessment at every treatment plan review, per TMRSN's Level of Care Guidelines, until the risk assessment score is at an acceptable level (less than 4). An updated crisis plan shall be developed at six (6) months if necessary.

17.11. Choice of Mental Health Care Provider (MHCP)

17.11.1. The Contractor shall offer each enrollee a choice of an open MHCP accepting new client's within the Contractor's agency. If the enrollee does not make a choice, the Contractor or its designee must assign an MHCP no later than 14 calendar days following the request for mental health services. The enrollee may change MHCPs during the first 90 calendar days of enrollment and once during a twelve-month period for any reason. Any additional change of an MHCP requested by an enrollee during a twelve-month period may be approved at the Contractor's discretion, provided that justification for the change is documented.

17.11.2. For continuity of care, the Contractor shall encourage the subcontractor(s) to assign enrollees to clinicians who are anticipated to provide services to the enrollee throughout the authorization period.

17.12. Second Opinions

17.12.1. The Contractor shall provide, upon request, a second opinion from another Network Provider within the Service Area. If an additional Provider is not currently available within the network, the Contractor must provide or pay for a second opinion provided by a Network Provider outside the network at no cost to the enrollee. The Provider providing the second opinion must hold a contract with a RSN to provide mental health services to Medicaid enrollees. The appointment for a second opinion must occur within 30 calendar days of the request. Only the enrollee may request to postpone the second opinion to a date later than 30 calendar days.

17.13. Enrollees Non-Liability

17.13.1. The Contractor shall ensure enrollees are not held liable for any of the following covered metal health services:

17.13.1.1. Provided by insolvent community psychiatric hospitals with which the Contractor has directly contracted.

17.13.1.2. Including those purchased on behalf of the enrollee.

17.13.1.3. For which the State does not pay the Contractor.

17.13.1.4. Provided to the enrollee, for which the State or TMRSN does not pay the Contractor that furnishes the services under a contractual, referral, or other arrangement.

17.13.1.5. Payments for covered services furnished under a Contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

17.13.1.6. Provided by insolvent federally funded RSNs.

17.14. Thurston Mason RSN Mental Health Ombuds Services

17.14.1. The Contractor shall:

17.14.1.1. Provide information to enrollees regarding the availability of Ombuds' services for assistance in resolving a specific enrollee's concern or grievance.

17.14.1.2. Respond to the Ombuds' requests or inquiries within 24 hours of the initial contact by the Ombuds'.

17.14.1.3. Provide the Ombuds with reasonable access to enrollees, service sites, and records relating to the enrollee, with written consent, for the purpose of outreach and resolving concerns and grievances.

17.14.1.4. Take no measure or action that might threaten, intimidate, or otherwise diminish the ability of the Ombuds to fairly and independently execute her duties, and assure there will be no retaliation against the enrollee/grievant.

17.14.1.5. Respond in writing to recommendations of the Ombuds regarding possible changes in the delivery of services to meet enrollee needs within 30 calendar days of any recommendation from the Ombuds.

17.14.1.6. Comply with WAC 388-865-0250 or any successor.

17.14.1.7. Continue to serve the enrollee while addressing the issue contained in a concern or grievance.

17.14.1.8. Work with the enrollee and Ombuds towards an agreeable resolution in the best interest of the enrollee.

17.14.1.8.1. If the Contractor and the Ombuds do not agree on a suggested resolution, the Contractor and the Ombuds shall contact the TMRSN Grievance Coordinator for assistance.

17.14.1.9. Identify the staff that is responsible for coordinating the agency's information and response regarding the resolution of any concern or grievance.

17.15. Advance Directives

17.15.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects enrollees' Advance Directives for psychiatric care and medical Advance Directives. If State law changes, TMRSN shall send notice to the Contractor who must then ensure the provision of notice to enrollees within 90 days of the change.

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

17.15.3. The Contractor shall inform all Enrollees of their right to a Mental Health Advance Directive, and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.

17.15.4. The Contractor shall inform enrollees that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with HRSA by contacting the Compliance section at (360) 236-2620.

17.15.5. The Contractor shall attend trainings on Advance Directives through DBHR, TMRSN, or Ombuds and disseminate information to enrollees and family members of enrollees.

17.15.6. Inform enrollees in writing about an Advance Directive in anticipation of clinical situations where enrollees are unable to advocate or provide clear information for him or herself.

17.15.7. Assist and/or refer the enrollee to the Ombuds for assistance in developing and implementing Advance Directives for psychiatric care.

17.15.8. Inform the enrollee in writing that he/she has the right to choose whether or not to have an Advance Directive. A record of the enrollees signed statement of their choice shall be maintained in the enrollee's record per 42 CFR 438.10 (g) or any successor.

17.15.9. Advance Directives shall be used as ancillary assistance to any concurrent psychiatric assessment or community based needs assessment for an acute episode, provided that the directive is clinically appropriate to the enrollee's needs and condition at the time.

17.15.10. Make available as part of, or in lieu of the crisis plan, an advanced directive, if the enrollee so chooses.

17.15.11. Assist the enrollee in making their Advance Directive available to those individuals identified in the plan.

17.15.12. Provide access and support to all TMRSN identified individuals including but not limited to the Ombuds, to provide training and support to enrollees interested in developing an Advance Directive, on site, at the Contractor's facility.

18. MANAGEMENT INFORMATION SYSTEM

18.1. Data Submission and Error Correction

18.1.1. The Contractor shall provide TMRSN with all data and encounters described in the TMRSN Data Dictionary that includes the Reporting Guidelines for programs and services, the TMRSN HIPAA and Native Transaction Companion Guides, and the TMRSN File and Data Submission Guide, or, any successors, incorporated herein by reference.

18.1.2. The Contractor shall have in place policies, procedures and/or instructions that address all requirements under Section 18 of the contract.

18.1.3. The Contractor shall electronically submit to or enter encounters directly into the TMRSN Managed Care Organization (MCO) Management Information System (MIS) within 45

calendar days from the date of service.

18.1.3.1. Accurate encounters accepted by TMRSN will be included for payment according to Exhibit B, the Compensation section of this contract, including any amendments to Exhibit B. The cut-off dates for service submission and payment is the Friday before "Date Invoice for Review by Thurston County & Providers" as listed in Exhibit B.

18.1.3.2. No submitted encounter shall be accepted for initial entry/submission or data correction after one year from the date of service, unless by special exception.

18.1.4. The Contractor shall submit or enter all other required staff data, client data, and electronic documentation within ten (10) calendar days from the date of collection or receipt, as this data is required for encounter submissions/entries to be processed and accepted.

18.1.4.1. Periodic Review data shall be submitted or entered upon admission, at change, and at discharge for enrolled clients. At a minimum, the primary case manager of record shall review the entire periodic review record for accuracy and submit changes for entry into the Contractor MIS at least every six (6) months.

18.1.4.2. If a crisis plan is necessary, the Contractor must submit an electronic file of the client's crisis plan to the RSN MCO MIS within 30 days of admit or when it is determined a crisis plan is needed, per Section 17.10.

18.1.5. Upon receipt of Contractor data and encounters, TMRSN will generate error reports. The Contractor shall have in place documented procedures to ensure that data submitted/entered and pended/denied due to provider errors or incompleteness are corrected and resubmitted within 30 calendar days of initial submission to TMRSN.

18.1.5.1. Pended or denied encounters that are not corrected, resubmitted, and accepted within the 45-day requirement for encounter submission timeliness will not be considered timely.

18.1.5.2. In addition, the Contractor shall have in place documented procedures to ensure that Contractor data submitted by TMRSN that is rejected by DBHR and/or ProviderOne due to Contractor errors is corrected and resubmitted within ten (10) calendar days of notification by TMRSN.

18.1.6. The Contractor shall incur all costs including, but not limited to, hardware, equipment maintenance, software, and connection costs necessary to transmit data and transactions to the TMRSN MCO MIS and/or access the TMRSN MIS/MCO MIS, the DBHR Enrollee Information System (DBHR-CIS), and the HRSA ProviderOne system.

18.1.7. The Contractor shall participate in regularly scheduled TMRSN MIS System Operator (SysOp) Committee meetings. TMRSN and the Contractor's designated SysOp member(s) shall work together to respond to inquiries or to assist in TMRSN decisions regarding data requirements and compliance. Meetings may include changes to data collection and information systems to meet the terms of this and other contracts, implementation of data collection requirements, monitoring of MIS access and security, error correction, incomplete or invalid data issues, and data timeliness.

18.1.8. The Contractor shall implement data-related changes and requirements as directed by and in coordination with TMRSN Contracts and/or Protocols.

18.1.8.1. Changes shall be implemented within 90 days from the date of published changes or as otherwise specified by TMRSN and/or by DBHR. These changes may be the result of an update to DBHR requirements in the DBHR Service Encounter Reporting Instructions for RSNs (SERI), the DBHR-CIS

Data, and/or the ProviderOne Encounter Data Reporting Guide for MCOs and RSNs, or any of their successors, incorporated herein by reference.

18.1.8.2. The Contractor shall send at least one test batch of data containing the required changes no later than 15 days prior to the implementation date.

18.1.8.2.1. The test batch must include a sample of all Programs / Project codes, Service Activity Codes, and/or other data elements affected by the change in requirement.

18.1.8.2.2. The processed test batch must result in at least 90% successfully posted transactions or an additional test batch is required.

18.1.9. For data/information not covered by the TMRSN or DBHR-CIS Data Dictionaries or the DBHR Service Encounter Reporting Instructions, the Contractor shall ensure that TMRSN receives requested information in a manner that shall allow for a timely response to requests or inquiries from TMRSN, Centers for Medicaid Services (CMS), the State Legislature, DBHR/DSHS, and other parties.

18.2. Contractor and Subcontractor Data Quality Verification

18.2.1. The Contractor shall have in place mechanisms to verify the health information collected and submitted by the Contractor to TMRSN, as well as all data received from any Subcontractors. Mechanisms shall include the following:

18.2.1.1. Verifying the accuracy of Contractor and Subcontractor data by a review of DBHR, TMRSN, or Contractor error reports, error resolution reports and/or timeliness reports;

18.2.1.2. Screening and performing data quality monitoring on all data for accuracy, completeness, logic, consistency, and timeliness of submission. This includes, but is not limited to ensuring appropriate services are provided by allowable staff, that only allowable services are provided within programs, and that all data requirements and guidelines have been adhered to according to the TMRSN and DBHR-CIS Data Dictionaries and the DBHR Service Encounter Reporting Instructions (SERI) for RSNs.

18.2.1.3. Verifying that duplicative or overlapping services are not submitted to TMRSN.

18.2.1.4. In addition, the following is information that is required, at a minimum, for reporting an encounter to a consumer, documenting that encounter in a progress note, and submitting that encounter to TMRSN and DBHR:

18.2.1.4.1. Be of sufficient duration to accomplish the therapeutic intent;

18.2.1.4.2. The record must be legible to someone other than the writer;

18.2.1.4.3. Each printed page (front and back if two-sided) of the record must contain the consumer’s name and agency record number;

18.2.1.4.4. Clinical entries must include the Author identification, which may be a handwritten signature or unique electronic identifier, but must be clearly identifiable as to whom the rendering clinician/staff is;

18.2.1.4.5. Date of the service;

18.2.1.4.6. Time of the service.

- For providers that are unable to submit time of day for the service in their 837P electronic transaction, this information

must be provided within 7 days of the initial service submission date to the RSN in a format that can be imported into the MCO MIS.

18.2.1.4.7. Location of the service;

18.2.1.4.8. Provider credentials, which must be appropriate to the service (e.g., medication management can only be done by a prescriber);

18.2.1.4.9. Length of time/service duration;

18.2.1.4.10. Narrative description of the service provided as evidenced by sufficient documentation that can be translated to a service description title or code number (this may be standard CPT/HCPCS or local nomenclature with a RSN approved crosswalk) and describes therapeutic content;

18.2.1.4.11. The service addresses an issue on the care plan or issue addressed is added to the care plan; and

18.2.1.4.12. The service is specific to the consumer; e.g., group therapy progress note is specific to the consumer.

18.2.2. The Contractor shall submit to an administrative and/or on-site MIS audit and Encounter Data Validation chart audits by TMRSN during this contract period. The audits shall be IS- and/or IT-related and shall include, but not be limited to, the review of data, encounters and data/encounter documentation, internal IS and IT policies and procedures, MIS data accuracy, timeliness, completeness, and consistency practices, and MIS training practices.

18.3. Data Certification

18.3.1. The Contractor shall provide certification of data and encounters required by this Contract and submitted to TMRSN. The data and encounters shall be certified by one of the following:

18.3.1.1. The Contractor's Chief Executive Officer (CEO);

18.3.1.2. The Contractor's Chief Financial Officer (CFO);

18.3.1.3. An individual who has delegated authority to sign for and who reports directly to the CEO or CFO.

18.3.2. The certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and encounters submitted to TMRSN according to the following:

18.3.2.1. For Contractors using TMRSN's Direct Data Entry (DDE) process to submit data/encounters, a certification must be provided to TMRSN for each month of the contract period for all data and encounters submitted within the given month.

18.3.2.2. For Contractors submitting electronic transactions/files, a certification must be provided to TMRSN for each month of the contract period for the batches/files submitted within the given month.

18.3.2.3. Data and encounters that contain errors shall not be considered certified until corrections for all errors are successfully received and processed by TMRSN.

18.3.3. The Contractor shall use only the TMRSN-supplied certification form as provided in TMRSN Policy IS801: Provider Data Certification.

18.3.3.1. The Contractor shall submit a signed certification form in either electronic format or by mail within 60 calendar days from the end of each month in the

contract period. The Contractor shall ensure that each certification contains an original signature of the signing authority.

18.4. Information System Security and Protection of Confidential Information

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

18.4.2. The Contractor shall ensure that confidential information provided through or obtained by way of this Contract or services provided is protected in accordance with the Data Security Requirements contained in Exhibit D.

18.4.3. The Contractor shall maintain a statement on file for each employee and all Subcontractor employees that have access to the Contractor's electronic health record database or the RSN MIS/MCO database (such as RSN Look) that is signed by the individual and attested to by a witness's signature acknowledging that the individual understands and agrees to follow all regulations on confidentiality.

18.4.3.1. Contractor staff requiring access to the TMRSN database must be granted access based on "need-to-know" or role-based security standards in accordance with HIPAA Security Rule guidelines, TMRSN policies and procedures, the Business Associate Agreement Addendum, and TMRSN MIS Instructions.

18.4.3.2. The Contractor shall provide the appropriate confidentiality and security training to personnel that have access to client confidential data (Protected Health Information or PHI).

18.4.4. The Contractor shall take appropriate action if a Contractor or Subcontractor employee wrongly or willfully releases confidential information according to HIPAA requirements and applicable TMRSN Policy and Procedures.

18.5. Business Continuity and Disaster Recovery

18.5.1. The Contractor shall demonstrate a primary and backup system for electronic submission of data required or requested by TMRSN and DBHR. This must include the use of the Inter-Governmental Network (IGN), Information Systems Services Division (ISSD), Thurston County approved secured Virtual Private Network (VPN), or other approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission shall be considered based on TMRSN and/or DBHR approval.

18.5.2. The Contractor shall create and maintain a business continuity and disaster recovery plan that ensures timely reinstitution of their connectivity and access to the MIS following a total loss of primary connection or a substantial loss of functionality. The plan must be in written format, have an identified update process (at least annually), and a copy must be stored off site.

18.5.3. The Contractor must require a business continuity and disaster recovery plan for all Subcontractors that are required to submit data and/or encounters either electronically or by other means such as a Service Activity Log (SAL), an MIS Demographic or Short Form, or a copy of a Subcontractor's invoice if TMRSN-required data is entered and submitted to TMRSN from these documents.

18.5.4. The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must be submitted by January 1 of each year of this Agreement. The certification must indicate that the plans are up to date, the system and data backup and

recovery procedures have been tested, and copies of the Contractor and Subcontractor plans are available for TMRSN, DBHR, and or the contracted EQRO to review and audit. The business continuity and disaster recovery plan must address the following:

18.5.4.1. A mission or scope statement;

18.5.4.2. An appointed Information Services Disaster Recovery Team;

18.5.4.3. Provisions for Backup of Key personnel; Identified Emergency Procedures; Visibly listed emergency telephone numbers

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

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

18.5.4.6. Off-site storage of system and data backups; Ability to recover data and systems from back-up files;

18.5.4.7. Designated recovery options, which may include use of a hot or cold site; and

18.5.4.8. Evidence that disaster recovery tests (data recovery from a back-up file) or drills have been performed.

19. PERSONNEL AND STAFF TRAINING

19.1. The Contractor, through delegation, shall verify all staff credentials, education, and competency prior to initiating work with clients.

19.1.1. Ensure Mental Health Professionals, Designated Mental Health Professionals, and Mental Health Specialists are credentialed in accordance with *TMRSN Policy SD230 Credentialing of Mental Health Professionals and Specialists and TMRSN Policy SD231 Designated Mental Health Professionals*.

19.2. The Contractor shall conduct upon hire and at every annual employee review a criminal background check and an excluded provider check through the Office of Inspector General (OIG).

19.2.1. Any staff to be found on the OIG Excluded Provider Lists or to have committed a crime listed on the DSHS Secretary Lists of Crimes and Negative Actions (available at http://dshs.wa.gov/bccu/bccucrimeslist.shtml), must immediately stop providing any services under this contract or any other contract between TMRSN and the Contractor.

19.3. Document that staff, clinical supervisors, and management staff are qualified, as set forth in WAC 388-865-0551, for the positions they hold and have the education, experience, or skills to perform job functions.

19.4. Assign, orient, supervise, monitor and perform regularly scheduled performance review sessions for all staff positions.

19.5. The Contractor shall conduct or make available formal training for all staff pertinent to their position. An individualized annual training plan must be implemented for each direct service staff person and supervisor, to include at a minimum:

19.5.1. The skills he or she needs for his/her job description and the population served;

19.5.2. Least restrictive alternative options available in the community and how to access them;

19.5.3. Managing assaultive/aggressive behavior, including proper use of seclusion and/or restraint procedures;

19.5.4. Safety and violence prevention per RCW 49.19.030;

19.5.5. Confidentiality of records and client information;

19.5.6. Quality assurance and process improvement;

19.5.7. Emergency / Disaster Response;

19.5.8. Consumer's Rights;

19.5.9. TMRSN Grievance System;

19.5.10. Professional Ethics and Fraud and Abuse;

19.5.11. Suicidal risk identification and intervention;

19.5.12. Cultural diversity and sensitivity training;

19.5.13. Strategies for treatment-resistant Consumers and discharge planning;

19.5.14. Utilizing natural supports, building on Consumer strengths, and recovery and resiliency;

19.5.15. Basic Life Support (CPR and first aid);

19.5.16. Infection control, including HIV / AIDS;

19.5.17. Customer Service with Behaviorally Challenged Consumers; and

19.5.18. Psychotropic medications (if applicable).

19.6. Ensure all Registered Nurses shall have training in the following topics annually:

19.6.1. Invasive nursing procedures;

19.6.2. High risk / low frequency nursing procedures;

19.6.3. Psychotropic medication update;

19.6.4. Laws and trends related to the use of seclusion and restraint; and

19.6.5. Delegation of tasks.

19.7. The Contractor shall maintain a central record of all trainings provided and who attended, as well as document in staff personnel files completion of trainings, and other educational pursuits, and whether staff attended in person or training was obtained through electronic media.

19.8. Ensure all trainings are provided as required by federal or state laws, rules and regulations, and in accordance with professional standards of practice and the terms of this Contract, including provisions for annual training and staff development under individualized staff training plans.

20. GRIEVANCE SYSTEM

20.1. The Contractor is required to have a Grievance system that complies with the requirements of TMRSN Policy QM603: Grievances and TMRSN AP1101: Grievance Plan, as well as the requirements of this Contract.

20.2. The Contractor must provide information about the Grievance System to all Enrollee's.

20.3. The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract.

20.4. The Contractor shall provide enrollees with any assistance necessary to complete forms and other procedural steps for Grievances. Assistance may be provided by the Ombuds serving the Contractors geographic area, the Enrollee's provider, the Contractor, or any other person of the enrollee's choice.

20.5. An Enrollee or their authorized representative may file a Grievance either orally or in writing with the Contractor or its providers.

20.6. Recordkeeping and Reporting Requirements:

20.6.1. If an Enrollee expresses a concern that can be categorized into one of the topics below, it shall be considered a grievance and shall be reported to TMRSN. The Contractor shall report all Grievances to the TMRSN Quality Manager on the Provider Grievance Notification Form attached herein. Topics include:

20.6.1.1. Access to Outpatient

20.6.1.2. Dignity and Respect

20.6.1.3. Quality/Appropriateness

20.6.1.4. Phone Call Not Returned

20.6.1.5. Service: Intensity, Not Available, Coordination

20.6.1.6. Consumer Rights

20.6.1.7. Physicians and Medications

20.6.1.8. Financial and Admin Services

20.6.1.9. Transportation

20.6.1.10. Emergency Services

20.6.1.11. Violation of Confidentiality

20.6.1.12. Access to Inpatient Services

20.6.2. The Contractor shall complete the report form located on the TMRSN website at https://ftp.co.thurston.wa.us/tmrsn-report/index.aspx for each concern or grievance received by the Contractor.

20.6.3. The Quality Manager will review the concern/grievance and determine the appropriate action, which may include follow-up by the Ombuds, TMRSN, or the Contractor.

20.6.4. The Contractor's grievance system must maintain records of all concerns and Grievances originating at the Contractor.

20.6.5. The Contractor shall incorporate the results of concerns and grievances, appeals and fair hearings into its quality management plan and address any trends in a quality improvement plan.

20.7. Fair Hearings – **This function is only available to Medicaid Funded enrollees**

20.7.1. Enrollees may request a Fair Hearing conducted by independent state agency in accordance with WAC 388-02 and provisions of mental health services per WAC 388-865 and 388-877.

20.7.2. The parties to a Fair Hearing include TMRSN, the Contractor as well as the enrollee and his or her representative or the legal representative of a deceased enrollee's estate.

20.7.3. A Fair Hearing may be requested from the State of Washing Office of Administrative Hearings when:

20.7.3.1. An enrollee believes there has been a violation of DSHS rule.

20.7.3.2. The Contractor does not provide a written response to a grievance within the required timeframes.

20.7.3.3. An enrollee receives an adverse ruling by the Contractor or its agent to a grievance.

20.7.3.4. If the enrollee elects to request a Fair hearing, the request must be filed within 20 calendar days from the date of notice of adverse ruling.

