



SPOKANE COUNTY

**CONTRACT AMENDMENT
Behavioral Health Services
Program: MH Outpatient, Crisis, and
SUD Outpatient**

This Amendment is by and between **SPOKANE COUNTY**, a political subdivision of the State of Washington, by and between **SPOKANE COUNTY REGIONAL BEHAVIORAL HEALTH ORGANIZATION, (SCRBHO), A DIVISION OF SPOKANE COUNTY COMMUNITY SERVICES, HOUSING, AND COMMUNITY DEVELOPMENT