20.7.4. TMRSN and/or DBHR will notify the Contractor of hearing determinations. The Contractor will be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision.

21. COMMUNITY COORDINATION

21.1. Disaster Response

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

21.1.1.1. Attend TMRSN and DBHR-sponsored training regarding the role of the public mental health system in disaster preparedness and response.

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

21.1.1.3. Provide Disaster Outreach in Contractor's Service Area in the event of a disaster/emergency; "Disaster Outreach" means contacting person's in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.

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

21.1.1.4.1. Locating persons in need of disaster relief services.

21.1.1.4.2. Assessing their needs.

21.1.1.4.3. Engaging or linking persons to an appropriate level of support or disaster relief services.

21.1.1.4.4. Providing follow-up mental health services when clinically indicated.

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

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

21.1.1.7. Provide the name and contact information to TMRSN for person(s) coordinating the Contractor's disaster/emergency preparedness and response upon request.

21.1.1.8. Provide information and preliminary disaster response plans to TMRSN within seven days following a disaster/emergency or upon request.

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

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

21.1.1.9.2. Coordination of disaster outreach activities following an event.

21.1.2. For EXTERNAL emergency or disaster situations where there may be a change in structural or functional integrity, a need for evacuation of clients, a sudden influx of clients or community-wide effects the Contractor shall:

21.1.2.1. Maintain mutual agreements with local facilities for temporary emergency shelter;

21.1.2.2. Identify how the premises shall be evacuated, if necessary, and the meeting location after evacuation;

21.1.2.3. Identify actions the staff shall take if clients cannot return to the building;

21.1.2.4. Identify methods to address care of clients with special needs during and after the emergency;

21.1.2.5. Identify how family contacts shall be facilitated;

21.1.2.6. Have mechanisms in place to provide for post-disaster counseling;

21.1.2.7. Provide for disaster outreach as defined in Exhibit A for the Contractor's community at large in the event of a disaster;

21.1.2.8. Ensure provisions for clients including but not limited to emergency medications, food, water, clothing, shelter, heat and power.

21.1.2.9. Ensure protection of client records.

21.1.3. For INTERNAL emergency situations where the care of current clients and safety of others in the Evaluation & Treatment Facility are in jeopardy, such as medical emergency, elopement, stalking or violent behaviors, the Contractor shall:

21.1.3.1. Ensure emergency phone numbers are adjacent to phones;

21.1.3.2. Ensure proper function of duress alarm and paging systems;

21.1.3.3. Ensure staff competency in response to violent behaviors, including, but not limited to the safe and appropriate use of seclusion and restraint;

21.1.3.4. Ensure staff competency in basic life support and first aid procedures.

21.1.3.5. Develop and maintain protocols for client supervision, movement and transfers, in specific emergencies, in collaboration with law enforcement, local emergency departments, and other professionals.

22. TRIBAL RELATIONSHIPS

22.1. The Contractor shall attempt to build relationships as well as support the efforts of TMRSN to develop Coordination Implementation Plans with each Tribe and any Recognized American Indian Organization (RAIO) identified in the Thurston Mason service area.

22.1.1. If an Enrollee is a Tribal Member and is referred to or presents for non-crisis services and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the Enrollee.

22.1.2. Supporting efforts may consist of taking part in plan development, having a role in the process and outcome of the plan, and/or providing training about the mental health system and how to access outpatient services provided by the Contractor to Tribes and RAIO's.

22.1.3. The Tribes or RAIOs listed below have service areas within the contracted Service Area of the RSN which are defined in the following documents:

22.1.3.1. The Indian Health Services map that represents Contract Health Service Delivery areas as published in the Federal Register;

22.1.3.2. The Bureau of Indian Affairs Service Area map; and

22.1.3.3. The DSHS 7.01 Policy, which identifies the Recognized American Indian Organizations (RAIOs).

Chehalis, Cowlitz, Nisqually, Puyallup, Skokomish, Squaxin Island, Suquamish.

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

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

23. REMEDIAL ACTIONS

23.1. TMRSN may initiate remedial action if it is determined that any of the following situations exist:

23.1.1. A problem exists that negatively impacts individuals receiving services.

23.1.2. The Contractor has failed to perform any of the mental health services required in this Contract.

23.1.3. The Contractor has failed to develop, produce, and/or deliver to TMRSN any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Contract.

23.1.4. The Contractor has failed to perform any administrative function required under this Contract. For the purposes of this section, “administrative function” is defined as any obligation other than the actual provision of mental health services.

23.1.5. The Contractor has failed to implement corrective action required by TMRSN and within prescribed timeframes.

23.2. TMRSN may impose any one or more of the following remedial actions in any order:

23.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to TMRSN within 30 calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Contract. TMRSN may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

23.2.1.1. Corrective action plans must include:

23.2.1.1.1. A brief description of the situation requiring corrective action.

23.2.1.1.2. The specific actions to be taken to remedy the situation.

23.2.1.1.3. A timetable for completion of the actions.

23.2.1.1.4. Identification of individuals responsible for implementation of the plan.

23.2.1.2. Corrective action plans are subject to approval by TMRSN, which may:

23.2.1.2.1. Accept the plan as submitted.

23.2.1.2.2. Accept the plan with specified modifications.

23.2.1.2.3. Request a modified plan.

23.2.1.2.4. Reject the plan.

23.2.1.3. Any corrective action plan that was in place as part of a previous Contract shall be applied to this Contract in those areas where the Contract requirements are substantially similar.

23.2.2. Withhold up to five percent of the next monthly payment and each monthly payment thereafter until the situation has been resolved. TMRSN, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

23.2.2.1. Increase withholdings identified above by up to an additional three percent for each successive month during which the remedial situation has not been resolved.

23.2.3. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Contract or any other arrangement by which TMRSN provides incentives.

23.2.4. Terminate for Default as described in the General Terms and Conditions; this may include releasing a Request for Proposals to re-procure the services provided under this Contract.

23.2.4.1. If the Contract is terminated for default the Contractor may not respond to the released Request for Proposal as described above unless authorized by TMRSN.

24. CONTRACT DELIVERABLES

24.1. The Contractor is responsible for submitting all deliverables described in this section and throughout the Contract in a timely manner. Deliverables shall be submitted in the format that is identified or provided by TMRSN and shall be submitted through one of the following mechanisms; the SFTP site, email, fax, or hard copy mail. All deliverables shall be submitted to Kristy Lysell. If a deliverable is submitted through the SFTP site, a notification shall be emailed to lysellk@co.thurston.wa.us indicating a deliverable is available.

24.2. If this Contract requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Contract between the parties the Contractor may provide one (1) report or deliverable that contains the information required by both Contracts.

24.3. *Excluded Providers

24.3.1. The Contractor shall submit an Employee Roster for the purpose of monitoring excluded providers, which must include employees first name, last name, and date of birth. The Report shall be submitted electronically, in an Excel spreadsheet, by no later than the 10th of each month.

24.3.2. The Roster shall include any individuals/entities with a direct or indirect ownership or control interest of 5% or more, including, but not limited to;

24.3.2.1. Providers that furnish mental health services, to include supervisory employees even if they don't provide direct service;

24.3.2.2. Individuals directly or indirectly conducting day-to-day operations;

24.3.2.3. Employees who exercise operational or managerial control (e.g. CEO, general manager, business manager, accountant, claims processor, utilization reviewer, administrator or director);

24.3.2.4. Any other employee, consultant or subcontractor that provides items or services significant or material to entity's obligations under the contract with TMRSN; and

24.3.2.5. Board members, Interns, and Volunteers.

24.3.3. TMRSN may require the Contractor to submit additional employee information if there is a possible name match between the Employee Roster and the OIG Excluded Provider database. Additional information may include; middle names, address, and type of license and/or specialty.

24.4. Quality Management Reports

24.4.1. Seclusion & Restraint per Section 16.3.

24.4.1.1. The Contractor shall submit the seclusion and restraint deliverable quarterly by the 10th of month per the table below.

24.5. *Staff Training

24.5.1. The Contractor shall submit on a quarterly basis, a roster of all employees who attended the training identified in Section 19.5.4 of this Contract.

24.6. *Staffing Report

24.6.1. The Contractor shall submit the staffing report, provided by TMRSN as an Excel document, per 24.1 on a quarterly basis. All columns of the report must completed or an N/A must be entered.

24.7. Hospital Liaison FTE Report

24.7.1. The Contractor shall submit a monthly report with the monthly invoice per section 10.3.2.3 that includes the total FTE and total number of clients seen.

24.8. Deliverable Table

Deliverable	Submitted	Report Period Example	Report Due Date	Format
*Excluded Provider	Monthly	Active employees as of the 1st of each month	By the 10th of each month	Excel File
Seclusion & Restraint	Quarterly	Jan 1 – March 31	May 10th	Excel File
*Staff Training	As provided	Employees in attendance at each training	After each training	Provider List
*Staffing Report	Quarterly	Active employees	April 10, 2015 July 10, 2015 Oct 10, 2015 January 10, 2016	TMRSN Provided Excel File
Hospital Liaison Report	Monthly	Jan 01 – Jan 31	By the 10th of each month	Provider Report
Exhibit B	Section 6			
CIO Activity Log and Performance Tracking: Excel File, See Attachment 1 and Exhibit C				

*All staffing reports can be combined into one single report if the Contractor chooses. However, if it does become one report, then it must be submitted on a monthly basis, not quarterly or as occurs. In addition, all required information from each individual report must be captured in one Excel Spreadsheet.

ATTACHMENT 1

Community Integration Outreach Services
STATEMENT OF WORK

Services provided under this Contract Attachment shall be delivered in accordance with all laws, regulations, and service delivery requirements as described in this Exhibit A: Statement of Work.

1. PROGRAM DESCRIPTION

1.1. The purpose of the Community Integration Outreach (CIO) program is to provide team based intensive services in three (3) distinct but inter-related service areas. Services are intended to engage, stabilize and coordinate care for "hard to serve" and "at risk" mentally ill adults. The three service areas, general locations and target populations are:

1.1.1. Incarcerated individuals with a known or suspected mental illness, which contributed to their involvement in the criminal justice system;

1.1.2. Incarcerated mentally ill individuals ready for release and transition back to the community; and

1.1.3. Mentally ill enrolled individuals in the community or unenrolled consumers in institutions or other settings ready for discharge, who are homeless or are likely to become homeless due to their mental illness and eligible for RSN services. This would include homeless individuals who are high utilizers of emergency services.

1.2. Services are to be provided in the jails and in the community, and should complement and not duplicate other services available and/or being provided.

1.3. Community based services will emphasize outreach and not be provider clinic/facility based. Outreach services will include case finding for enrolled and un-enrolled clients where traditional clinic based services are ineffective.

1.4. Services are intended to focus on symptom management and community stabilization through direct intervention. Transition to the community and linkage permanent support housing is an essential element.

1.5. Services are to be provided in collaboration with other systems, such as law enforcement/criminal justice, housing supports/programs, outpatient and inpatient mental health providers and DSHS/Health Care Authority, to ensure a coordinated response for the individual.

1.6. Services are intended for individuals who meet the criteria for "priority population" as defined in RCW 71.24. This includes those with an acute or chronic mental illness, and those individuals that meet the Access to Care criteria that are Medicaid eligible or potentially eligible but need assistance to apply for benefits.

1.7. A blend of funding resources is provided to meet the objectives of serving Medicaid eligible individuals and/or facilitating Medicaid enrollment for individuals with a mental illness. Flexible funds will also be available to assist with housing related rental costs, such as security/utility deposits and monthly rent/utilities on a time limited basis when necessary.

2. SPECIFIC PROGRAM AREAS

Program Staff (6.10 FTE)	Jail Intensive Case Management (ICM)	Transitional Case Manager (TCM)	Intensive Case Manager (ICM)
Type of Service Area	**Jail/incarcerated/ diversion/pre-release**	**Transitional/ Community Integration**	**Outreach/ Engagement**
Types of services/ activities	Screen/ID MI; Brief intake; Crisis intervention; brief tx; psychoeducation; transition planning; diversions; warm hand-offs to TCM; cross system collaboration; identify jail staff training/consultation needs & provide	Transitional CM; brief Tx; intakes; psychoeducation; supportive interventions to stabilize & return to community; post-release & post-d/c links to OP, housing, other community resources; cross system collaboration; warm hand-offs to OP	Early outreach; identification of MI; screen & referrals, intakes; mental health interventions and stabilization, diversions; links to housing, OP services, community resources; psychoeducation; cross system collaboration; identify need for consultation on MI to shelters, community stakeholders
Locations	In jails – Olympia City, Thurston County and Mason County Jails	In jails and out in the community – E&T, inpatient psychiatric facilities	In the community - shelters, streets, homeless camps, E&T, inpatient psychiatric facilities
Source of Referrals/Access	Jail staff, court liaison/staff, booking reports, self/family	Jail/corrections staff, courts, CIO staff, TMRSN, Providers, E&T, IP d/c planners, housing resources, cross-systems	Shelters, homeless advocates, providers, E&T, IP d/c planners, care managers, CIO staff, TMRSN
Service Overlaps	With TCM for post-release Transitional planning, community outreach & integration as needed	With Jail Coordinator for pre-release planning; ICM for outreach & engagement, IP d/c housing options, linkages to OP, housing providers, other community resources	With TCM for stabilization interventions, brief tx, IP d/c housing options, links to OP, housing providers, other community resources
Target Population/ Eligibility	Incarcerated or pre-booking & Identified with mental illness, history of hospitalization &/or OP MH tx; symptoms of acute MI; at risk of harm	Incarcerated pending release/post release; in E&T or IP hospital pending or post discharge; enrolled/previously enrolled in MH tx	MI or symptoms of acute MI & homeless or risk of losing housing; IP d/c & others with MI and barriers to housing access; Non-enrolled but eligible for Medicaid

3. PROGRAM COMPONENTS/ACTIVITIES

3.1. The Contractor shall:

3.1.1. Identify key contacts in each jail location and develop specific communication and referral process.

3.1.2. Provide crisis intervention and brief treatment to incarcerated individuals as requested/needed.

3.1.3. Screening and referral to most appropriate service area.

3.1.4. Identify eligibility and enrollment status.

3.1.5. Provide brief or full intake assessments to determine provisional mental health

diagnosis, and determine if Medical Necessity and Access to Care criteria are met.

3.1.6. Assist with SSI/SSDI applications and reinstatements as needed.

3.1.7. Assist with enrollment in Health Exchange and assignment of a health plan/primary care provider as needed.

3.1.8. Provide brief treatment and psycho-educational interventions to all identified populations as needed.

3.1.9. Provide case management and stabilization treatment services.

3.1.10. Provide coordination of care with other outpatient mental health and chemical dependency services, housing supports, and community resources as needed.

3.1.11. Facilitate "warm hand-offs" as needed to ensure connection with subsequent services and supports.

3.1.12. Provide training and consultation to cross system partners on mental illness.

3.1.13. Accept and prioritize referrals from law enforcement, TMRSN, and points of critical care such as homeless shelters and emergency rooms.

3.1.14. Services are not intended to be based on "normal business hours", i.e. Monday thru Friday 8:00 am to 5:00 pm; service hours will fluctuate with the community need. Thurston County Jail requires intensive case management services during weekend hours.

3.2. Intensive Case Management (ICM)

3.2.1. Intensive Case Management is defined as providing a sufficient level of services to ensure the client remains stable in the community and is diverted from inpatient hospitalization, incarceration and homelessness.

3.2.2. For ICM staff **not** housed in a correctional facility, caseloads shall be kept between ten (10) and fifteen (15) clients per case manager. Length of stay is based on necessary time to stabilize the client in the community. This would include assisting the client to find and remain in housing. If the client is not stable or at risk of recycling to an acute state, they may continue on the ICM caseload. The projected target is approximately one third (33%) of a caseload is for "long term" clients.

3.2.3. The Contractor shall provide services within the community where the homeless or near homeless population is located, to include; shelters, the "street", hospitals, emergency rooms housing programs, and the jail. ICM personnel are expected to accept "warm handoffs" from the transition case manager in the Thurston and Mason County jails and the Olympia City Jail.

3.2.4. The Contractor is expected to provide ICM services to expedite and facilitate an individual's return to the community. This will include going on site to initiate treatment.

3.2.5. ICM will include stabilization services to maintain the person in the community when at risk for inpatient care, homelessness, and incarceration.

3.2.6. If the client is already enrolled in outpatient services, the ICM and primary case manager are expected to collaborate with one another and coordinate services, including scheduling, to ensure the adequate level of care for the mutual client.

3.2.7. Referrals to ICM will come from any number of critical sites, to include, law enforcement, the RSN, community housing personnel, and other behavioral health stakeholders.

3.2.8. The ICM case load will target approximately 50% community referrals and 50% incarceration all of whom would be determined to be "high utilizers" or at risk of going inpatient or becoming incarcerated. No more than 20% of the case load will be from existing outpatient contractor services without RSN authorization.

3.3. Housing Component of Intensive Case Management Services

3.3.1. The Contractor shall document all efforts to facilitate housing for consumers who are homeless or at imminent risk of becoming homeless, in the appropriate ICM record.

3.3.1.1. The primary goal of housing assistance is to link mentally ill adults and their families, with or without chemical dependency issues, to safe and permanent housing. The Contractor shall partner with qualified housing programs utilizing the housing support funds from this contract to assist in identifying housing options and placement for this highly vulnerable and high utilizer homeless population. All efforts shall be made to assist with discharge planning from institutions to prevent homelessness including placement into shelters. These services may include, but not be limited to:

3.3.1.1.1. The Contractor partnering with other Thurston County Public Health and Social Services (PHSS) programs (specifically Housing) for the purpose of assisting and placement of mentally ill individuals with sustainable housing;

3.3.1.1.2. The Contractor facilitating linkage to all necessary services to assist the individual. Such services include primary care and chemical dependency treatment services;

3.3.1.1.3. Assisting consumers with rental applications, credit checks, background checks, and other tasks associated with securing housing;

3.3.1.1.4. Assisting consumers, on a case-by-case basis, with damage and security deposits, along with other associated rental fees; and

3.3.1.1.5. Coordinating with the consumer's primary Case Manager.

3.3.1.2. Rental subsidies are not intended to underwrite existing BHR owned property without prior authorization from the RSN.

4. PROGRAM OBJECTIVES

4.1. Decrease the number and duration of inappropriate incarcerations of persons with mental illness.

4.2. Reduce recidivism of mentally ill individuals incarcerated and/or hospitalized by providing meaningful assistance with transition planning and return to the community.

4.3. Decrease the number of homeless mentally ill individuals and those at risk of losing housing.

4.4. Provide timely response to requests for screening, identification and brief treatment of individuals with mental illness or symptoms associated with an acute mental disorder.

4.5. Decrease the need for more restrictive levels of care by providing early outreach and engagement, referrals and linkage to appropriate community resources.

4.6. Reduce barriers to obtaining stable housing by partnering and linking individuals with available housing supports and resources, including but not limited to, Thurston County Housing Program, Rapid Re-housing, and other housing programs.

4.7. Expedite the SSI application/reapplication process in accordance with SB 1290 and the MOU between TMRSN and the CSO, to facilitate timely access to entitlements and benefits for "classic Medicaid" and "welcome mat" Medicaid individuals.

4.8. Increase the likelihood of mentally ill individuals living successfully in the community by providing timely mental health interventions along with coordinated "warm hand-offs" to outpatient mental health services, housing providers, and other community resources.

4.9. Strengthen cross-system coordination and relationships by developing a screening and referral

process, and actively communicating and collaborating with other related systems, programs and services.

5. SCREENING/ELIGIBILITY

5.1. Contractor shall develop a screening and referral process and use a **Screening Log** that incorporates the following at a minimum:

- 5.1.1. Individual's name and DOB;
- 5.1.2. Source of referral;
- 5.1.3. History of mental illness, hospitalizations, and previous treatment;
- 5.1.4. Status of enrollment with the RSN, Network Provider, and Medicaid;
- 5.1.5. Disposition (CIO services recommended/provided)
- 5.1.6. Reason for not serving if applicable.

5.2. Contractor will **screen in** the following individuals with a history of mental illness or symptoms of an acute mental disorder regardless of funding. This includes individuals:

- 5.2.1. Incarcerated and experiencing a mental health crisis;
- 5.2.2. Incarcerated and nearing release from jail;
- 5.2.3. Released from jail and requesting outpatient mental health services or housing support;
- 5.2.4. At risk of being arrested or arrested, but not booked;
- 5.2.5. Staying at a homeless shelter, in temporary housing, at risk of losing housing, or identified by a housing provider as homeless;
- 5.2.6. Being discharged from inpatient psychiatric treatment to a shelter for lack of more appropriate housing; or
- 5.2.7. Enrolled in Medicaid that may need referrals to other available services.

5.3. Contractor will provide access to ProviderOne, TMRSN's MCO "RSN Look" and other resources to identify:

- 5.3.1. Medicaid eligibility and benefit information;
- 5.3.2. TMRSN/CMHA Network Provider enrollment status and history, treatment history, and current individual mental health care provider.
- 5.3.3. Other programs and services being provided to coordinate but avoid duplication of services.

6. PERSONNEL/STAFFING

6.1. The CIO Program shall be staffed by a team of Mental Health Professionals with sufficient experience to effectively work with the identified populations. The **6.10 FTEs** shall be assigned to provide sufficient coverage for each location in the following service areas:

- 6.1.1. **(3 FTE) Jail Intensive Case Management** – Olympia City Jail, Mason County Jail, and Thurston County Jail. Thurston County Jail requires case management services on the weekend.
- 6.1.2. **(1 FTE) Transitional Case Management** – Olympia City Jail, Mason County Jail, Thurston County Jail, and E&T/IP d/c of Non-enrolled needing housing assistance.
- 6.1.3. **(2 FTE) Intensive Case Management** – Community based services to the Thurston County service area, including E&T/IP d/c of Non-enrolled needing housing assistance, jail and homeless who are high utilizers of emergency services.
- 6.1.4. **(.10 FTE) Supervisor –** Is responsible for oversight of the CIO Program.

6.2. Each of the three (3) service areas must have a staff lead designated for that area and develop identified contacts in the associated locations to provide consistency.

6.3. Staff shall be cross-trained in each area and staffing patterns sufficiently fluid and flexible enough to respond to the service areas of most critical need without excessive wait times or wait lists.

6.4. Ensure sufficient availability of supervision and oversight of the CIO services to provide clinical supervision and respond to concerns from cross system partners and the community as needed.

6.5. Hours of operation are generally intended to be Monday through Friday, but may be flexible depending on the needs of the client and types of interventions needed. Any after- hours' crisis support required will be the responsibility of Crisis Response Services and coordinated with those providers as needed.

6.6. Ensure each CIO program staff has an annual training plan that includes all necessary and required trainings as specified in the General Terms and Conditions of this contract.

7. CLINICAL/DOCUMENTATION REQUIREMENTS

7.1. General Clinical Requirements

7.1.1. Screening and referral for CIO services focuses on identification of individuals that are or could be Medicaid eligible and meet the priority population of acute/chronic mentally ill, and that meet the Medical Necessity and Access to Care criteria.

7.1.2. Individuals that don't meet Access to Care or Medical Necessity will be referred to other appropriate community resources, to include the Healthy Options Plans.

7.1.3. Clinical services are intended to provide sufficient encounters to meet the housing and stabilization objectives of this service. This may require multiple services per week for Intensive Case Management services.

7.1.4. Services may be prioritized based on available resources, with safety and the presence of other systems and supports in mind.

7.1.5. Clinical focus should be on stabilization and community integration. Those clients who are likely to remain stable in the community may be transferred to outpatient mental health services if eligible.

7.1.6. Facility based intakes may be brief in order to make appropriate referrals, and can be supplemented with a prior Intake Assessment if it has been done within the last twelve (12) calendar months.

7.1.7. Transitions to outpatient mental health services should include informing consumer of their choice of outpatient providers.

7.2. General Documentation Requirements

7.2.1. Provider must maintain a separate medical record of all documentation of CIO services provided.

7.2.2. Documentation for all services and activities will be maintained on standard forms/format and available on-site and upon request.

7.2.3. Provider must maintain confidentiality of all personal health information, and request a signed Release of Information prior to sharing information when indicated.

7.2.4. Service provision and documentation must be provided and recorded in accordance with the TMRSN Data Dictionary that includes Reporting Guidelines, TMRSN HIPAA and Native Transaction Companion Guides, the TMRSN File and Data Submission Guide, the TMRSN Outpatient Invoice and Data Send Calendar, and any other requirements consistent with provider's outpatient services. Allowable service codes that can be reported to TMRSN by this program are contained within the TMRSN Data Dictionary.

7.2.5. A Jail Program Record must be recorded and submitted to TMRSN that includes the following data elements. kept in the database that includes:

7.2.5.1. Program Start Date; and

7.2.5.2. Program End Date.

8. DELIVERABLES

8.1. The Contractor shall document hours and services not typically entered into the MIS on the CIO Specialized Service Activity Log, provided by TMRSN.

8.1.1. The Contractor shall ensure that information is gathered on the 'Activity Log" tab as well as the "Performance Tracking" tab. The timeframe of this report is every two (2) weeks and shall be submitted within 3 days after the reporting period has ended.

ATTACHMENT 2

Evaluation and Treatment Facility
Maintenance Responsibilities

Services Provided by Thurston County

Service Name	Services Description
Bids and Estimates	Provide cost estimates for doing minor remodel or maintenance work not included within Base Level Services. Provide assistance in obtaining bids from outside contractors or vendors for work not included within Base Level Services.
Bldg. Warranty Work	Provide coordination services with contractors for repair of work within the contractor's warranty period.
Building Appearance	Provide repairs and service to problems that arise regarding the appearance of building interiors or exteriors, e.g. removing vandalism, painting under projects or approved painting requests only, etc.
Building Construction for RSN only	Implement major enhancements to buildings and/or building systems. Funding to be determined.
Building Control System	Provide maintenance and repairs to the building automation control system that monitors and controls building heating/cooling and other building mechanical functions or systems, i.e. fire alarm systems, security systems, and building automation systems, etc. Includes testing as required.
Building Drawings	Provide electronic or hard copies of Master Drawing floor plans for county-owned or leased facilities.
Building Modification	Implement major and minor enhancements to buildings and/or building systems. Funding to be determined.
Building Repairs-floors, walls, ceilings	Provide maintenance and repairs to the building, including doors, Doors, windows, flooring, walls, and ceilings. For specific building system problems: see also electrical, security, plumbing, or lighting, etc.
CCTV/Monitors	Repair to CCTV, monitors, cables, and pan tilt units.
Contracts	Initiating a contract for services or materials.
Detention System	Provide maintenance and repairs to the detention system. Includes electronic detention systems, i.e. intercoms, MC panels, duress systems and electronics.
Electrical	Provide maintenance and repairs to the electrical systems. May support the addition of new circuits in County-owned buildings only for workstations and copy machines or other equipment. New circuits requested by a Tenant for their unique operation or workstation may be funded by that Tenant.
Emergency Power Systems	Provide maintenance of generators, UPS's and Transfer Switches.
Fire Protection	Provide periodic maintenance and testing of fire sprinkler, fire smoke systems and fire extinguishers.

Furniture Repair	Furniture repair, assembly and/or moving services **NOT PROVIDED**. Contact an outside vendor or moving company for assistance.
HVAC Systems	Provide maintenance and repairs to building Heating, Ventilation and Air Conditioning Systems (Also see work and space comfort).
Hazards Response	Respond to reports of hazardous smells or situations, e.g. smoke, Smell of Gas/Haz. Spills smells.
Keys/Key Cards	Use the email work request system with the person's name and the type of key(s) required. (One work request per person.) Have the person authorized to approve the key request send the email work order as authorization.
Lighting	Provide maintenance and repairs to building lighting systems. Includes replacement of light bulbs and fixture repairs. (See also-Site Issues for outside lighting).
Locks and Door Hardware	Work on doors, door locks, hardware, closers, door closed indicators and access as needed.
Master Drawing Modifications	Make modifications to County master Drawing as a result of changes that have been made to the building with a construction or remodel project. As resources are available.
Mounting to Walls	Bulletin Boards, Wall Hung Cabinet, Pencil Sharpeners, or any wall mounting of any kind MAY be installed on a LOW priority basis if and when time permits.
Pest Control	Provide assistance in response to apparent pest infestations in compliance with the county pest control policy. Coordinate the work of an outside pest control contractor.
Plumbing	Provide maintenance and repairs to the building plumbing systems.
Preventive Maintenance	Provide PM to major and minor Facilities-owned equipment, including filter changes, new belts, grease bearings, cleaning, pumps, motors, chillers, etc.
Safety Issues/Trip Hazards	Respond to Safety Issues.
Signage	Provide signs in parking lots and/or to buildings related to the County-owned buildings. No service is provided to tenant's own unique operation.
Site Issues – Parking/Drainage/Lighting	Provide maintenance and repairs to systems servicing the entire Outside e.g. drainage, parking, outside lighting.
Snow Removal	Provided deicing materials and walk behind snow blower for building. Some snow and ice removal would be provided as resources become available.
Tenant Provided Services	Custodial services including minor facility repairs as a result of normal wear and tear or vandalism; maintenance, repair, and replacement of appliances and equipment associated with program operations. Replacement of security glazing is performed by M&O with materials paid for by tenant.
Technical Consultation	Provide assistance in acquiring the services for Central Services on-call consultants (architects and/or engineers) for technical consultations.
Work Space Comfort Heating-Cooling	Research comfort issues in individual workspaces; provide modifications to heating/cooling as available within the HVAC system.
Work Order System	Provide a system for requesting the above.

The following list may contain items Facilities maintains but tenant may pay for parts and support:

- Kitchen Equipment repairs and parts: Stainless on walls, freezers, refrigerators, steam kettle, ovens, dishwasher, garbage disposal, etc. are outsourced, i.e. tenant contracts with outside contractor.

- Kitchen duct wash down and fire suppression system outsourced some wash down maintained by Facilities with parts by tenant.

- Laundry Equipment outsourced.

- CCTV cameras, monitors, repairs and parts maintained by Facilities.

- Internal door controls and lock parts maintained by Facilities.

- Door closures maintained by Facilities.

- Secure area intercom system repair and parts maintained by Facilities.

- Vandalism: All: Toilets, light fixtures, etc. paid by tenant.

- Control Electronics. Some outsourcing and some maintenance by Facilities.

- Office furniture repair. Outsourced.

- Requests to add to the Facility: Such as fences, barbed wire, CCTV, new electrical circuits, etc., will be negotiated between Facilities and Tenant.

- Secure area glass for cells, doors, nurses station, etc. Maintained by Facilities.

- Sally port roll up door. Maintained by Facilities.

- Anything owned by tenant: Such as rotating property rack, TVS, copy machines, UA Equipment, gun locker, visitor's boxes and locks, etc. Outsourced or by others.

- Card Reader Systems: The card reader device at each door and the controller will be covered against defects. Client damage will be covered by the tenant. The request for added reader devices and controllers in order to expand the system will be negotiated. The County will coordinate the upgrade and cost of software as required. The County will upgrade the PC operating the card reader system and the card reader system through the County's ITRP replacement program only to the required standard to operate the card reader software. Tenant is responsible for the tracking, storage, archiving of data, and all card related costs/efforts.

EXHIBIT B

Evaluation and Treatment Facility Services
COMPENSATION

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1. COMPENSATION

1.1. Program funding is based on the actual level of staffing, program costs and job performance as set forth in the Program Contract. A portion of the monthly payment may be withheld if service data is not entered into the MIS system in a timely manner for all programs that invoice based on actual costs.

1.2. The Contractor shall use all funds provided pursuant to this Contract, including interest earned to support only the services as described within this Contract.

1.3. Funding allocations are contingent upon the receipt of funds from contractual agreements between TMRSN and other government agencies (DSHS-DBHR, DDD, and Mental Health Block Grant contracts).

1.4. Appropriate DOH Licensing and DBHR Certification as set forth in Exhibit A are required for payment under this contract. If, at any time, licensing or credentials required for any portion of the services or operation set forth in the Program Contract are going to be revoked, the Contractor shall submit a corrective action plan to TMRSN. Corrective action plans developed by the Contractor must be submitted to TMRSN within 30 calendar days of notification or sooner. TMRSN may extend or reduce the time allowed for submitting corrective action depending upon the nature of the situation as determined by TMRSN. Corrective action plans shall be subject to approval by TMRSN, which may accept the plan as submitted, accept the plan with specified modifications, or reject the plan. Should corrective actions fail to be implemented within 30 calendar days of receipt of written notice of revocations, the TMRSN may reduce funding by 20% for the first month, 50% for the second month, and all funding shall be discontinued thereafter until licensing and/or certification is re-established.

1.5. The Contractor shall invoice TMRSN for services based on actual costs. All costs shall be divided and invoiced as such between Medicaid allowable and State Funded services. Medicaid allowable services include those services to Medicaid clients whose program and match have a Medicaid mental health benefit and/or whose service modality is allowable under the State Plan, **except inpatient services provided to persons involuntarily admitted must be paid with state funds, regardless of the client's pay source**. Costs such as room and board, even for Medicaid clients, are not allowable under Medicaid.

1.6. Funding that supports this contract may come from Mental Health Block Grant funds from the Department of Health and Human Services (DHHS), Catalog of Federal Domestic Assistance (CFDA) # 93.958. Mental Health Block Grant funds may **not** be used for:

1.6.1. Services and programs that are covered under the capitation rate for Medicaid covered services to Medicaid enrollees;

1.6.2. Inpatient mental health services;

1.6.3. Construction and/or renovation;

1.6.4. Capital assets or the accumulation of operating reserve accounts;

1.6.5. Equipment costs over $5,000.00;

1.6.6. Cash payments to consumers; or

1.6.7. State match for other federal funds.

1.7. The TMRSN shall compensate the Contractor for services as set forth in this contract as expenses are accrued for maintenance of a staffing level and program expenses for all program components. Payment for these services is based on and not to exceed actual expenses. TMRSN reserves the right

to: a) adjust the budgeted line item, or b) reconcile the difference if the amount exceeds the line item.

1.8. Funding under this Contract shall not be utilized for retainer fees for contracted Primary Care Physicians who perform medical services at the E&T Facility. Medical services must be delivered under the physicians Medicaid license and not through the E&T. This requirement shall go into effect **May 01, 2015**.

1.9. Payment shall be based on the following table. It is the responsibility of the Contractor to monitor their monthly expenses and ensure that they do not exceed the annual contract lid for each fund source. In addition, any funds identified in an attachment must be used only for the service indicated and shall not be used to supplement any other programs and/or services.

Payment Period: January 1, 2015 through December 31, 2015				
Service Designation	**Rate Method**	**Fund Source**	**Project Code**	**Not to Exceed 12 Month Total**
E&T Inpatient Unit	Actual Costs	Medicaid State	41408 41409	$3,124,245 $1,338,963 **Subtotal: 4,463,208**
ITA Services (DMHP and Court Services)	Actual Costs	Medicaid State	41408 41409	$67,872 $886,224 **Subtotal: $954,096**
Hospital Liaison Only *Funding thru June 30, 2015	Based on 1 FTE and must see a minimum of 20 clients per month.	MHBG	41401	$45,738
CSTU	Actual Costs	Medicaid State Reserves	41408 41409 41499	$802,920 $294,000 $348,000 **Subtotal: $1,444,920**
1:1 Safety Staff	Actual Costs	Medicaid	41408	$120,000
Reserves	Up to 5% per Section 4.4	Medicaid	41408	$300,000
Attachment 1: Community Integration Outreach	CIO (Jail and Transitional): Actual Costs	State Proviso TST Jails	41409 41417 CW006 41410	$42,456 $207,552 $83,640 $16,140 **Subtotal: $349,788**
	CIO Intensive Case Management	Medicaid	41408	$199,992
	CIO Housing Supports	Reserves	41499	$87,996
	CIO Performance Measure Incentives	Medicaid	41408	$30,000
Total Contract Lid for January 01, 2015 through December 31, 2015:				**$7,995,738**

1.10. Any monitoring process, including TMRSN encounter validation audits that shows encounter invalidation will result in corrective action and funding reconciliation. Funding will be reconciled if the service event data does not comply with the DBHR Encounter Instructions; does not comply with TMRSN reporting guidelines; or does not match or is missing from the clinical record.

1.10.1. Corrective action and funding reconciliation will occur for any missing or inaccurate encounters reported by the Contractor. Reconciliation for outstanding invalid encounters

will occur fifteen days (15) after the Contractor has received notification of errors. Within this fifteen day period, the Contractor may resolve errors, and unresolved invalid encounters will then be reconciled. Overall encounter validation accuracy outcome expectation is 100% after necessary corrections.

2. OTHER FUNDING SOURCES

2.1. The Contractor shall make all effort to collect from Third Party Insurers when available. The Contractor shall be able to show by individual, those clients eligible for third party benefits, including which services, how much was billed by service, and how much was collected. All third party funding resources available to clients shall be identified and pursued in accordance with the reasonable collection practice that the Contractor applies to all other payors for services. The Contractor shall reduce the TMRSN invoice by the amount received from all third party payments for services related to this Contract.

3. FISCAL MANAGEMENT

3.1. The Contractor shall provide services in the most effective, efficient and economical manner possible to establish a prudent financial management system. This shall include, but not be limited to:

3.1.1. Establishing a sliding fee scale. The sliding fee scale schedule shall be posted and accessible to staff and clients and may not require payment from clients with income levels equal to or below the grant standards for the general assistance program.

3.1.2. In accordance with Federal and State regulations and statutes, ensuring Medicaid or other RSN funds are not utilized to support administrative and/or direct services to non-TMRSN authorized clients.

3.2. The Contractor shall maintain records in such a manner so as to reasonably ensure that all third-party resources available to clients are identified and pursued, in accordance with Medicaid being the payer of last resort. This information must be reported in the Financial Statement referenced in Section 6.3 of this exhibit. Third party revenue received by the Contractor for TMRSN funded services will be deducted from the RSN payment for same services.

3.3. The Contractor shall ensure that Medicaid enrollees are not charged or held liable for any of the following:

3.3.1. Medicaid services covered under the terms of this Contract (42CFR447.15);

3.3.2. Contractor's debts in the event of insolvency;

3.3.3. Covered services provided to an enrollee for whom DSHS does not pay TMRSN;

3.3.4. Services for which DSHS or TMRSN does not pay the individual or health care provider that furnishes the services under a contractual, referral or other arrangement;

3.3.5. Any service provided under contract, on referral, or other arrangement, which exceeds what TMRSN would cover if TMRSN provided the services directly.

4. ACCOUNTING AND REPORTING REQUIREMENTS

4.1. Each month an initial invoice shall be submitted with the monthly budgeted amount. After all expenses are accounted for, a final invoice shall be submitted for payment of the difference between actual total expenses and the previously submitted estimated invoice. At the same time, a complete invoice with cost reports shall be submitted reflecting all costs for that month.

4.2. Funding for this program is only to be used to provide the services, as depicted in the Program Contract, and may not supplement any other programs. The Contractor shall bill TMRSN for services based on actual costs, provided the total billable amount is not exceeded during the term of this Contract. Invoices must be submitted on forms provided by the TMRSN and follow the invoicing instructions issued by the TMRSN. The Contractor shall be able to provide

documentation that will substantiate any expenditure billed for this program.

4.3. A minimum of 90% of the available amount from primary funding to the Contractor shall be used for direct mental health services and the Contractor shall fully cooperate to assure compliance with this requirement.

4.4. The Contractor shall have the right to establish capital, operating and risk reserves in accordance with generally accepted accounting principles and prudent business practices, the total of which is not to exceed 5% of total funding for this contract. Reserves may be retained with each monthly invoice, however total costs are not to exceed the annual contracted amount. It is solely the Contractors' responsibility to manage monthly costs and maintain costs within the total allowable contract lid. When any reserves are expended, such funds shall be appropriately reported as either direct or indirect costs. The contractor shall maintain records sufficient to evidence that it has incurred eligible Medicaid cost for reserve dollars and shall make such records available for TMRSN's review upon reasonable request. **MHBG funds and the CIO Program are excluded from reserves.**

4.5. The Contractor shall have an annual audit performed by an outside CPA firm. If Mental Health Grant Funds (MHBG) are indicated in the Compensation Section 1 above, see the general terms and conditions for A133 Single Audit requirements.

5. BILLING PROCEDURE

5.1. The Contractor shall bill the TMRSN for services using the specified forms and instructions referenced in this Exhibit. TMRSN reserves the right to: amend, delete, or add to the billing or reporting forms required in this Exhibit.

5.2. The Contractor must submit invoices to arrive at the TMRSN no later than the 10th calendar day of the month in order to receive TMRSN reimbursement by the last working day of the month. Billings received after the 10th calendar day shall be reimbursed no later than the last working day of the following month. The Contractor agrees that receipt of any payment from the TMRSN is expressly conditioned on submission to the TMRSN of any and all required reports and documentation prior to the TMRSN deadlines. All invoices must be sent to the address listed on the invoice form.

5.3. Included in this exhibit is an invoice form that must be completed for reimbursement in accordance with instructions provided by the TMRSN. An original signed invoice must be received prior to dispersal of funds.

5.4. All invoices must have an invoice number provided which must be unique and not be repeated.

5.5. TMRSN shall not release reimbursement until the Contractor provides requisite reports identified in this Contract.

5.6. The Contractor must enter encounter information for services provided at the E&T into the MIS data system according to policies, procedures, instructions, and protocols issued by the TMRSN.

6. DELIVERABLES

6.1. The Contractor shall submit a budget vs actual report with each monthly invoice. Invoices submitted without the report will not be processed until the report is received.

6.2. A copy of the annual audit referenced in section 4.5 of this exhibit must be submitted to the TMRSN upon receipt of the audit report by the Contractor.

6.3. The Contractor will submit Certification that the Administrative Costs incurred by the Contractor are no more than ten percent (10%) of the total revenue under this contract. Certification must be submitted to the TMRSN no later than August 14, 2015.

6.4. An individual financial statement for services set forth in this Contract shall be provided monthly. Financial Statements may be sent electronically or via mail. The Financial Statement shall include

all third party revenues collected for services provided in this program and shown as revenue for the program.

6.5. For MH Services in Residential Settings provided at the CSTU, a certification from the Contractor that expenses was for allowable costs under this contract.

6.6. The Contractor shall run and submit monthly data error reports for any services that are considered "cost reimbursed" or services paid on "actual costs" with the monthly invoice. Reports shall include all pended and denied claims from the previous month(s) – please reference TMRSN MCO Instruction: 402.01 MCO Provider Reports & Instructions, Section 4 – "837 Claims Reports" for report details on "Claims Pended or Denied for Date Range".

If the report shows there are claims data errors, the Contractor will have 60 days to correct and resolve all claims errors listed. If 100% of the errors are not corrected, *penalties will apply per the table below. The Contractor shall submit all reports as described in the table below each month. This schedule is for the entire duration of the contract, not just the dates listed below.

TMRSN reserves the right to apply Remedial Actions per Section 23.2.2 of Exhibit A in addition to the penalties below if the Contractor does not comply with this deliverable.

Due Date	Deliverables
February 10th	• January Invoice • Claims Data Error report for Jan 01-31
March 10th	• February Invoice • Claims Data Error Report for Feb 01-28
April 10th	• March Invoice • Claims Data Error Report for Mar 01-31 • Re-run Claims Data Error Report for Jan 01-31 All claims errors for January must be corrected by this time. If claims errors are not corrected, the following penalties will apply: • 91-100% errors are corrected – No penalty • 81-90% errors are corrected – 2.5% will be deducted from the total April Payment. • 71-80% errors are corrected – 5% will be deducted from the total April Payment. • 70% errors or less are corrected – 10% will be deducted from the total April Payment. **NOTE – Providers will not be able to recapture these penalties.**
May 10th	• April Invoice • Claims Data Error Report for Apr 01-30 • Re-run Claims Data Error Report for Feb 01-28 All claims errors for February must be corrected by this time. If claims errors are not corrected, the following penalties will apply: • 91-100% errors are corrected – No penalty • 81-90% errors are corrected – 2.5% will be deducted from the total May Payment. • 71-80% errors are corrected – 5% will be deducted from the total May Payment. • 70% errors or less are corrected – 10% will be deducted from the total May Payment. **NOTE – Providers will not be able to recapture these penalties.**
June 10th	• May Invoice • Claims Data Error Report for May 01-31 • Re-run Claims Data Error Report for Mar 01-31 All claims errors for March must be corrected by this time. If claims errors are not corrected, the following penalties will apply: • 91-100% errors are corrected – No penalty • 81-90% errors are corrected – 2.5% will be deducted from the total June Payment. • 71-80% errors are corrected – 5% will be deducted from the total June Payment. • 70% errors or less are corrected – 10% will be deducted from the total June Payment. • **NOTE – Providers will not be able to recapture these penalties.**
This formula will continue monthly with the final reports due in February 2015.	

Community Integration Outreach
COMPENSATION

1. ATTACHMENT 1 – Community Integration Outreach

1.1. Program funding is based on compliance with the Program Services Statement of Work per Program Services, Attachment 1.

1.2. TMRSN shall reimburse the Contractor for services performed by 6.10 FTE under this attachment, payable based on the table below. Incentive funding will be provided only when performance measures are met, per Exhibit C.

Payment Period: January 1, 2015 through December 31, 2015			
Type of Service(s)	**Rate**	**Fund Source**	**Contract Lid**
Community Integration Outreach: • Jail Case Management • Transitional Case Management	Actual costs	State Proviso TST Jails	$42,456 $207,552 $83,640 $16,140 **Subtotal: $349,788**
Intensive Case Management	Actual costs	Medicaid	$199,992
Housing Support (Rent, security deposits, etc)	Actual Costs	Reserves	$87,996
Performance Measures Incentives	$30 per SSI Application $30 per OP Enrollment $100 for Housing Placement **(Up to $2500 per month)**	Medicaid	$30,000
		Total Annual Program Lid:	**$667,776**

1.3. When invoicing TMRSN, expenses for each program with multiple fund sources shall be charged in order of Proviso, TST, Jails, and State.

1.4. Housing support funding shall be accessed only to provide assistance to clients that are homeless or are at imminent risk of becoming homeless. Funds shall be used towards rent support, application assistance, security deposits, or any other time limited rental assistance that will either assist an individual in obtaining housing, maintaining housing, or prevent them from losing housing.

1.4.1. Receipts must be attached to the invoice below in order to receive reimbursement for this funding.

1.5. Performance measure incentive funding shall be based on the performance of meeting the goals set per the CIO logic model under Exhibit C.

1.5.1. The Specialized Service Activity Log, including the Performance Tracking, must be submitted per the timelines indicated under Attachment 1, Section 8 in order to receive incentive funding. This funding has its own invoice below.

Performance Measure / Logic Model

INVOICE FORM

From:	Behavioral Health Resources 3857 Martin Way East Olympia WA 98506-5218	Submit To:	Public Health & Social Services Fiscal Department 412 Lilly Rd NE Olympia WA 98506 wagnerf@co.thurston.wa.us

Invoice Number:		**Submitted Date:**		**Vendor #:**	**62**
For Service Dates:					

Org	Object	Project
	541000	41499

Performance Measure (per Exhibit C)	Number of Clients	Actual Amount
SSI/SSDI Applications completed		
Enrolled into outpatient services		
Housing placement		
	Total:	

I attest that the information contained on this invoice and the accompanying cost report(s) is complete, accurate, and in accordance with the terms of the contract.

For Evaluation and Treatment Facility ________ Date ________

TMRSN Authorized Signature ________ Date ________

Hospital Liaison
COMPENSATION

1. HOSPITAL LIAISON

1.1. Funding is based on compliance with the Exhibit A Statement of Work Section 10.3.

1.1.1. TMRSN shall reimburse the Contractor for services performed by 1.0 FTE payable based on the table below. Services include providing case management services at WSH including documentation, collaboration, discharge planning, and residential placement for a minimum of 20 individuals per month.

1.1.1.1. Should the Contractor provide less than the equivalent of 1.0 FTE in any month of service, funding shall be reduced accordingly. For example, if the Contractor only provides .75 FTE, then the Contractor shall only invoice 75% of allowable funding, .5 FTE – 50% funding, etc.

1.1.1.2. The number of minimum clients seen per month can be averaged over the term of the contract, and will not necessarily effect payment, unless the average number of individuals seen by the end of the contract term is less than 75% of minimum individuals. If this occurs, final payment will be less 25% of allowable monthly amount.

Payment Period: January 1, 2015 through June 30, 2015				
Type of Service(s)	**Rate**	**Fund Source**	**Monthly Lid (this program ONLY)**	**Not to Exceed 6 Month Lid**
Hospital Liaison	Based on 1 FTE and must see a minimum of 20 clients per month.	MHBG	$7,623	$45,738

Hospital Liaison
INVOICE FORM

From:	Behavioral Health Resources 3857 Martin Way East Olympia WA 98506-5218	Submit To:	Public Health & Social Services Fiscal Department 412 Lilly Rd NE Olympia WA 98506 wagnerf@co.thurston.wa.us

Invoice Number:		**Submitted Date:**		**Vendor #:**	**62**
For Service Dates:					

Item	Org	Object	Project	Monthly Max	Amount Invoiced
Hospital Liaison	1500D441	541000	41401	$7,623	

☐ FTE Report Attached (if less than 1.0 FTE, amount invoiced must be prorated)

☐ Number of Individuals Served Reported

I attest that the information contained on this invoice and the accompanying cost report(s) is complete, accurate, and in accordance with the terms of the contract.

For Evaluation and Treatment Facility ____________ Date ____________

TMRSN Authorized Signature ____________ Date ____________

EXHIBIT C

PERFORMANCE MEASURE(S)

1. Performance Measure(s)

1.1. For each program identified hereunder in Exhibit C, the Contractor shall follow the indicated Performance Measure (PM). The PM shall be based on quality improvement for "outputs" in specified areas of contracted mental health service. Identified program PMs do not replace any other specific contract requirements, deliverables, or performance standards under other Exhibits or Attachments to this contract. The intent is to support program integrity in the specific programs by clearly identifying targeted areas for improvement and/or for maintaining quality of care and resource management. Such targets will be based on levels of service, size of eligible population, state averages, actuarial information, and funding per program.

1.1.1. The PM(s) shall be outlined in the attached "Logic Model(s)." The Logic Model shall have one or more expected "outputs" with targets for service delivery.

1.1.2. Outputs will be determined by TMRSN, with input from the Contractor, when requested, based on industry program standards, expected levels of service delivery, funding, and service method to be measured.

1.1.3. All outputs will determine a baseline for performance. For any new program, there will be a three (3) month period to develop a baseline for expected program outputs. For established programs, baseline for performance will be based on historical program data either from the MIS or from contract deliverables. A PM will then identify the target level, if baseline performance is not sufficient to achieve value service levels.

1.1.4. TMRSN may include a level of variance for each output to offset fluctuations in service delivery.

1.1.5. Output data shall be tracked on a monthly basis and reported quarterly (see table below). The party responsible for providing the quarterly report shall be identified on the PM; either TMRSN or the Contractor. If the Contractor is identified as the responsible party for the quarterly report, the report shall be submitted to TMRSN, in the format provided, by the due date in the table below. TMRSN shall be responsible for analyzing all reports and determining if the Contractor has or has not met the output.

1.1.5.1. If the Contractor fails to meet the output for a quarter based on TMRSN's review, then the Contractor shall be required to submit a performance improvement plan (PIP). The PIP shall include, the reason for not meeting output(s), the reason for any exceptional variance of service delivery (when applicable), and what change will be made, if any, to meet the output. The PIP shall be submitted within thirty (30) calendar days after the request by TMRSN. If a PIP is not submitted within the 30 days, 5% of the payment for the program shall be withheld each month until the PIP is received. TMRSN will review the PIP and respond accordingly to the Contractor within two (2) weeks.

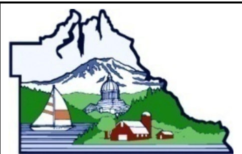
1.1.5.2. If the Contractor fails to meet the output during the quarter following the PIP, then corrective action shall be initiated by TMRSN. Please see Exhibit A – Section 19, Remedial Action for a complete description. TMRSN shall determine type of corrective action to be applied.

1.1.5.3. If the output is failed during the third quarter, TMRSN shall complete a full review of outputs and determine if the failure is due to under performance by the Contractor or if the initial outputs were unattainable. Based on the results of this review, TMRSN shall determine if a contract amendment is required to

adjust the contract requirements or PM, including outputs and current funding levels for expected delivery of services. Under performance by the Contractor may result in contract termination per the remedial action section of the contract.

1.1.6. Quarterly Report Table – Report due dates apply to both TMRSN and the Contractor:

Quarter	Report Due
January 01 – March 31	May 15th
April 01 – June 30	August 15th
July 01 – September 30	November 15th
October 01 – December 31	February 15th
**Note* – If the contract start dates do not coincide with these quarters, please include previous months data into the first full quarterly report. Example, if the contract starts February 1, the first quarterly report will include data from each month, Feb 1 – June 30.	



THURSTON MASON
REGIONAL SUPPORT NETWORK
Performance Measure – Logic Model

TITLE of MEASURE:	**Community Integration & Outreach (CIO) Program**
BASELINE TIME PERIOD USED:	CY 2014
QUARTERLY REPORT PROVIDED BY:	TMRSN Quality Manager (supplemental information required from BHR)
CONTRACT:	**2015-62ET**

Standard Performance Expectations				
Resources	**Program Components**	**Goals**	**Outputs**	**Outcomes**
• 1 (.1 FTE) Supervisor • 3 (1.0 FTE) MHP for Diversion and Discharge • 1 (1.0 FTE) MHP for Transitional Case Management • 2 (1.0 FTE) for Intensive Case Management / Outreach	• Screening and referral process for individuals identified as having a mental illness or in need of mental health services • Intake assessments for unenrolled persons who meet priority populations defined in RCW 71.24 and WAC 388-865-0215 • Transitional Case Management services to expedite and facilitate an individual's return to the community. • Intensive Case Management services related to finding and obtaining permanent housing for individuals released from inpatient mental health facility. • Assistance with completing and submitting benefit applications prior to release • Collaboration with other jail, correctional or court staff to facilitate less restrictive diversion options and/or alternatives to jail • Pre-release direct mental health/co-occurring services and assistance prior to discharge	• Decrease the number and duration of inappropriate incarcerations of persons with mental illness and facilitate access to available community services for this population per the Memorandum of Understanding between TMRSN, the Contractor and: Thurston County Jail, Mason County Jail and Olympia City Jail. • Provide intensive case management services for individuals who are homeless, or are at risk of becoming homeless, by successfully linking consumers with appropriate housing services and facilitating permanent housing • Coordinate with local law enforcement and jail personnel, Community Service Office(s) (CSOs) and TMRSN Network Providers to expedite and facilitate return of incarcerated individuals to the community. • Assess individuals placed in Thurston County, Olympia City and Mason County Jails to determine whether they have an acute or chronic mental illness. • Expedite and facilitate prompt reinstatement and speedy eligibility determinations for persons likely to be eligible for medical assistance and/or federal benefits upon release from confinement • Provide short-term crisis intervention and brief treatment services to inmates who are in an acute state. • Identify training and consultation needs of correctional staff, community housing staff, and court employees regarding issues related to the mentally illness and homelessness.	*A.* Maintain total hours of service on behalf of consumers (based on 46 week/year working at 50% productivity). *Productivity is a combination of encounters and services tracked on the Activity Log.* **Target: 76.67 hours/month** **Variance: +/- 7 hours/month** B. Staff training and consultation hours, per calendar year. **Target: 300 hours combined** **Variance: +/- 25 hours** C. Provision of services for BHR-enrolled consumers within 7 calendar days of release from jail or inpatient mental health facility. **Target: 95 percent** **Variance: +/- 3%**	• Percent of eligible consumers referred for ongoing outpatient services. • Percent of consumers assisted with completion of benefits application. • Percentage of consumers who presented themselves for ongoing outpatient services.

Standard Contract-Based Deliverables			
Resources	**Contract Section**	**Description**	**Reporting Requirements**
See Above	**7.2.6.1.1:** Number of individuals diverted from jail prior to booking	This output number refers to the number of individuals who were diverted from jail due to the direct intervention of CIO staff. These consumers were diverted because the courts / law enforcement saw the consumer's mental illness as the primary factor for the infraction, and a more appropriate resolution for the consumer was identified.	This should be reported each month as a raw number. Each number represented must be backed up with documentation in the CIO chart which supports the diversion.
See Above	**7.2.6.1.3:** Number of individuals served in each service area	This output number refers to the total number of consumers served in each of the primary areas within the CIO program. This includes jails (by facility), shelters, and any mental health facility or hospital.	This should be reported each month by key program area and by facility and location.
See Above	**7.2.6.1.6:** Number of community referrals from law enforcement	The output number refers to the number of individuals who were referred to the CIO program by any correctional official – including court staff, jail personnel, or probation.	This should be reported each month by facility and location.

Performance-Based Incentives			
Resources	**Contract Section**	**Description**	**Incentive**
See Above	**7.2.6.1.2:** Number of individuals provided assistance with SSI/SSDI applications /reapplications	This performance-based output refers to the number of successful Medicaid applications submitted and accepted (approved). It is expected that CIO staff sit with consumers and fill out online Medicaid applications. A successful application is approved and can be verified through documentation in the consumer's CIO chart. ***Note – In order to access incentive, must complete 10 or more applications.***	• $30 will be paid for each successful Medicaid application made on behalf of the consumer. This incentive will become effective starting after the first full quarter of this contract (beginning with applications made during the fourth month of this contract). Each request for payment must be verified with documentation from the consumer's CIO record. Incentive not to exceed $750 per month.
See Above	**7.2.6.1.4:** Number of individuals successfully linked with TMRSN Outpatient services	This performance-based output refers to the number of successful referrals made to a TMRSN Outpatient provider. A successful referral is defined as a consumer who becomes enrolled within any outpatient provider within the TMRSN catchment area, and must be documented in the consumer's CIO chart. ***Note – In order to access incentive, must complete 10 or more enrollments.***	• $30 will be paid for each successful referral (enrollment) made to a TMRSN outpatient provider. This incentive will become effective starting after the first full quarter of this contract (beginning with referrals made during the fourth month of this contract). Each request for payment must be verified with documentation from the consumer's CIO record. Incentive not to exceed $750 per month.
See Above	**7.2.6.1.5:** Number of individuals successfully linking with housing supports.	This performance-based output refers to the number of CIO consumers who have been successfully linked with a housing support. A successful housing linkage refers to **both** of the following: (1) A referral to a housing support agency has been made and documented, **and** (2) the consumer has been accepted, and has moved into, a permanent housing option. ***Note – In order to access incentive, must complete 5 or more placements.***	• $100 will be paid for each successful housing linkage and placement into a permanent housing option. This incentive will become effective starting after the first full quarter of this contract (beginning with permanent placements made during the fourth month of this contract). Each request for payment must be verified with documentation from the consumer's CIO record. Incentive not to exceed $1000 per month.

EXHIBIT D

DATA SECURITY REQUIREMENTS

1. **Data Transport.** When transporting Protected Health Information (PHI) electronically, including via email, the data will be protected by:
   1.1. Transporting the data within the (State Governmental Network) SGN or contractor's internal network, or;
   1.2. Encrypting any data that will be in transit outside the SGN or contractor's internal network. This includes transit over the public Internet.
2. **Protection of Data.** The contractor agrees to store data on one or more of the following media and protect the data as described:
   2.1. **Hard disk drives.** Data stored on local workstation hard disks. Access to the data will be restricted to authorized users by requiring logon to the local workstation using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards.
   2.2. **Network server disks.** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the data will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
   2.3. **Optical discs (CDs or DVDs) in local workstation optical disc drives.** Data provided by the contractor on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a secure area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access PHI data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
   2.4. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers.** Data provided by the contractor on optical discs which will be attached to network servers and which will not be transported out of a secure area. Access to data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
   2.5. **Paper documents.** Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

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

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

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

2.8.1. PHI data shall not be stored by the Contractor on portable devices or media unless specifically authorized within the Special Terms and Conditions of the contract. If so authorized, the data shall be given the following protections:

2.8.1.1. Encrypt the data with a key length of at least 128 bits

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

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

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

2.8.2.1. Keeping them in locked storage when not in use

2.8.2.2. Using check-in/check-out procedures when they are shared, and

2.8.2.3. Taking frequent inventories

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

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

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

3. Data Segregation.

3.1. PHI data must be segregated or otherwise distinguishable from non-PHI data. This is to ensure that when no longer needed by the contractor, all PHI data can be identified for return or destruction. It also aids in determining whether PHI data has or may have been compromised in the event of a security breach.

3.2. PHI data will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no non-PHI data. Or,

3.3. PHI data will be stored in a logical container on electronic media, such as a partition or folder dedicated to PHI data. Or,

3.4. PHI data will be stored in a database which will contain no non-PHI data. Or,

3.5. PHI data will be stored within a database and will be distinguishable from non-PHI data by the value of a specific field or fields within database records. Or,

3.6. When stored as physical paper documents, PHI data will be physically segregated from non-PHI data in a drawer, folder, or other container.

3.7. When it is not feasible or practical to segregate PHI data from non-PHI data, then both the PHI data and the non-PHI data with which it is commingled must be protected as described in this exhibit.

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

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

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

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

EXHIBIT E

STATE PLAN MODALITY DEFINITIONS

Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid Enrollee's Individual Service Plan must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the Enrollee's current level of functioning and assistance with self care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

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

Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid Enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a Mental Health Professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

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

Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-

hospital/non-IMD) facilities licensed by the Department of Health and certified by DBHR to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care. This service does not include cost for room and board.

DBHR must authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

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

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

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

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

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

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

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

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

Medication Monitoring: Face-to-face, one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional. Time spent with the Enrollee is the only direct service billable component of this modality.

Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for

other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

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

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

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

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

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

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

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

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

needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

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

Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increase knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc. Services are provided at locations convenient to the consumer, by or under the supervision of a Mental Health Professional. Classroom style teaching, family treatment and individual treatment are not billable components of this service.

EXHIBIT F

ACCESS TO CARE STANDARDS

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of a mental illness.**	* **Must demonstrate moderate functional impairment in at least one life domain requiring assistance in order to meet the identified need AND-** * **Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least one life domain requiring assistance in order to meet the identified need AND-** * **Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

- * The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
- * The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
- * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
- * The individual is expected to benefit from the intervention.
- * The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One</u>, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders. * The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. * The individual is expected to benefit from the intervention. * The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. In addition to the modalities listed in Level of Care One, individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS DEPRESSIVE DISORDERS	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive	B

	Type	
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A

	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	A

300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
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301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

<u>Additional Criteria for Diagnosis B</u>

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

- High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
- At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
- Two or more hospital admissions due to a mental health diagnosis during the previous two years
- Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
- Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
- <u>Child is under six years of age</u> and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

BUSINESS ASSOCIATE AGREEMENT ADDENDUM

THIS BUSINESS ASSOCIATE AGREEMENT (the "Addendum") is effective this 1st day of June 2014 (the "Effective Date") between Thurston County ("Covered Entity"), and Behavioral Health Resources ("Business Associate").

RECITALS

WHEREAS, Covered Entity and Business Associate are parties entering into Thurston Mason RSN General Terms & Conditions, Program Contracts, and all accompanying documents dated on, or after, January 01, 2012 and incorporated herein by reference (the "Underlying Agreement") pursuant to which Business Associate will deliver mental health services and such services involve the use and disclosure of Individually Identifiable Health Information that is subject to protection under HIPAA and the HIPAA Rules (all as hereinafter defined); and

WHEREAS, Business Associate has created and maintains security safeguards for the protection from unlawful disclosure of Protected Health Information (as hereinafter defined); and

WHEREAS, Covered Entity and Business Associate desire compliance with the Standards for Privacy of Individually Identifiable Health Information set forth under the HIPAA and the HIPAA Privacy Rule;

NOW, THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions herein contained, Covered Entity and Business Associate enter into the following Addendum to provide a full statement of their respective responsibilities as more fully described below:

ARTICLE 1
DEFINITIONS

Definitions. Unless otherwise provided herein terms used shall have the same meaning as set forth in HIPAA and the HIPAA Rules.

1.1 **"Addendum"** means this Business Associate Agreement Addendum.

1.2 **"Business Associate"** as used in this Addendum means the Business Associate named in this Addendum and generally has the same meaning as the term "business associate" at 45 C.F.R. § 160.103. Any reference to Business Associate in this Addendum includes Business Associate's employees, agents, officers, subcontractors, volunteers, or directors.

1.3 **"C.F.R."** means and refers to the Code of Federal Regulations.

1.4 **"Covered Entity"** means Thurston County, a Covered Entity as defined at 45 C.F.R. § 160.103, in its conduct of covered functions by its health care components.

1.5 **"Designated Record Set"** means a group of records maintained by or for a Covered Entity that is: the medical records and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used, in whole or in part, by or for the Covered Entity to make decisions about Individuals.

1.6 **"Electronic Protected Health Information" or "EPHI"** means Protected Health Information that is transmitted by electronic media or maintained in electronic media.

1.7 **<u>“HIPAA”</u>** means the Health Insurance Portability and Accountability Act of 1996, Pub.L. No. 104-191, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as Title XIII of The American Recovery and Reinvestment Act of 2009, H.R. 1, Pub.L. 111-5 (February 17, 2009), as amended or superseded, and any current and future regulations promulgated under HIPAA.

1.8 **<u>“HIPAA Rules”</u>** means the Privacy, Security, Enforcement, and Breach Notification Rules at 45 C.F.R. Part 160 and Part 164, in effect or as amended.

1.9 **<u>“Individual”</u>** means the person who is the subject of Protected Health Information and includes a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 **"<u>Material Alteration</u>"** means any addition, deletion or change to the PHI of any subject other than the addition of indexing, coding and other administrative identifiers for the purpose of facilitating the identification or processing of such information.

1.11 **<u>“Privacy Rule”</u>** means the Privacy Standards at 45 C.F.R. Part 164, Subpart E, in effect or as amended.

1.12 **<u>“Protected Health Information” or “PHI”</u>** means individually identifiable health information created, received, maintained or transmitted by Business Associate on behalf of a health care component of the Covered Entity that relates to the provision of health care to an Individual; the past, present, or future physical or mental health or condition of an Individual; or the past, present, or future payment for provision of health care to an Individual. 45 C.F.R. § 160.103. PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe can be used to identify the Individual. 45 C.F.R. § 160.103. PHI is information transmitted or held in any form or medium and includes Electronic Protected Health Information. 45 C.F.R. § 160.103. PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USCA 1232g (a)(4)(B)(iv) or employment records held by a Covered Entity in its role as employer.

1.13 **<u>“Security Rule”</u>** means the Security Standards at 45 C.F.R. Part 164, Subparts A and C, in effect or as amended.

1.14 **<u>“Subcontractor”</u>** as used in this Addendum means a Business Associate that creates, receives, maintains, or transmits Protected Health Information on behalf of another Business Associate.

1.15 **"<u>Underlying Agreement</u>"** means Thurston Mason RSN General Terms & Conditions, Program Contracts, and all accompanying documents.

<u>ARTICLE 2</u>
SCOPE OF USE OF PHI

2.1 **<u>Services.</u>** Except as otherwise specified herein, the Business Associate may use PHI solely to perform its duties as set forth in the Underlying Agreement. Except as otherwise limited in this Addendum, Business Associate may use and disclose PHI for the proper management and administration of the Business Associate, to carry out the legal responsibilities of the Business Associate and to provide any data aggregation services pursuant to the Underlying Agreement.

2.1.1 Business Associate may disclose PHI for the purposes pursuant to the Underlying Agreement only to its employees, subcontractors and agents, in accordance with Section 2.3.4 as directed by the Covered Entity.

2.1.2 Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that such disclosures are required by law or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed

only as required by law or for the purpose for which the PHI was disclosed to the person, the person implements reasonable and appropriate security measures to protect the PHI, and the person notifies the Business Associate of any instances of which it is aware where the confidentiality of the PHI has been breached.

2.2 **Breach or Misuse of PHI.** Business Associate recognizes that any breach of confidentiality or misuse of information found in and/or obtained from records may result in the termination of the Underlying Agreement and this Addendum and/or legal action. Unauthorized disclosure of PHI may give rise to irreparable injury to the Individual or to the owner of such information, and the Individual or owner of such information may seek legal remedies against Business Associate.

2.3 **Responsibilities of Business Associate**. With regard to its use and/or disclosure of PHI, the Business Associate hereby agrees to do the following:

2.3.1 Use and/or disclose PHI only as permitted or required by this Addendum, HIPAA and HIPAA Rules, or as otherwise permitted or required by law. Business Associate agrees that it will not use or disclose PHI in any manner that violates federal law, including but not limited to HIPAA and any regulations enacted pursuant to its provisions, or applicable provisions of Washington State law. The Business Associate agrees that it is subject to and directly responsible for full compliance with the Privacy Rule that applies to the Business Associate to the same extent as the Covered Entity.

2.3.2 Use commercially reasonable efforts to maintain the security of the PHI and to prevent unauthorized use and/or disclosure of such PHI, including, but not limited to the following:

Any files on location at the agency must be kept in locked cabinets. Any client information transported must be kept from unauthorized access at all times.

In addition, the Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of all Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity in accordance with 45 C.F.R. Part 164, subpart C for as long as the PHI is within its possession and control, even after the termination or expiration of this Addendum. The Business Associate agrees that it is subject to and directly responsible for full compliance with the HIPAA Security Rule that applies to Business Associates, including sections 164.308, 164.310, 164.312, and 164.316 of title 45 C.F.R., to the same extent as the Covered Entity.

2.3.3 Business Associate shall apply the HIPAA Minimum Necessary standard to any use or disclosure of PHI necessary to achieve the purposes of the Underlying Agreement. See 45 C.F.R. 164.514(d)(2) through (d)(5).

2.3.4 Require all of its employees, representatives, subcontractors and agents that create, receive, maintain, or transmit PHI or use or have access to PHI under the Underlying Agreement to agree in writing to adhere to the same restrictions and conditions on the use and/or disclosure of PHI that apply herein, including the obligation to return or destroy the PHI if feasible, as provided under Sections 5.4 and 5.5 of this Addendum.

2.3.5 Promptly report to the designated privacy officer of the Covered Entity, any use and/or disclosure of the PHI that is not permitted or required by this Addendum by telephoning the privacy officer within twenty-four (24) hours of becoming aware of it, and providing a written report of the unauthorized disclosure within five (5) business days.

The name and contact information for the Covered Entity's privacy officer is as follows:

Contact Officer:	Tammy Devlin
Telephone:	(360) 786-5498
E-mail:	devlint@co.thurston.wa.us
Address:	929 Lakeridge Drive SW, Building 4, Room 202 Olympia, WA 98502

2.3.6 Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum or the law.

2.3.7 Within twenty-four (24) hours of the discovery of a breach as defined at 45 C.F.R. § 164.402 notify the Covered Entity's privacy officer of any breach of unsecured PHI and take actions as may be necessary to identify, mitigate and remediate the cause of the breach. A breach shall be treated as discovered by the Business Associate in accordance with the terms of 45 C.F.R. § 164.410. The notification shall include the following information which shall be updated promptly and provided to the Covered Entity as requested by the Covered Entity:

a. the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during such breach;

b. a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

c. a description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

d. any steps individuals should take to protect themselves from potential harm resulting from the breach;

e. a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches;

f. contact procedures of the Business Associate for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address; and

g. any other information required to be provided to the individual by the Covered Entity pursuant to 45 C.F.R. § 164.404, as amended.

To the extent the Covered Entity deems warranted, the Covered Entity may provide notice or may require Business Associate to provide notice at Business Associate's expense to any or all individuals whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used, or disclosed as a result of such breach. In such case, the Business Associate shall consult with the Covered Entity regarding appropriate steps required to notify third parties. The Business Associate shall reimburse the Covered Entity, without limitation, for all costs of investigation, dispute resolution, notification of individuals, the media, and the government, and expenses incurred in responding to any audits or other investigation relating to or arising out of a breach of unsecured PHI by the Business Associate.

2.4 **<u>Covered Entity Obligations</u>.** With regard to the use and/or disclosure of PHI by the Business Associate, the Covered Entity hereby agrees to:

2.4.1 Provide the Business Associate a copy of the notice of privacy practices that the Covered Entity provides to Individuals pursuant to 45 C.F.R. § 164.520 by attaching it to this Addendum (Attachment A), and inform the Business Associate of any changes in the form of the notice;

2.4.2 Inform the Business Associate of any changes in, or withdrawal of, the authorization provided to the Covered Entity by Individuals whose PHI may be used and/or disclosed by Business Associate under the Underlying Agreement pursuant to 45 C.F.R. § 164.508; and

2.4.3 Notify the Business Associate, in writing and in a timely manner, of any restrictions on the use and/or disclosure of PHI agreed to by the Covered Entity in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

ARTICLE 3
AMENDMENT OF PHI

3.1 **Amendments by Business Associate.** Should Business Associate make any Material Alteration to PHI, Business Associate shall provide Covered Entity with notice of each Material Alteration to any PHI and shall promptly cooperate with Covered Entity in responding to any request made by any subject of such information to Covered Entity to inspect and/or copy such information. Business Associate shall not deny Covered Entity access to any such information if, in Covered Entity's sole discretion, such information must be made available to the subject seeking access to it. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 within twenty (20) days of the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

3.2 **Amendments Requested by Covered Entity.** Business Associate shall promptly incorporate all amendments or corrections to PHI when notified by Covered Entity that such information is inaccurate or incomplete.

ARTICLE 4
AVAILABILITY, ACCOUNTING OF DISCLOSURES, AUDITS AND INSPECTIONS

4.1 **Availability of PHI.** To the extent Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make PHI available to Covered Entity or, as directed by Covered Entity, to an Individual, within twenty (20) days of the request of the Covered Entity and in the manner designated by Covered Entity in accordance with 45 C.F.R. § 164.524.

4.2 **Accounting of Disclosures.** Business Associate agrees to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528. Business Associate will provide such accounting of disclosures to Covered Entity as soon as possible, but at least twenty (20) days from request by Covered Entity. Each accounting shall provide (i) the date of each disclosure; (ii) the name and address of the organization or person who received the PHI; (iii) a brief description of the PHI disclosed; and (iv) the purpose for which the PHI was disclosed, including the basis for such disclosure, or a copy of a written request for disclosure under §§ 164.502(a)(2)(ii) or 164.512. Business Associate shall maintain a process to provide the accounting of disclosures for as long as Business Associate maintains PHI received from or on behalf of Covered Entity.

4.3 **Access to Department of Health and Human Services.** Business Associate shall make its facilities, internal practices, books, records, documents, electronic data and all other business information relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity available to the Secretary of the Department of Health and Human Services, governmental

officers and agencies within five (5) business days of written request by the Covered Entity for the purpose of determining compliance with HIPAA .

4.4 **Access to Covered Entity.** Upon written request, Business Associate agrees to make its facilities, internal practices, books, records, documents, electronic data and all other business information available to Covered Entity within five (5) business days during normal business hours so that Covered Entity can monitor compliance with this Addendum.

ARTICLE 5
TERM AND TERMINATION

5.1 **Term.** This Addendum is valid as of the Effective Date and remains effective for the entire term of the Underlying Agreement, or until terminated as set forth herein.

5.2 **Termination.** This Addendum may be terminated by Covered Entity for convenience upon the same number of days prior written notice to the Business Associate as set out in the Underlying Agreement, otherwise upon thirty (30) days prior written notice. The notice will specify the date of termination.

5.3 **Termination for Cause.** Covered Entity may immediately terminate this Addendum and the Underlying Agreement without penalty if Covered Entity, in its sole discretion, determines that Business Associate has: (a) improperly used or disclosed PHI in breach of this Addendum; or (b) violated a material provision of this Addendum. Alternatively, the Covered Entity may choose to provide the Business Associate with written notice of the existence of an alleged material breach and a period of fifteen (15) days in which to cure the alleged material breach upon mutually agreeable terms. Failure to cure in the manner set forth in this paragraph is grounds for the immediate termination of this Addendum and the Underlying Agreement.

5.4 **Alternative to Termination.** If termination is not feasible, the Covered Entity shall report the breach to the Secretary of the Department of Health and Human Services.

5.5 **Return/Destruction of PHI.** Business Associate agrees that, upon termination of the Underlying Agreement, for whatever reason, it will return or destroy all PHI, if feasible, received from, or created or received by it on behalf of Covered Entity which Business Associate maintains in any form, and retain no copies of such information. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. An authorized representative of Business Associate shall certify in writing to Covered Entity, within five (5) days from the date of termination or other expiration of the Underlying Agreement, that all PHI has been returned or disposed of as provided above and that Business Associate no longer retains any such PHI in any form.

5.6 **No Feasible Return/Destruction of PHI.** If the return or destruction of PHI is not feasible, Business Associate shall notify Covered Entity of the conditions that make return or destruction infeasible. To the extent that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to the PHI retained and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. Business Associate shall remain bound by the provisions of this Addendum notwithstanding termination of the Underlying Agreement, until such time as all PHI has been returned or otherwise destroyed as provided in this section.

ARTICLE 6
INDEMNIFICATION/INSURANCE

6.1 **Defense and Indemnification.** Business Associate shall defend, indemnify and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including, without limitation attorney’s fees, expert witness

fees, and costs of investigation, litigation, or dispute resolution, relating to or arising out of any breach of this Addendum by Business Associate, its employees, officers, agents, or subcontractors.

6.1.1 Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with the Addendum or HIPAA or the HIPAA Rules will be adequate or satisfactory for Business Associate's own purposes or that any information in the possession of Business Associate or Business Associate's control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure; nor shall Covered Entity be liable to Business Associate for any claim, loss or damage relating to the unauthorized use or disclosure of any information received by Business Associate from Covered Entity or from any other source. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

6.2 **Insurance.** If Covered Entity requires, Business Associate shall obtain and maintain insurance coverage against improper uses and disclosures of PHI by Business Associate naming Covered Entity as an additional named insured. Promptly following a request by Covered Entity for the maintenance of such insurance coverage, Business Associate shall provide a certificate evidencing such insurance coverage.

ARTICLE 7
MISCELLANEOUS

7.1 **Construction.** This Addendum shall be construed as broadly as necessary to implement and comply with HIPAA and the HIPAA Rules. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules.

7.2 **Notice.** All notices and other communications required or permitted pursuant to this Addendum shall be in writing, addressed to the party at the address set forth in the Underlying Agreement, or to such other address as either party may designate from time to time. All notices and other communications shall be mailed by registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or telegram. All notices shall be effective as of the date of delivery of personal notice or on the date of receipt, whichever is applicable.

7.3 **Modification of Addendum.** The parties agree to take such action as is necessary to modify this Addendum to ensure consistency with amendments to and changes in the applicable federal and state laws and regulations, including, but not limited to, HIPAA and the HIPAA Rules. This Addendum shall not be waived or altered, in whole or in part, except in writing signed by the parties.

7.4 **Invalid Terms.** In the event that any provision of the terms and conditions are held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Addendum will remain in full force and effect.

7.5 **Transferability.** Covered Entity has entered into this Addendum in specific reliance on the expertise and qualifications of Business Associate. Consequently, Business Associate's interest under this Addendum may not be transferred or assigned or assumed by any other person, in whole or part, without the prior written consent of Covered Entity.

7.6 **Governing Law and Venue.** This Addendum shall be governed by, and interpreted in accordance with the laws of the State of Washington in accordance with HIPAA and the HIPAA Rules without giving effect to the conflict of laws provisions. Thurston County, Washington, shall be the sole and exclusive venue for any litigation, special proceeding or other proceeding as between the parties that may be brought under, or arise out of, this Addendum.

7.7 **No Third Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor anything herein shall confer, upon any person other than the parties hereto any rights, remedies, obligations or liabilities whatsoever.

7.8 **Binding Effect.** This Addendum shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective permitted successors and assigns.

7.9 **Execution.** This Addendum may be executed in multiple counterparts, each of which shall constitute an original, all of which shall constitute but one agreement.

7.10 **Gender and Number.** The use of the masculine, feminine or neuter genders, and the use of the singular and plural, shall not be given an effect of any exclusion or limitation herein. The use of the word "person" or "party" shall mean and include any individual, trust, corporation, partnership or other entity.

7.11 **Priority of Agreements.** If any portion of the Addendum is inconsistent with the terms of the Underlying Agreement, the terms of this Addendum shall prevail. Except as set forth above, the remaining provisions of the Underlying Agreement are ratified in their entirety.

7.12 **Survival.** The obligations of Business Associate shall survive the termination of this Addendum and the Underlying Agreement.

7.13 **Recitals.** The preamble to this Addendum is not a mere recital of facts, but consists of binding agreed upon statements that form the basis of this Addendum.

IN WITNESS WHEREOF, the parties hereto have signed this Addendum effective the day and year first above written.

BUSINESS ASSOCIATE:	**COVERED ENTITY:** **THURSTON COUNTY**
____________________ *Signature (Authorized Representative)* ____________________ *Printed Name* ____________________ *Title* ____________________ *Date*	____________________ *Signature* Don Sloma *Printed Name* Director *Title* ____________________ *Date*

ATTACHMENT A
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

Thurston County is required by law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are required to notify you following a breach of your unsecured protected health information. We must follow the privacy practices that are described in this Notice currently in effect.

Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. We reserve the right to change our privacy practices and the terms of this Notice at any time. Changes will be available from the County office that provides your service. Any changes in our privacy practices and the new terms of our Notice will be effective for all protected health information that we maintain, including protected health information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your health information:

For treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. For example, if we refer you to a physician for a service that we cannot provide, your health information will be disclosed to that office.

For payment: We may use and disclose your health information to obtain payment for services we provide to you or to coordinate your medical benefits. For example, if an insurance company pays for your service, it may be necessary to disclose your health information to that company.

For healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To provide appointment reminders: We may disclose limited health information to provide you with appointment reminders such as voicemail messages, postcards, or letters.

To persons involved in your care: We may use or disclose health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, then we will provide you with an opportunity to object to such uses or disclosures before they are made. In the event of your incapacity or emergency circumstances, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

As required by law: We may disclose your health information when we are required to do so by federal, state or local law.

Business Associates: We may disclose health information to third party "business associates" who perform various activities involving your health information (e.g., claims payment or case management services) for the County. The County will implement written contracts to ensure the business associates will appropriately safeguard the information and to limit the use or disclosure of health information.

For public health activities: We may use and disclose medical information about you for public health activities, including to report births and deaths, and notify appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other crimes.

For public safety: We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

For health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law.

For judicial and administrative proceedings: We may disclose health information about you in response to a court or administrative order. We may disclose health information in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

For law enforcement purposes: We may disclose health information to law enforcement officials when certain conditions are met.

To coroners, medical examiners and funeral directors: We may disclose health information to coroners, medical examiners and funeral directors as authorized by law.

For workers' compensation: We may release health information about you for workers' compensation or similar programs.

For national security and similar government functions: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities.

To correctional institutions or law enforcement officials: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose information about you to the institution or official under certain circumstances.

For organ and tissue donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research protocol and determined that adequate safeguards exist to ensure the privacy of your health information.

With your authorization: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. Unless otherwise allowed by law, your written authorization is required before use or disclosure of psychotherapy notes or use or disclosure of protected health information for marketing purposes or disclosure for the sale of health information. (Thurston County does not market or sell health information in any event.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Specially Protected Types of Health Information: Some types of health information have greater protection under Washington State or federal laws. When required by law we will obtain your authorization before releasing HIV-related and sexually transmitted disease information that is protected by Washington State laws; alcohol and substance abuse treatment information that is protected under both Washington State and federal laws; and mental health treatment information that is protected under both Washington State and federal laws.

YOUR RIGHTS

Access: You have the right to look at and get copies of your protected health information, with limited exceptions. You may make your request for access to your medical records orally or in writing by using forms we provide or sending us a letter to the address at the end of this Notice. If you request copies, we will charge you

$0.50 for each page plus postage if you want the copies mailed to you. We may deny your request in certain very limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed. Another licensed health care professional not directly involved in the decision to deny your request will review your request and the denial. We will abide by the outcome of the review.

Disclosure accounting: You have the right to receive a list of disclosures we or our business associates made of your protected health information for purposes other than treatment, payment, healthcare operations and certain other activities for a period of time up to six years prior to the date of the accounting request, but not including dates before April 14, 2003. You must make this request in writing to our Contact Officer. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for providing the list.

Request restrictions: You have the right to request that we restrict how we use or disclose your protected health information for treatment, payment, or health care operations or the disclosures we make to someone who is involved in your care or the payment for your care, such as a family member, other relative, or friend. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operations and the information you seek to restrict pertains solely to a health care item or service for which you have paid the health care provider out-of-pocket in full.

Confidential communication: You have the right to request that we communicate with you about your protected health information by alternative means or at alternative locations. You must make your request in writing to the Contact Officer and may use forms we provide. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must give a reason for your request. We may deny your request if you ask us to amend information that was not created by us, is not part of the information kept by the County, is not part of the information you would be permitted to inspect and copy, or is accurate and complete. Any denial will be in writing and state the reason for the denial.

Paper Copy: You have the right to get a paper copy of this Notice if you request it, even if you have agreed to receive the Notice electronically.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or if you disagree with a decision we made about use or disclosure of your protected health information, you may complain to us using the contact information listed here. You also may submit a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Contact Officer: Tammy Devlin
Telephone: (360)786-5498
E-mail: devlint@co.thurston.wa.us
Address: 929 Lakeridge Drive SW, Building 4, Room 202
Olympia, WA 98502

Attachment 13

Attachment 13: Superior Court Felony Drug Court Review

COUNTY COMMISSIONERS
Cathy Wolfe
District One
Sandra Romero
District Two
Bud Blake
District Three

THURSTON MASON
REGIONAL SUPPORT NETWORK

September 21, 2015

Superior Court Felony Drug/ DUI Court Program
2400 Bristol Court
Olympia WA 98506

Dear Ms. Craig:

Thank you for the recent opportunity to review the clinical charts from Pierce County Alliance's treatment program for Thurston County Felony Drug/ DUI Court program. The review was in response to your notification that there were some potential problems with the type of services being provided, the documentation of these services, and whether or not the agency (Pierce County Alliance) was operating out of its authorized scope of licensure. On July 7, 2015 Thurston County Chemical Dependency and Quality Management staff visited your offices to conduct a file review. A representative sample of 2013, 2014 and current charts from 2015 were reviewed. The following questions defined the scope of this review:

- Did the agency adequately document the need for mental health services on the bio-psychosocial assessment?
- If yes, did the agency adequate document the need for mental health services on individualized services/treatment plan?
- Is there evidence in the record that the CDP made appropriate referrals for mental health treatment, or that symptoms of the identified mental illness were incorporated into the individualized services/treatment plan to be addressed by the agency CDP?
- Is there evidence in the record that no mental health diagnoses were being made by staff the agency outside of the contracted scope of work?
- If mental health conditions were separately identified – as a focus of treatment – were independent mental health assessment tools utilized in order to appropriately assess such conditions?

Findings

1. **Bio-Psychosocial Assessments:** There was ample evidence that mental health information presented in Dimension III was thorough and well documented. In most cases sufficient information was gathered to appropriately assess the client's need for treatment in these areas. Several reviewed charts documented how clients were referred out (to an outside agency) for further mental health treatment. In other cases, there was documentation that the client would be "referred" internally to an "in-house" mental health professional (Victor Steffens).

2. **Individual service/treatment plans:** At time of review, Pierce County Alliance was not licensed to provide mental health services. Additionally, had there been a license in place to provide those services, there was a significant lack of continuity between the identified mental health issue on the assessment and the treatment plan developed by the MHP (Victor Steffens). In most cases the "golden thread" of treatment was broken at this point. In other words, there did **not** appear to be continuity between what was listed as an issue on the assessment and what was listed on the MHP's treatment plan. Furthermore, there were no additional mental health assessments or evaluations in the record

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www.co.thurston.wa.us/health/ssrsn

that supported the mental health treatment. For example, in several of the records Dimension III identified significant trauma experienced by the client. When looking at the separate mental health section of the record, new issues (problems) were identified. These new issues were not supported by any sort of assessment, intake or evaluation. They simply appeared on the "problem list" and were a focus of mental health treatment.

This is a significant finding for several reasons. First, the agency was not licensed to provide the services they reported or documented under mental health. Second, charts were divided into two (2) primary sections: Substance Use Disorder treatment **and** Mental Health treatment. If the agency were a dually licensed facility (with both SUD and MH services) separate and distinct chart sections (or charts) would have been appropriate. However, as Pierce County Alliance is strictly an SUD provider (and licensed as such), one would not expect to see a separate section for mental health services. The agency is not licensed as a Community Mental Health Agency (CMHA). Thirdly, the lack of diagnostic tools used to develop treatment plans under the mental health section of the record is very concerning. There was no evidence that mental health treatment, or treatment modalities (i.e., EMDR & psychotherapy) were supported by reasonable mental health diagnostic instruments. Finally, even if the agency were licensed to provide mental health services, and even if the MHP used solid mental assessments to develop a diagnosis and treatment plan, there was generally no link between the bio-psychosocial assessment and what was listed on the client's mental health treatment plan. One would expect to see continuity of care between the work of the CDP and the mental health worker providing the mental health treatment. This continuity was not evident.

3. **Scope of Care:** As mentioned above, it appears that Pierce County Alliance is working outside the constructs of their current contract. This is evidenced by the absence of licensure to complete treatment, the dividing of charts into separate (and not aligned) mental health and SUD sections. As this is a service contracted to provide SUD services only, one would not expect to see separate, unsupported treatment needs being addressed within a discreet mental health section. The application of treatment services to address identified "symptoms" of a potential mental health diagnosis would be appropriate – and is common within SUD services across the system. This means that when a client is suffering from debilitating and self-reported anxiety, a CDP can offer assistance to help alleviate these symptoms. However, such treatment would (1) clearly be indicated on the client's bio-psychosocial assessment, and (2) be clearly integrated into the client's overall treatment/service plan. In the records reviewed it appears that the MHP was operating independently from the rest of the program (almost as a standalone provider), and no efforts were made to align all services under the contracted SUD contract.

Recommendations

1. It is recommended that Pierce County Alliance documentation / charting practices be immediately reviewed and changed. It is important that services reflect substance use disorder treatment services. As noted above, records are currently organized in such a way as to suggest that the program has a mental health component when in fact it is not licensed to provide that service, nor were the services connected or documented in a way that showed continuation of care.

2. It is recommended that all mental health needs identified in the bio-psychosocial assessment be clearly identified as being (1) referred out to an outside mental health provider for treatment, or (2) being provided in-house by a qualified CDP. If mental health needs are being provided by an MHP, these services need to be incorporated into the primary treatment/service plan and should have clear alignment with issues identified in Dimension III.
3. Should Pierce County Alliance choose to continue to provide EMDR within the scope of co-occurring substance use disorder services, the following will be required:
   - Include in the chart, the array of screens, outlined in the treatment policy and procedures, used to identify Trauma and PTSD
   - Include the screen outcomes, referral, and need in the individual's assessment, service plan, and progress notes ensuring the continuum of care is evident through all documentation

- Prepare an individualized service plan to address the PTSD/Trauma as a co-occurring issue(s) using EMDR and the exercises included in that model as the means to address them.

If you would like any further clarification or technical assistance, please feel free to contact me.

Sincerely,

Larry Horne, MS LMHC

Larry Horne, MS LMHC
BHO Quality Manager
(360) 867-2567

Attachment 14

Attachment 14: Crisis Clinic Review

THURSTON MASON REGIONAL SUPPORT NETWORK

Crisis Information and Referral Program
Administrative Review

Reviews Performed By/Title:	**Kristy Lysell / TMRSN Provider Network Coordinator**
Date of Report:	**July 25, 2014**
Agency Reviewed:	**The Crisis Clinic**
Contract Number:	**P2014-8661**
Contract Duration:	**April 2014 – December 2014**
	☒ **General Terms & Conditions**
	☒ **Statement of Work**
Focused Review:	☒ **Employee, Volunteer, Intern Files**

Introduction

The Thurston Mason Regional Support Network (TMRSN) conducted an administrative review of The Crisis Clinic – Information and Referral program during the start of the second quarter of the contract. This Administrative review examined elements of the contract including sections of the general terms and conditions, employee/volunteer files for required conditions of employment, and statement of work requirements. This was the first review of The Crisis Clinic since TMRSN began directly contracting with them in April 2014. The reason this review was performed so early in the duration of the contract was to determine a baseline of performance. This contract was previously subcontracted through Behavioral Health Resources (BHR) who had not performed any program reviews.

Employee/Volunteer Review

The first part of the administrative review consisted of reviewing all three (3) employee files and a random sample of nineteen (19) volunteer files. The employee/volunteer review instrument consisted of nineteen (19) items. The items, and the corresponding score achieved during the employee/volunteer review, are presented in the table below. Each of the nineteen (19) items was scored as follows: A two (2) indicates that the item was fully met; A one (1) indicates that the item was partially met; and, a (0) means that the item was not met. Items that did not apply to the specific employee/volunteer were scored as "not applicable" and do not figure into the program's overall achieved score.

#	Item Reviewed	Qualified Responses	Composite Raw Score	Percent Compliant
1	Background Check Complete	44	42	95%
2	Policy Orientation	44	34	77%
3	60 Hours of Crisis Training	42	16	38%
4	Annual Crisis Training Refresher	NA	NA	NA
5	HIPAA Compliance	NA	NA	NA
6	Oath of Confidentiality	44	36	82%
7	Training Plan in File and Includes:	42	0	0%
8	● Understanding Crisis	42	0	0%
9	● Connecting Across Diverse Values	42	0	0%
10	● Listening and Empathy	42	6	14%
11	● Empowering Problem Solving	42	0	0%

12	● Healthy Boundaries	**42**	**0**	**0%**
13	● Suicidality	**42**	**6**	**14%**
14	● Relationship Violence	**42**	**6**	**14%**
15	● Mental Health Issues	**42**	**6**	**14%**
16	● Chemical Dependency	**42**	**6**	**14%**
17	● Information and Referral	**42**	**6**	**14%**
18	● Self-care and Vicarious Trauma	**42**	**0**	**0%**
19	● 20 Hrs Intensive Phone Room	**42**	**32**	**76%**
Employee/Volunteer File – Section Score		**196/720**		**27.22%**

Overall, the employee/volunteer file review portion of this review revealed a **27.22 percent** compliance rate, which sets the baseline for performance expectations. This established performance standard for this section of the review is ninety (90) percent. The Crisis Clinic will work towards bringing their compliance to this section up to the standard listed. While there were identified strengths and changes already occurring, there are areas for future quality improvement, listed below:

Strengths:

- The background checks in the employee/volunteer files were consistent.
- The Director has already identified areas of improvement and has begun implementing changes in regards to ensuring each file contains consistent information including a redesigned training certificate.
- Employees and volunteers sign "oaths of confidentiality" that are located in their file.
- Complete copies of the volunteers 20 hour phone training is included in their file.

Areas of Improvement/Recommendations:

While the Employee/volunteer files have some positive consistencies, overall, files were not organized well and it was difficult to find information that should be readily available, for example: hire dates, training certificates and/or records of trainings, etc. Therefore, again since this is only a baseline review, TMRSN recommends the below actions be implemented in some form before the next annual review:

- Files should have a record or cover sheet/check off list indicating what items are kept in the employee/volunteer files and each file should be organized accordingly.
- Hire dates should be indicated somewhere readily available within the record. This information is vital to ensure that employees/volunteers did not begin work until after a background check was completed.
- The current training record in the file only shows the 20 hours of phone training. There needs to be a certificate or record of all trainings required per contract and a copy needs to be placed in the file to ensure contract compliance. ***Note:*** The Director has already developed a revised training certificate, now it just needs to be implemented and employee/volunteer files need to be updated to reflect the change.
- Employees/Volunteers currently only sign off on a "Network Usage Policy." However, employees/volunteers would benefit from being orientated to all policies and procedures and signing a form that have read and understood expectations of all polices.
- Annual Training Refresher is marked NA because as of now it is an optional training. However, in the future the Crisis Clinic may want to ensure that employees/volunteers who are there for over a year receive a refresher course, even if it is shorter and modified from the original training.
- HIPAA Compliance is also marked NA because it was just added to the contract and the Crisis Clinic has not yet been trained and been able to implement a HIPAA Compliance Training. Even though the Crisis Clinic is supposed to be an anonymous service and no Protected Health Information (PHI) is supposed to be collected, at times PHI does get collected and entered into the Crisis Tracker system. Therefore, there needs to be a HIPAA Compliance training for all employees/volunteers including a sign off which can be included in the overall "oath

of confidentiality" sign off, or as a standalone. Note: Please also see Contract review section below for additional HIPAA Compliance recommendations.

GT&C and Statement of Work Review

The second part of the administrative review consisted of reviewing six (6) sections of the General Terms & Conditions (GT&C) and ten (10) sections of the Contract Statement of Work (SOW). The items, and the corresponding score achieved during the GT&C and SOW, are presented in the table below. Each of the sixteen (16) items was scored as follows: A two (2) indicates that the item was fully met; A one (1) indicates that the item was partially met; and, a (0) means that the item was not met. Items that did not apply to the review were scored as "not applicable" and do not figure into the program's overall achieved score.

#	Item - Reviewed	Qualified Responses	Composite Raw Score	Percent Compliant
1	Contractor has policy and/or procedure on Safeguarding Personal Information, which includes requirements about not releasing any personal data collected for the purpose of the contract other than required by state or federal law. Policy also includes procedure for breach of information. (GTC 6.a, 6.c)	**2**	**1**	**50%**
2	Contractor has electronic and managerial safeguards to prevent unauthorized access to personal information. (GTC 6.b)	**2**	**2**	**100%**
3	Contractor has current insurance coverage that meets all insurance requirements including loss and aggregate amounts. (GTC 9)	**2**	**2**	**100%**
4	Contractor has not outsourced or subcontracted any contractual requirements without written consent by the County. (GTC 13)	**2**	**2**	**100%**
5	Contractor has policies and procedures on Compliance with Laws that align with the services being provided under this contract, including HIPAA compliance. (GTC 14)	**NA**	**NA**	**NA**
6	Contractor has Nondiscrimination policy. (GTC 16)	**2**	**2**	**100%**
7	Contractor has between 70-90 active volunteers and 10-20 youth volunteers. (SOW 2.1.2)	**2**	**1**	**50%**
8	There is documented evidence the Contractor provides a minimum of 1200 community based referrals per year. (SOW 2.1.3)	**2**	**2**	**100%**
9	Contractor has guidelines on the number and type of information that is maintained and provided through the 211 Directory. (SOW 2.2.1)	**2**	**1**	**50%**
10	Directory includes TMRSN Network Providers, employment and education, housing and shelters, emergency services, and healthcare. (SOW 2.2.1.1. - 2.2.1.5.)	**2**	**2**	**100%**
11	There is documented evidence that (10,000) Community Service Lists have been distributed within the community. (SOW 2.2.3)	**2**	**2**	**100%**
12	Contractor has designed and printed teen resource calling cards. (SOW 2.2.4)	**2**	**2**	**100%**
13	There is documented evidence that (10,000) teen resource cards have been distributed within the community. (SOW 2.2.4)	**2**	**2**	**100%**
14	The Contractor will attend the October 27th TMRSN Advisory Board meeting to exchange information and provide an update about services at the Crisis Clinic. (SOW 3.4.1)	**2**	**2**	**100%**
15	The Contractor maintains call logs documenting telephone and information distribution. (SOW 3.5.1)	**2**	**2**	**100%**
16	The Contractor has a policy on mandated reporting has records to show evidence that reporting has occurred. (SOW 3.5.2)	**2**	**2**	**100%**
GT&C and Statement of Work – Section Score		**30/27**		**90%**
Administrative Review Overall Percent		**226 pts / 747 pts possible**		**30.25%**

Overall, the GT&C and Contract Statement of Work review portion of this review revealed a **90 percent** compliance rate, which sets the baseline for performance expectations, but also meets the expected 90% compliance rate. Many areas of strength and a few areas for future improvement are listed below:

Strengths:

- The Crisis Clinic has a solid foundation of policies and procedures to build on as they make changes to their employee/volunteer training and orientation.
- Even though they only scored a 67% on number of volunteers maintained, they had a scheduled training for 10 new youth volunteers and they maintain a sufficient pool of adult volunteers.
- The Crisis Clinic does an excellent job at maintaining community services lists, teen calling cards, and referral and resource information on 211. In addition, there is documentation that tracks distribution of the required resources. ***Note:*** It was brought to my attention during the review that agencies can request not to be listed on the 211 website. Therefore, to meet the contract requirement, the Manager will track agencies that receive a request to be on 211 but decline.
- The Crisis Clinic is on time with contract deliverables, which includes annual insurance certificates and monthly call data reports.

Areas of Improvement/Recommendations:

The area of most concern under this portion of the review is HIPPA Compliance. As recommended under the employee/volunteer portion of the review, the Crisis Clinic needs to become compliant with HIPPA regulations to ensure that any PHI data captured in notes, over the phone during a call, or recorded in the Crisis Tracker System is securely protected. It is recommended the Crisis Clinic:

- Create a HIPAA Compliance training for all employees/volunteers.
- Create a HIPAA Compliance policy and procedure, which also includes information about what to do if/when a breach of PHI occurs.
- Work with the developer of the Crisis Tracker System to create a unique log in ID for each volunteer employee. ***Note:*** The Manager is looking into this possibility, but it may not be possible with the current system. However, there are other safeguards in place including, secure entry into the location and the Manager changed the universal log in system for each of the four (4) onsite computers used by the volunteers by changing the usernames and creating a stronger password for each computer. In addition, usernames and passwords were removed from visual site and an INK was created to communicate to the volunteers about the change.
- Change the usernames and passwords on the computers a minimum of every three months.

Summary

Even though the overall score of the review was a much lower score that the 90% compliance rate, this review was performed only to establish a baseline and provide some feedback for future contract reviews so it does not require a Performance Improvement Plan (PIP) from the Crisis Clinic. During the review TMRSN recognized that the Crisis Clinic has a solid foundation to build on and with time to develop and implement recommended changes to their systems, TMRSN is confident that the Crisis Clinic will meet and exceed expectations and the next reivew.

Attachment 15

Attachment 15: PACT OP Review

THURSTON MASON
REGIONAL SUPPORT NETWORK

Program of Assertive Community Treatment (PACT)
Operational Review

Reviews Performed By/Title:	**Larry Horne, MS LMHC CMHS / TMRSN Quality Manager**
Date of Report	**October 01, 2015**
Agency Reviewed:	**Behavioral Health Resources (BHR)**
Program:	☒ **Adults: Thurston Co.** ☐ **Children: Thurston Co.** ☐ **Adults: Mason Co.** ☐ **Children: Mason Co.**
Type of Review	☐ **Comprehensive Outpatient Services** ☒ **Operational Review – Check all that apply** ☐ **Focused – check all that apply**

Operational Review Type	Focused Review Type
☐ **Access Program**	☐ **Request for Services**
☐ **MIJOP**	☐ **Treatment Planning**
☐ **MIO**	☐ **Client Rights/Provision of Services**
☒ **PACT**	☐ **Psychiatric, Medical and Crisis Planning and Services**
☐ **Residential Care Pathway**	☐ **Access to Care / Level of Care Authorizations**
☐ **PATH**	☐ **Practice Guidelines**
	☐ **CRS**
	☐ **ETU**
	☐ **CSTU**

Introduction

The Washington Institute for Mental Health Research & Training (WIMHRT) and Thurston Mason Regional Support Network (TMRSN) conducted two (2) independent reviews on the PACT program in recent months. WIMHRT concluded its review on May 21st and 22nd, 2015 and issued its draft report on August 06, 2014. TMRSN conducted its review on August 24th and 25th, 2015. This report is intended to summarize both reviews and provide a framework for the Performance Improvement Plan (PIP) that will be required from BHR. WIMHRT focused exclusively on adherence to the Washington PACT Standards (6/6/2009) – or, the **Program portion** of the Operational Review. TMRSN's review was primarily a clinical chart audit and utilization review.

The period under review for this operational review was Calendar Year 2014. This is the fifth year that TMRSN reviewed the PACT program in conjunction with WIMHRT, and the third year that both reviews were combined into one (1) report. This should make response to TMRSN easier as only one (1) PIP will need to be created by BHR. The Operational Review for the PACT Program is a process that will take place on an annual basis, independent of any other fidelity reviews or audits conducted by outside entitles. Results from this review are presented below.

Clinical Chart Review

The first part of this review consisted of reviewing a random sample of eight (8) clinical charts from consumers who had been engaged in PACT services during the period under review. All of the reviewed charts were open, with no discharged consumer charts being reviewed this year. The review instrument consisted of 152 items across fourteen (14) domains. Each item for the review was scored as follows:

3 – Item was fully met. This indicates that the requirements for this item were completely met.
2 – Item was substantially met. This indicates that the requirements for this item were largely met, with some minor elements missing, or with some small concerns with overall quality of completion.
1 – Item was partially met. This indicates that the requirements for this item were not fully met, and that there were some major concerns with quality.
0 – Item was not met. This indicates that the requirements for this item were not met. This could mean that the requirement was missing from the record, or that it was not addressed in the documentation.
N/A – Item was not applicable to the specific consumer. Items that did not apply to the specific consumer do not figure into the agency's overall achieved score.

Results from this year's review demonstrated a fairly significant decline from last year's review (CY 2013). The overall score from this year's clinical review was **78.64%** which is significantly lower than last year's score of **90.20%.** A Performance Improvement Plan (PIP) will be required for this year – based on recommendations included in this report. **Table one** below presents the results of the clinical chart review in each of the individual domains.

#	Domain	Total Possible Score	Total Achieved Score	CY 2014 Percent Compliant	CY 2013 Percent Compliant
1	Admission Criteria	228	228	100%	98.89%
2	Assessments	339	194	57.23%	83.33%
3	Person Centered Treatment Planning	288	208	72.22%	86.72%
4	Core Services (Generally - PACT Standards VIII.A-M)	432	341	78.94%	85.09%
5	Core Services (Case Management and Rehabilitation Services)	120	104	86.67%	94.00%
6	Core Services (Medical and Medication Services)	240	220	91.67%	100%
7	Core Services (Drug and Alcohol Use)	48	40	83.33%	93.59%
8	Core Services (Crisis Planning and Support Services)	417	351	84.17%	91.23%
9	Core Services (Vocational Services)	90	65	72.22%	88.89%
10	Core Services (Services in a Residential Setting)	96	91	94.79%	94.02%
11	Core Services (Peer Support Services)	216	135	62.50%	88.89%
12	Consumer Rights	72	65	90.28%	100%
13	Discharge Criteria	0	0	N/A	81.82%
14	Documentation	72	43	59.72%	88.89
	Total	2682	2109	78.64%	91.04%

Table One: PACT Clinical Chart Review results: Calendar Year 2014

Overview

Over the past several years the BHR/PACT program has shown tremendous improvements in several areas – most notability the stabilization of staffing resources and an adherence to PACT Fidelity Standards and staff training and development. It was readily apparent that key systemic changes were being made and followed. It appears that for

the period under review (Calendar Year 2014) the BHR PACT team has experienced some significant staffing losses – which, not surprisingly – have been reflected in this year's report.

Observations and Recommendations

- All of the records reviewed contained appropriate referral and eligibility information. It was apparent that each consumer was adequately screened for services and met criteria for inclusion into PACT. This continues to be a strength for the PACT team.

- There is ample evidence in the clinical record where each PACT consumer is staffed on a regular basis. It appears that each team member knows and works, as appropriate, with all PACT consumers.

- Medication management and monitoring services were – as in last year's review – a tremendous strength of the PACT program. Adherence to psychiatric medication requirements was timely and well documented.

- **Comprehensive Assessment:** Many of the Comprehensive Assessments were **not** completed by BHR/PACT. As noted in last year's review, there were several instances where the entire Comprehensive Assessment was not found in the record. In fact, of the eight (8) consumer charts reviewed, there were **no** instances where all elements of the Comprehensive Assessment could be found. This is not to suggest that they were not completed, only that they were not included in the documentation. Similarly, in most cases the Comprehensive Assessment was **not** completed within the required thirty (30) day time frame. Currently the PACT program has various team members completing different sections of the Comprehensive Assessment. This practice allows for some sections to be completed in a timely manner, while other sections are not. There does not appear to be a primary team member assigned whose responsibility it is to ensure timely completion of the Comprehensive Assessment. Similarly, there are sections of the Comprehensive Assessment that appear to have only minimal, or cursory, information. The purpose of the Comprehensive Assessment is to develop a holistic picture of the consumer. In some of the records reviewed, information was very sparse or non-existent without any indication why. This topic (assessments) accounted for the single biggest decline from last year to the current year.

- **Person Centered Treatment Planning (Interventions in a Broad Range of Life Domains):** WIMHRT reviewers found considerably more diversity in the content of the treatment plans. It was noted that "a high-fidelity team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions and there is symmetry between the practices planned for and carried out." It was noted that significantly more treatment plans contained goals in various life domains. This was also true in 2013's review, however, when examining services provided under these treatment plan items, services could not be identified.

- **Person Centered Treatment Planning (General):** Plans are now much more inclusive of various life domains (as noted above), and there has been improvements in the specificity of the plans (which make them easier to follow and report upon). Treatment plans still continue to struggle with "measurability", however. This means that the plan **goals** are still overly broad and difficult to measure.

  As noted in last year's review, in many circumstances treatment plan goals were vague and did not appear to be consumer driven. For example, some of the treatment plans contained statements such as, "the client will be medication compliant," or, "the client will attend all appointments as directed." These goals are both directive and not specific to a particular consumer-identified problem that can be successfully resolved within a six (6) month period of time.

  Finally, as noted above, treatment plans and actual services did not appear to align. While treatment plans have improved – generally – there is very little evidence that actual services aligned to the treatment plan

are occurring. For example, many of the treatment plans discuss housing as a major area of concern for PACT consumers, yet it is difficult to find where actual housing services are being provided (i.e., referrals, skill development, etc.).

- **Treatment Plan Reviews:** A major improvement from last year is in the area of treatment plan reviews. Nearly all the records contained good information on progress related to previous treatment plans.

There are several recommendations related to clinical practice and documentation that are being this year. Many of these recommendations – to be included in this year's Performance Improvement Plan – are repeats from previous years. It is understood that the BHR PACT program is "new", in terms of many of its staff. This year presents a good opportunity to grow and build a sound, quality program.

Recommendation #1

Assessments: It is recommended that the BHR PACT program develop a better way to ensure that Comprehensive Assessments are (1) completed in a timely manner (within 30 days of admission into PACT), and (2) that the entire Comprehensive Assessment is completed. This includes ensuring that the following elements are adequately covered within the Comprehensive Assessment:

- Psychiatric history, mental status and diagnosis (PACT standards VII.B.2a);
- Physical health (PACT standards VII.B.2b);
- Use of drugs and alcohol (PACT standards VII.B.2c);
- Education and employment (PACT standards VII.B.2d
- Social development and functioning (PACT standards VII.B.2e
- Activities of daily living (ADL) (PACT standards VII.B.2f
- Family structure and relationships (PACT standards VII.B.2g); and
- Strengths and resources (PACT standards VII.B.2h

It is further recommended that the PACT Team Lead, or other designated person, have primary responsibility to ensure that all eight (8) subsections of the PACT Comprehensive Assessment are completed in a timely manner **and** included as part of the overall chart documentation.

Recommendation #2

Treatment Planning (General): It is recommended that treatment plan goals be developed with the consumer and include goals that are specific, easily measured, and can reasonably be expected to be completed within a given time period. In other words, it is strongly recommended to break down treatment plan goals into smaller, manageable benchmarks that can be reported upon every six months. It is further recommended that BHR/PACT continue to develop meaningful treatment plan reviews that can be used in the development of the consumer's new treatment plan. TMRSN recommends that further training and consultation take place around the development and follow-up of person centered treatment plans.

- **Service Provision (general):** While the content of the PACT treatment plans have improved, it was still noted that there was **not** symmetry between goals identified on the treatment plan and actual provision of service. In other words, information contained in the Comprehensive Assessment and/or the Person-Centered Treatment Plan is not translated into actual services.

  The review highlighted several service areas that were **not** adequately documented, or fully developed. It was noted in the WIMHRT review (both in 2013 and 2014) that the program did not contain fully developed psychosocial rehabilitation, vocational, and peer support services. Moreover, the services that were developed did not appear to be based on any particular best practice, or evidence-based practice.

- **Service Provision (Psychosocial Rehabilitation):** While the content of the PACT treatment plans have improved, it was still noted that there was **not** symmetry between goals identified on the treatment plan and actual provision of service. In other words, information contained in the Comprehensive Assessment and/or the Person-Centered Treatment Plan is not translated into actual services. Please see recommendation #1 below for more information.

- **Service Provision (Co-Occurring Services):** Several of the consumers in this year's review stated that substance use disorders were / or had been, a barrier to treatment. However, oftentimes SUD was left off the treatment plan, and/or there was not a corresponding SUD service provided. As stated above, oftentimes information contained in the Comprehensive Assessment and/or the Person-Centered Treatment Plan is not translated into actual services. Please see recommendation #1 below for more information.

- **Service Provision (Crisis Services):** While the content of the PACT treatment plans have improved, it was still noted that there was **not** symmetry between goals identified on the treatment plan and actual provision of service. In other words, information contained in the Comprehensive Assessment and/or the Person-Centered Treatment Plan is not translated into actual services. Please see recommendation #1 below for more information.

Recommendation #3

Service Provision: Many of the items on the consumer's treatment plans did **not** translate into provided services. In other words, there were many instances where *actual* services appeared to be a reaction to a new problem and not relatable to any goal on the treatment plan. In several reviewed charts identified goals were not addressed at all within a six (6) month period of time. This item relates to the Golden Thread wherein services need to tie into the consumer's treatment plan. It is recommended that BHR/PACT receive additional training related to treatment planning and service provision. It is further recommended that treatment plans and subsequent progress notes are reviewed together to ensure continuity.

Program Review

On May 21 and 22, 2015, Jonathan Beard, LICSW, CPRP, of the University of Washington, Division of Public Behavioral Health and Justice Policy, and Lucy Graves, MSW, formerly from Central Washington Comprehensive Mental Health reviewed the PACT program at BHR. The purpose of the review was to assess the team's adherence to the Assertive Community Treatment (ACT) model.

The Program Review section of the Operational Review is an opportunity to examine the PACT program as it operates "on the ground". Since the WIMHRT review not only covers fidelity measures for an ACT program, but also provides comments and suggestions on day to day operations, TMRSN will use their report to complete this section. In addition, TMRSN will also examine contract deliverables and information gathered through the clinical review portion of this review to complete the report.

This section of the Operational review is intended to reinforce the Fidelity Review conducted by WIMHRT, and to highlight some of the strengths and areas in need of improvement. Since WIMHRT does not require Performance Improvement Plans (PIPs) or Corrective Action Plans (CAPs) – and instead offers recommendations regarding how to improve overall scores – TMRSN uses their report to generate items for a PIP request, if necessary. It offers a framework to build the Performance Improvement Plan.

The 2015 PACT review is noteworthy for the overall decrease in scores – across al subscales – from 2014 to 2015. The primary reason for this decrease, as stated by the WIMHRT reviewers, is due to the fact that the BHR PACT program has lost the majority of its staffing and is, in effect, rebuilding the program.

> ***The significant attrition that the team has experienced in the last year is a barrier to fidelity in the evidence based practice (EBP) of assertive community treatment (ACT). This is referenced in the report and is deserving of attention from you and BHR management. The result of this is that the BHR Team is, essentially, a new team. New teams cannot be expected to be in high fidelity with ACT. The first review of a new team results in a report that details where growth and performance improvement is needed.***

Figure one below demonstrates how this year's Full Scale Measurement Score for PACT has decreased to level not seen since the 2012 review.

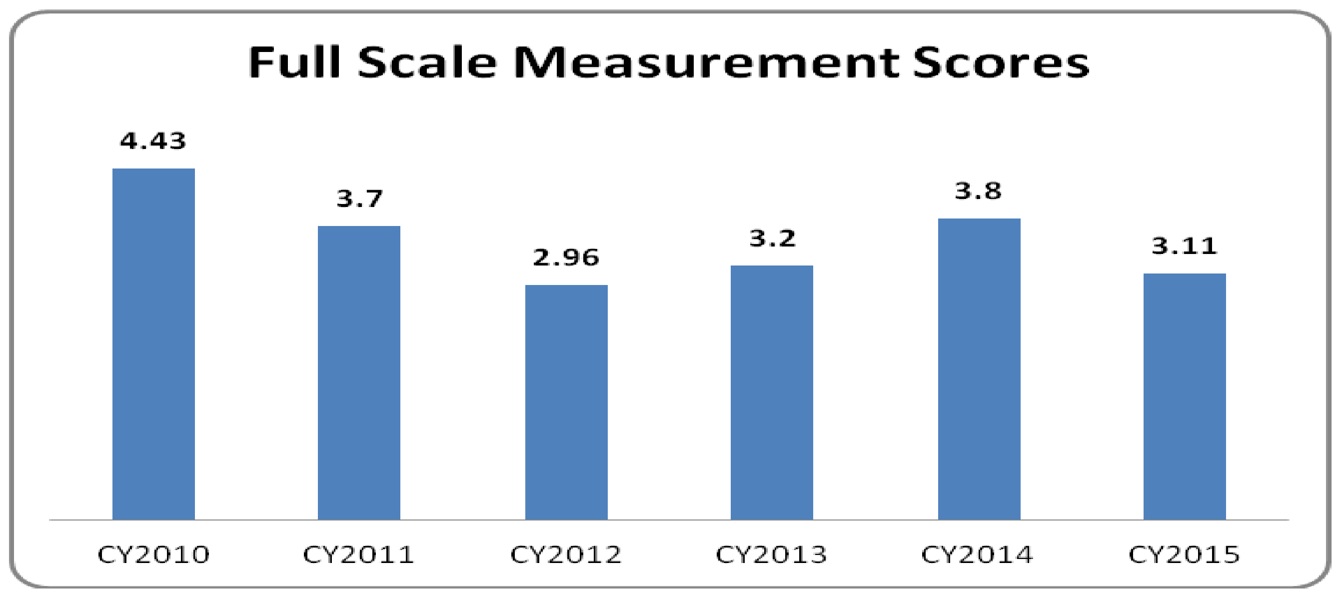

Figure One: PACT Full Scale Measurement Score Comparison (CY 2010 – CY 2015):

Observations and Recommendations

PACT fidelity standards are divided into six (6) dominant categories, or Subscales. Within these subscales there are a total of forty-seven (47) standards. One (1) item in the 2015 review has been rated as "N/A". This was due to the lack of a Peer Specialist being on board during the period under review. The means that the final score was developed using only the forty-six (46) standards (as opposed to the normal forty-seven (47)). The following pages will briefly discuss each of the subscales, provide a six (6) year comparison on BHR/PACT performance, and provide recommendations related to that section, if applicable. The recommendations will also be summarized on the Request for a Performance Improvement Plan (PIP) at the end of this report.

Operations and Structure

The Operations and Structure Subscale "provides the foundation upon which services to enrolled consumers are provided." This scale primary evaluates the overall structure of the team in terms of staffing, resources allocation, and management support. **Figure two** below shows how the BHR/PACT team has performed on this subscale over the past six (6) years:

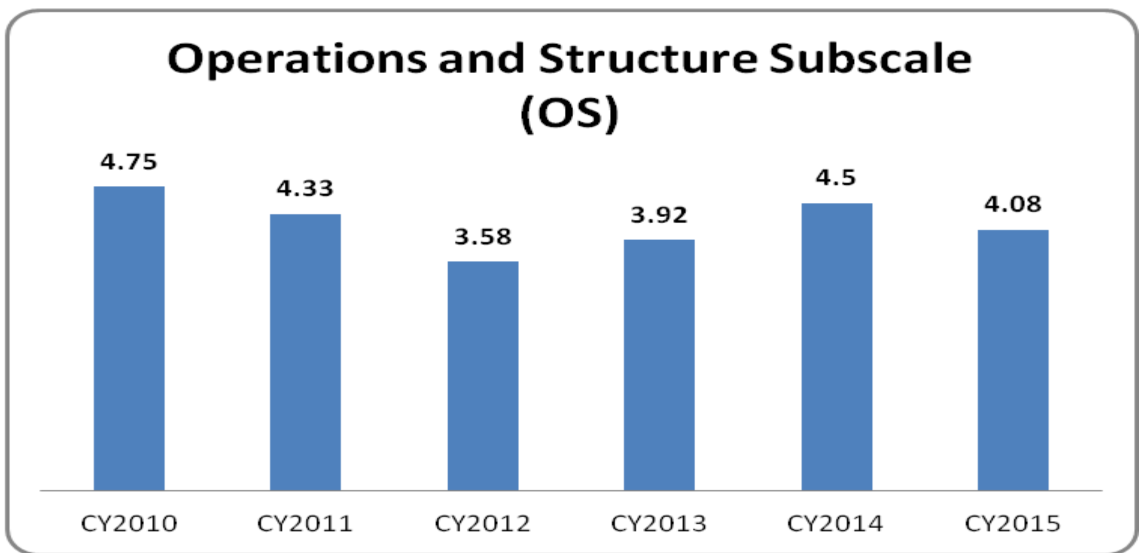

Figure Two: Operations and Structure Subscale Comparison (CY 2010 – CY 2015)

The lowest scored items in this subscale pertained to Active Recruitment of PACT consumers and Team Approach. Recruitment has traditionally scored low on this review, and may reflect a lack of overall community engagement and outreach for new PACT consumers. The area of Team Approach is an area that has dropped from previous year's reviews. These items are discussed further within the body of the WIMHRT report. One (1) recommendation is being made with regards to the Operations and Structure Subscale.

Recommendation #4

Team Approach: It was noted that the BHR/PACT program has experienced a steep decline in the area of team approach. As reported by WIMHRT, the team "doesn't formally track on a day-to-day level the assertive engagement techniques they use or their relative effectiveness in any way." This is an area that used to be a strength for BHR/PACT – the ability to, on a daily basis, staff consumers and discuss specific techniques used. It is recommended that BHR/PACT develop a plan to strengthen their overall team approach to the delivery of PACT services.

Core Team

The Core Team Subscale evaluates the team as a whole, and the assigned and realistic roles of each of the team members. **Figure three** below shows how the BHR/PACT team has performed on this subscale over the past six (6) years:

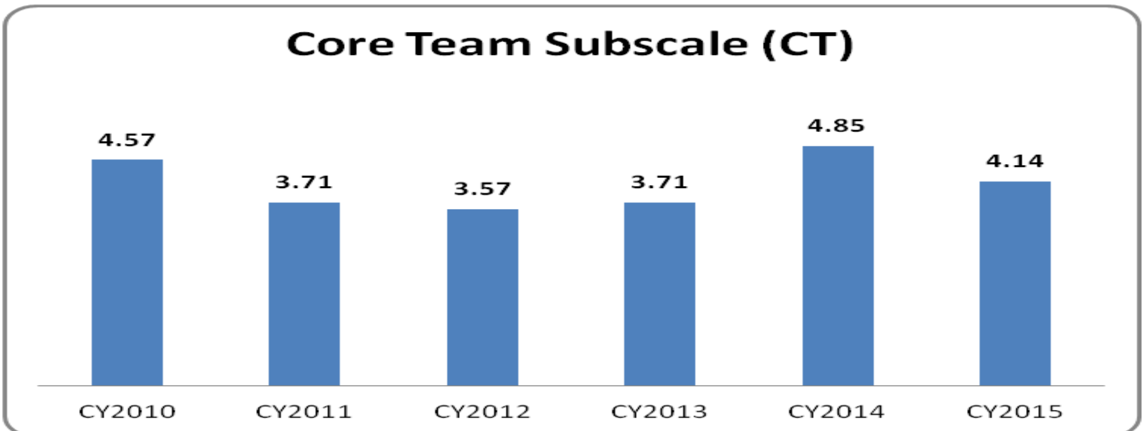

Figure Three: Core Team Subscale Comparison (CY 2010 – CY 2015)

The Core Team Subscale witnessed several areas where scores were lowered from previous years. These include the areas of Team Lead as a Practicing Clinician, the Role of the Psychiatric Care Provider, and the Role of Nurses. There was one (1) specific recommendation made with regards to the Core Team Subscale in this year's review.

Recommendation #5

Staffing and Retention: It was recommended that BHR closely examine the reasons for the significant turnover within the PACT program over the past several years. WIMHRT has recommended that BHR "Examine the significant turnover that the team has experienced in the last several years and develop a plan to intervene with the most significant contributors to staff turnover. " TMRSN concurs with this recommendation. Recommendation #1 within the WIMHRT annual report clearly discusses this issue of turnover. It is recommended that BHR/PACT conduct an analysis of turnover within the program and develop a plan to increase stability within the program.

Specialty Team

The Specialty Team Subscale looks at the role of each of the various specialists on the PACT team. This includes substance abuse, vocational and peer support specialists. **Figure four** below shows how the BHR/PACT team has performed on this subscale over the past six (6) years:

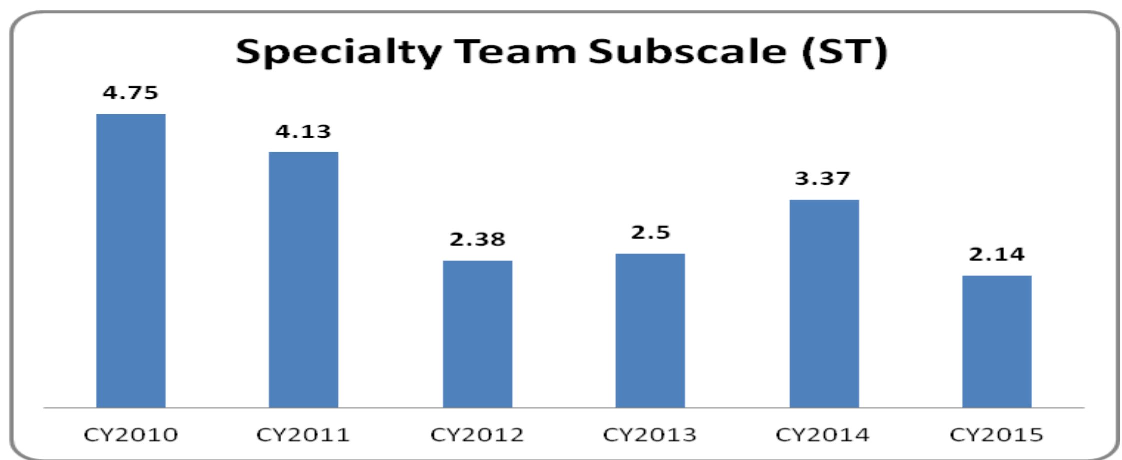

Figure Four: Specialty Team Subscale Comparison (CY 2010 – CY 2015

This subscale has shown a marked decrease between the 2014 and 2015 annual reports. Key roles such as substance use disorder provider, peer specialist and vocational specialist have all scored lower in this year's report. In fact, during the period under review the BHR/PACT program did not have a Peer Specialist at all.

Two (2) primary recommendations were made under the Specialty Team Subscale. These include:

Recommendation #6

Supported Employment: It was recommended – as in years past – that the BHR PACT team embrace and enhance the Vocational Specialist (and the entire team) ability to provide supported employment services. This recommendation is supported by WIMHRT within the body of the annual report: BHR should "Enhance Specialist and team capacity for delivering employment services based on the Supported Employment (SE) model." It is recommended that BHR develop a plan to address this recommendation from both WIMHRT and TMRSN.

Recommendation #7

Integrated Dual Disorder Treatment Services: WIMHRT made a series of recommendations around IDDT and BHR/PACT. TMRSN concurs with these recommendations and requests that BHR develop a strategy to meet these recommendations. These recommendations are summarized by WIMHRT as follows:

- **Substance abuse specialist focus on primarily delivering IDDT services:** In order to ensure that BHR PACT clients with an identified co-occurring substance use disorder are receiving this essential service intervention, it is important for Specialist to preserve most of his time (80%) toward delivering dual disorder services. This can be achieved if Specialist is scheduled to only serve clients with an identified co-occurring substance use disorder and if he is able to integrate dual disorder services with other case management/generalist services (e.g. while grocery shopping with a client, developing discrepancies between his desire to eat healthy and what he does to his body by using meth).
- **Further IDDT training and consultation from UW:** Jeff Roskelley is available to further assist Specialist in learning more about IDDT and applying those skills in his work with specific clients. While most team members appear to have a grasp of stage-wise treatment and embrace a harm reduction model, getting the full team up-to-speed on IDDT, particularly cognitive-behavioral approaches to addressing substance use, will also help to ensure that more team members can share the burden of delivering this service over time.
- **Ongoing cross-training to promote integration of IDDT services across the team:** As Specialist learns more about the IDDT model, we recommend that he provide focused cross-training on specific elements of IDDT. This will be particularly important now, as the team has experienced significant staff turnover since the fidelity review.

Core Practices

The Core Practices Subscale evaluates more generalist-type services, which includes direct service provision, as opposed to negotiating and referring (brokering) services from another provider. It also examines the nature, frequency and intensity of services. **Figure five** below shows how the BHR/PACT team has performed on this subscale over the past six (6) years:

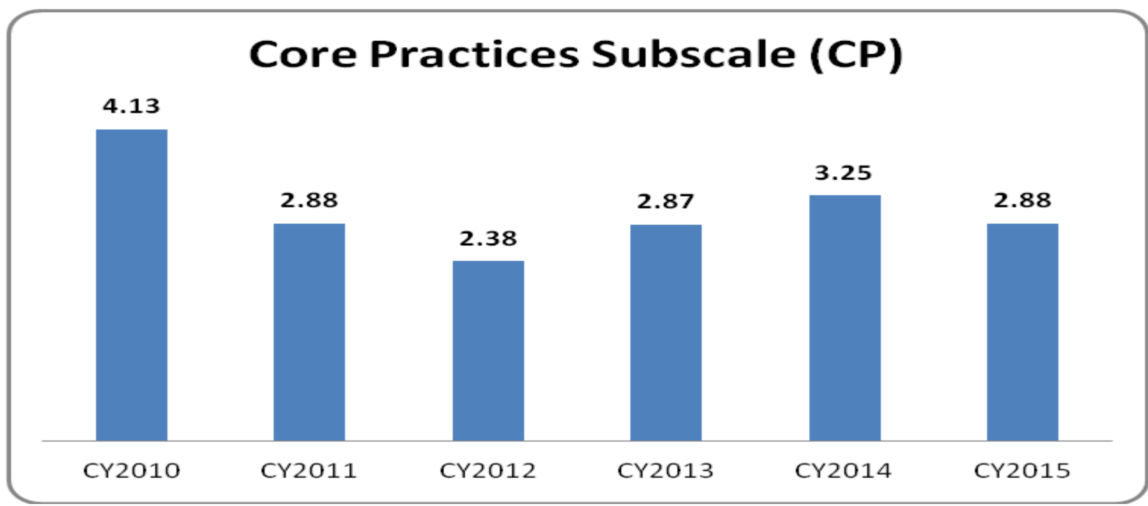

Figure Five: Core Practices Subscale Comparison (CY 2010 – CY 2015)

This subscale witness a drop in four (4) of the eight (8) measured items during the period under review. These areas included intensity and frequency of services and full responsibility for psychiatric and psychiatric rehabilitation services. The primary recommendation from this area, however, continues to be in the area of full responsibility for crisis services.

<u>Recommendation #8</u>

Responsibility for Crisis Services: The issue of crisis response and responsibility has long been a compliance issue brought forward by both TMRSN and WIMHRT. This item was also noted in the clinical chart review section of this review. WIMHRT has stated that "no credit was given to the team on this item as it failed to meet any of the criteria for this core fidelity item, even partially." The issue is that there is often a "disconnect" between crisis staff at the E&T/community hospitals and members of the PACT team. WIMHRT is viewing third-party crisis response systems (E&T, PSPH) as not related to, or communicating with, PACT. WIMHRT and TMRSN is offering, as a recommendation, that BHR/PACT end the use of third-party crisis response systems and use an after-hours on-call system (as most other PACT programs in the state use). It is recommended that PACT – as a self-contained program – develop an internal process whereby consumer's in crisis can connect with a PACT team member prior to admission so that primary responsibility remain with the program. Both TMRSN and WIMHRT strongly encourage that BHR/PACT adopt such an internal crisis response system.

BHR/PACT is encouraged to work TMRSN in developing this plan to provide 24/7 crisis services. It should be a priority of BHR/PACT that such service capacity be implemented within the next contract year.

<u>Recommendation #9</u>

Psychiatric Rehabilitation Services: WIMHRT again recommended that BHR/PACT adopt an evidence based practice related to the provision of Psychiatric Rehabilitation services. The report indicates that while the program believes it is currently providing such services, there is very little in the documentation that supports this assertion. Evidence from the clinical chart review portion of this review also bears this out. TMRSN and WIMHRT recommend that BHR/PACT adopt an evidence based practice around psychiatric rehabilitation services. WIMHRT recommends "that the team continue to broaden their skill base and extend this work to more consumers, in further consultation and training with {WIMHRT}." WIMHRT has offered to provide training and consultation to the BHR/PACT team around this area.

Evidence Based Practices

The Evidence Based Practices Subscale evaluates the degree in which specialized services utilizes and embraces the philosophy and practice of core evidence based practices (EBPs) for consumers in PACT. **Figure six** below shows how the BHR/PACT team has performed on this subscale over the past five (5) years:

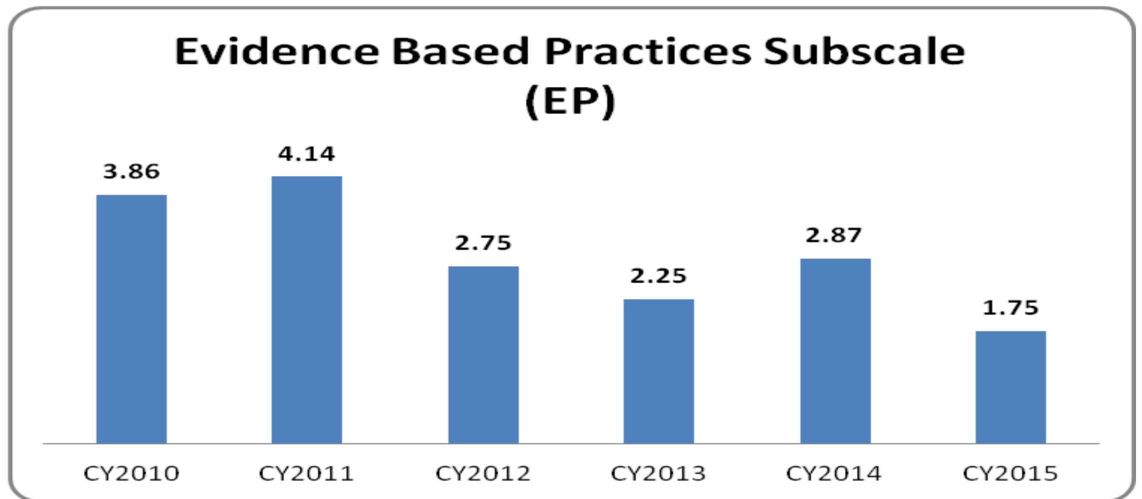

Figure Six: Evidence Based Practices Subscale Comparison (CY 2010 – CY 2015)

This subscale continues to be the most problematic for BHR/PACT. In fact, the overall rating for this item (1.75) was the lowest subscale rating seen since the PACT program was initiated at BHR in 2009. There was considerable conversation between BHR and WIMHRT on how to begin adopting and using evidence based practices with PACT consumers.

Several areas related to evidence based practices have already been discussed within the body of this report, and have been included as recommendations. For this reason, only one (1) specific recommendation is being made in this subscale. In the near future, however, more emphasis will be placed on EBPs as they provide a good opportunity to develop methods to measure consumer progress and create outcome measures – both which will become more of a focus with TMRSN in the coming years.

Recommendation #10

Engagement with Natural Supports: As WIMHRT has reported, only forty-five (45) percent of the consumer's natural supports had a contact with BHR/PACT staff during the period under review. The fidelity standard for this item is ninety (90) percent. Both TMRSN and WIMHRT recommend that "the team routinely identify the natural support(s) with whom the consumer is already connected, whether it be family, neighbors, church members, teachers, etc."

Person Centered Planning and Practices

The Person Centered Planning and Practices Subscale measures the service planning practices of PACT team, and the degree in which planning and services are developed in a strength-based and holistic fashion. **Figure seven** below shows how the BHR/PACT team has performed on this subscale over the past six (6) years:

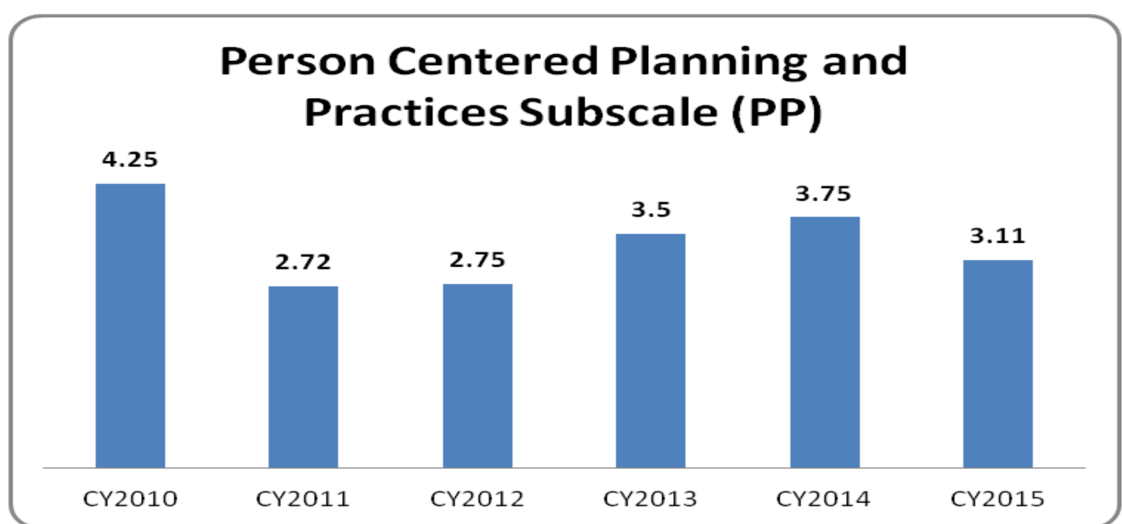

Figure Seven: Person Centered Planning & Practices Subscale Comparison (CY 2010 – CY 2015)

WIMHRT made no significant recommendations related to this subscale. There were several comments related to the lack of incorporated identified strengths into actual treatment (service) planning, however. TMRSN has identified issues related to treatment planning and has included a recommendation in the clinical chart review section of this report (Recommendations above).

Utilization Review

The final part of the operational review examined overall utilization. This includes reviewing the overall number of consumers served in PACT, the number and type of services provided, and the overall number of hours provided to each consumer. It also includes the number of hospitalizations (E&T, WSH and community hospitalizations) each consumer experienced during the period under review. Finally, the utilization review examines the total costs for the program – both in terms of average cost of encounter and average cost service hour provided. **Table two** below presents utilization review data for the period under review:

#	Item	CY 2014 Data	CY 2013 Data
1	**Total unduplicated number of consumers served by PACT during the period under review**	**51**	**52**
	Current number of PACT consumers (as of January 1, 2014)	39	46
	Total number of PACT admissions during the period under review	13	15
	Total number of PACT discharges during the period under review	7	6
2	**Average number of consumers enrolled in PACT at any given time during the period under review**	**36**	**36**
3	**Total hours of service hours provided to PACT consumers during the period under review**	**4,190.77**	**3,499.23**
	Medication Management / Monitoring Hours	905.77	515.72
	Crisis Intervention and Assessment Hours	140.15	34.08
	Co-Occurring Disorders Services Hours	0	0
	Vocational Services Hours	0	0
	Peer Support Services Hours	62.83	321.35
	Rehab. Case Management	21.52	19.87
	Psychological / Therapeutic Services Hours (individual)	102.88	135.45
	Psychological / Therapeutic Services Hours (group)	241.08	237
	Community Support	1,729.13	1951.55
	Other Case Management Hours	987.4	284.21
4	**Total number of hospitalizations / E&T (voluntary & Involuntary) stays during the period under review**	**34**	**41**
	Number of WSH hospitalizations	6	12
	Number of PSPH hospitalizations	1	1
	Number of Other hospitalizations	0	2
	Number of E&T (ETU and CSTU) voluntary and involuntary visits	27	26
5	**Average length of encounter per average number of PACT consumers served during the Period under Review**	**116.41 hrs**	**97.20 hrs**
	Per month	9.7 hrs	8.1 hrs
	Per Week	2.24 hrs	1.87 hrs
6	**Total number of encounters provided to all PACT consumers during the Period under Review**	**14,575**	**9,322**
	Average number of encounters per average number of PACT consumers during the Period under Review	**404.86**	**258.90**
	Per month	33.74	21.58
	Per Week	7.79	4.97
7	**Total TMRSN-Funded Program Cost**	**$ 858,700.00**	**$ 814,437.83**
8	**Total Cost per Total Consumer Served**	**$ 23,852.78**	**$ 15,662.27**
9	**Total Cost per Total Service Hour**	**$ 204.90**	**$ 232.75**
10	**Total Cost per Service Encounter**	**$ 58.92**	**$ 87.37**

Table Two: PACT Utilization Review: Calendar Year 2015

The utilization review examined data from the period under review (January 01, 2014 – December 31, 2014). For purposes of this report, the utilization review is **not** a scored section of the overall operational review; however specific recommendations have been made as a result of examining utilization data.

Observations and Recommendations

- The average number of consumers served by PACT during 2014 was 36. This matches the same number of enrollees as Calendar year 2013. In 2012 the average number of PACT consumers was 37.2. It is important to note that a half-PACT team is fifty (50) consumers served at all times – the average number of consumers served throughout the contract period should be fifty (50). In 2012 TMRSN issued a performance measure to increase the average number of consumers served to forty-three (43) as a mechanism to bring BHR/PACT into compliance with a half-PACT team. These numbers have not been realized and will be a recommendation going forward.

- The overall number of unduplicated PACT consumers served, in Calendar Year 2014 was fifty-one (51); in 2013 there were fifty-two (52).

- The number of services and the number of service hours have both dramatically increased from 2013 to 2014. This continues a trend from the increase over 2012. This is a very encouraging sign as it documents that significant work is being done with consumers.

    - In 2014 the average PACT consumer received 2.24 hours of service per week (as compared to 1.87 hours in 2013)
    - In 2013 the average PACT consumer received 7.79 services per week (as compared to 4.97 services per week in 2013)
    - The category of "Other Case Management" hours inexplicably tripled from 284.21 hours in 2013 to 987.4 hours in 2014

- As noted in the 2013 review, several of the service activity codes for specific services demonstrated that hours are **not** being accurately entered into the MIS. According to the data:

    - No Vocational services were provided during the period under review
    - No Co-Occurring Disorder services were provided during the period under review
    - Only 21.52 hours of Psychiatric Rehabilitation services were provided during the period under review
    - Peer support hours declined during the period under review (from 321.35 hours in 2013 to only 62.83 hours in 2014)

  This item relates to concerns that were brought forward in the clinical and program review sections of this review. PACT members are either not providing services in these required areas, or they are entering these services under erroneous codes (i.e., Community Support or Other Case Management hours).

Recommendation #11

PACT Enrollment: As noted above, a half-PACT team is required to maintain fifty (50) consumers at all times. TMRSN has expressed concerns in the past that enrollment is too low (averaging in the upper 30's for the past several years). In 2012 TMRSN instituted a performance measure to increase the number of enrollees incrementally (43, 47, and finally to 50). While numbers were on the uptick for a short while, it appears that the program has not been able to sustain expected utilization. It is recommended that BHR/PACT develop a recruitment strategy to achieve the expected number of enrollees. This measure will be closely monitored over the next year to ensure PACT is operating with under expected utilization.

Recommendation #12

Service Activity Codes: It is critical that BHR/PACT appropriately document hours spent with PACT consumers. It appears that many hours are being defaulted to the categories of **Community Support** (1,729.13 hours in 2014) and **Other Case Management** (987.4 hours in 2014) while no hours are being assigned to other categories such as vocational, co-occurring or psychiatric rehabilitation. It is recommended that PACT staff receive training/supervision around how to appropriately code services in order to provide a more realistic picture of service delivery.

Conclusion and Performance Improvement Plan

The results of the Operational Review suggest that 2014 was a tumultuous year of for the BHR PACT program. In 2013 it had appeared that the program was enjoying a period of sustained growth and improvement. However, due to several systemic issues within BHR, the program has seen a dramatic decline in 2014. It is understood that a new supervisor has been hired and that 2015 is proving to be a year of positive growth and improvement. This, however, is a troubling trend in and of itself. Over the past six (6) years the PACT program has had five (5) Team Leads. This rapid turnover leads to instability within the program and lends to the "up and down" swing in overall program performance. Recommendation #5 is especially important as BHR attempts to secure and stabilize PACT in the coming year.

This review highlighted some of the strengths, along with several concerns and troubling trends. Many of these issues are well known to BHR management and the new PACT Team Leader. It is critical that BHR/PACT pay close attention to the deficits highlighted in this report (both from TMRSN and WIMHRT), and create a Performance Improvement Plan that adequately and accurately reflect these concerns.

Please complete the Performance improvement plan (PIP) form below and submit it to TMRSN by the date indicated. Please take time to carefully strategize a plan that is both manageable and measureable within the next twelve (12) months. Once submitted, TMRSN will either approve the plan or request changes, and ultimately monitor the submitted plan. At the end of the plan year, TMRSN will need to re-evaluate the program (in consultation with WIMHRT) to see if the program is meeting WA PACT Standards and can be considered a high quality, high-fidelity program. Please submit BHR's plan for PACT no later than **November 25, 2015.** If there are any questions regarding the development of this plan, or questions or concerns regarding this report, please do not hesitate to contact the TMRSN Quality Manager at 360-867-2567.

Performance Improvement Plan (PIP) Request

Instructions – Please review the information included in this report. In the performance improvement plan (PIP) request form below, please review those items that require a PIP. Develop improvement strategies for each item in the space provided. In your response back to TMRSN, please indicate your performance improvement plan for each item, along with target dates for completion and persons responsible. Utilize the format presented below, or develop a similar format including all of the information requested. Please send the PIP back to the TMRSN Quality Manager by the date indicated below.

Provider Agency: **Behavioral Health Resources (BHR) / PACT**

Review Report Receipt Date: **October 25, 2015**

Responsible Staff/Title (Provider):

Responsible Staff/Title (TMRSN): **Larry Horne, TMRSN Quality Manager**

Performance Improvement Plan Response Due Date: **November 25, 2015**

The follow clinical chart review items were not met during the review period		
Review Instrument	**Recommendation**	
PACT TMRSN Clinical Chart Review	**Comprehensive Assessment:** It is recommended that the BHR PACT program develop a better way to ensure that Comprehensive Assessments are (1) completed in a timely manner (within 30 days of admission into PACT), and (2) that the entire Comprehensive Assessment is completed. It is further recommended that the PACT Team Lead, or other designated person, have primary responsibility to ensure that all eight (8) subsections of the PACT Comprehensive Assessment are completed in a timely manner **and** included as part of the overall chart documentation.	
Quality Improvement Plan **Responsible Person(s):** **Estimated Completion Date:**		☐ New form (please attach) ☐ New/revised policy (please attach) ☐ New curricula (please attach) ☐ Other document(s) attached
PACT TMRSN Clinical Chart Review	**Treatment Planning (General):** It is recommended that treatment plan goals be developed with the consumer and include goals that are specific, easily measured, and can reasonably be expected to be completed within a given time period. In other words, it is strongly recommended to break down treatment plan goals into smaller, manageable benchmarks that can be reported upon every six months. It is further recommended that BHR/PACT continue to develop meaningful treatment plan reviews that can be used in the development of the consumer's new treatment plan. TMRSN recommends that further training and consultation take place around the development and follow-up of person centered treatment plans.	
Quality Improvement Plan **Responsible Person(s):** **Estimated Completion Date:**		☐ New form (please attach) ☐ New/revised policy (please attach) ☐ New curricula (please attach) ☐ Other document(s) attached

PACT TMRSN Clinical Chart Review	**Service Provision:** Many of the items on the consumer's treatment plans did **not** translate into provided services. In other words, there were many instances where *actual* services appeared to be a reaction to a new problem and not relatable to any goal on the treatment plan. In several reviewed charts identified goals were not addressed at all within a six (6) month period of time. This item relates to the Golden Thread wherein services need to tie into the consumer's treatment plan. It is recommended that BHR/PACT receive additional training related to treatment planning and service provision. It is further recommended that treatment plans and subsequent progress notes are reviewed together to ensure continuity.
Quality Improvement Plan **Responsible Person(s):** **Estimated Completion Date:**	☐ New form (please attach) ☐ New/revised policy (please attach) ☐ New curricula (please attach) ☐ Other document(s) attached
PACT WIMHRT (Program) Review	**Team Approach:** It was noted that the BHR/PACT program has experienced a steep decline in the area of team approach. As reported by WIMHRT, the team "doesn't formally track on a day-to-day level the assertive engagement techniques they use or their relative effectiveness in any way." This is an area that used to be a strength for BHR/PACT – the ability to, on a daily basis, staff consumers and discuss specific techniques used. It is recommended that BHR/PACT develop a plan to strengthen their overall team approach to the delivery of PACT services.
Quality Improvement Plan **Responsible Person(s):** **Estimated Completion Date:**	☐ New form (please attach) ☐ New/revised policy (please attach) ☐ New curricula (please attach) ☐ Other document(s) attached
PACT WIMHRT (Program) Review	**Staffing and Retention**: It was recommended that BHR closely examine the reasons for the significant turnover within the PACT program over the past several years. WIMHRT has recommended that BHR "Examine the significant turnover that the team has experienced in the last several years and develop a plan to intervene with the most significant contributors to staff turnover. " TMRSN concurs with this recommendation. Recommendation #1 within the WIMHRT annual report clearly discusses this issue of turnover. It is recommended that BHR/PACT conduct an analysis of turnover within the program and develop a plan to increase stability within the program.
Quality Improvement Plan **Responsible Person(s):** **Estimated Completion Date:**	☐ New form (please attach) ☐ New/revised policy (please attach) ☐ New curricula (please attach) ☐ Other document(s) attached
PACT WIMHRT (Program) Review	**Supported Employment:** It was recommended – as in years past – that the BHR PACT team embrace and enhance the Vocational Specialist (and the entire team) ability to provide supported employment services. This recommendation is supported by WIMHRT within the body of the annual report: BHR should "Enhance Specialist and team capacity for delivering employment services based on the Supported Employment (SE) model." It is recommended that BHR develop a plan to address this recommendation from both WIMHRT and TMRSN.
Quality Improvement Plan **Responsible Person(s):** **Estimated Completion Date:**	☐ New form (please attach) ☐ New/revised policy (please attach) ☐ New curricula (please attach) ☐ Other document(s) attached

<table>
<tr><td>PACT WIMHRT (Program) Review</td><td colspan="2">Integrated Dual Disorder Treatment Services: WIMHRT made a series of recommendations around IDDT and BHR/PACT. TMRSN concurs with these recommendations and requests that BHR develop a strategy to meet these recommendations. These recommendations are summarized by WIMHRT as follows:

• Substance abuse specialist focus on primarily delivering IDDT services: In order to ensure that BHR PACT clients with an identified co-occurring substance use disorder are receiving this essential service intervention, it is important for Specialist to preserve most of his time (80%) toward delivering dual disorder services. This can be achieved if Specialist is scheduled to only serve clients with an identified co-occurring substance use disorder and if he is able to integrate dual disorder services with other case management/generalist services (e.g. while grocery shopping with a client, developing discrepancies between his desire to eat healthy and what he does to his body by using meth).
• Further IDDT training and consultation from UW: Jeff Roskelley is available to further assist Specialist in learning more about IDDT and applying those skills in his work with specific clients. While most team members appear to have a grasp of stage-wise treatment and embrace a harm reduction model, getting the full team up-to-speed on IDDT, particularly cognitive-behavioral approaches to addressing substance use, will also help to ensure that more team members can share the burden of delivering this service over time.
• Ongoing cross-training to promote integration of IDDT services across the team: As Specialist learns more about the IDDT model, we recommend that he provide focused cross-training on specific elements of IDDT. This will be particularly important now, as the team has experienced significant staff turnover since the fidelity review.</td></tr>
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<tr><td>PACT WIMHRT (Program) Review</td><td colspan="2">Responsibility for Crisis Services: The issue of crisis response and responsibility has long been a compliance issue brought forward by both TMRSN and WIMHRT. This item was also noted in the clinical chart review section of this review. WIMHRT has stated that “no credit was given to the team on this item as it failed to meet any of the criteria for this core fidelity item, even partially.” The issue is that there is often a “disconnect” between crisis staff at the E&T/community hospitals and members of the PACT team. WIMHRT is viewing third-party crisis response systems (E&T, PSPH) as not related to, or communicating with, PACT. WIMHRT and TMRSN is offering, as a recommendation, that BHR/PACT end the use of third-party crisis response systems and use an after-hours on-call system (as most other PACT programs in the state use). It is recommended that PACT – as a self-contained program – develop an internal process whereby consumer’s in crisis can connect with a PACT team member prior to admission so that primary responsibility remain with the program. Both TMRSN and WIMHRT strongly encourage that BHR/PACT adopt such an internal crisis response system.

BHR/PACT is encouraged to work TMRSN in developing this plan to provide 24/7 crisis services. It should be a priority of BHR/PACT that such service capacity be implemented within the next contract year.</td></tr>
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<tr><td>PACT WIMHRT (Program) Review</td><td colspan="2">Psychiatric Rehabilitation Services: WIMHRT again recommended that BHR/PACT adopt an evidence based practice related to the provision of Psychiatric Rehabilitation services. The report indicates that while the program believes it is currently providing such services, there is very little in the documentation that supports this assertion. Evidence from the clinical chart review portion of this review also bears this out. TMRSN and WIMHRT recommend that BHR/PACT adopt an evidence based practice around psychiatric rehabilitation services. WIMHRT recommends “that the team continue to broaden their skill base and extend this work to more consumers, in further consultation and training with {WIMHRT}.” WIMHRT has offered to provide training and consultation to the BHR/PACT team around this area.</td></tr>
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<tr><td>PACT WIMHRT (Program) Review</td><td colspan="2">Engagement with Natural Supports: As WIMHRT has reported, only forty-five (45) percent of the consumer’s natural supports had a contact with BHR/PACT staff during the period under review. The fidelity standard for this item is ninety (90) percent. Both TMRSN and WIMHRT recommend that “the team routinely identify the natural support(s) with whom the consumer is already connected, whether it be family, neighbors, church members, teachers, etc.”</td></tr>
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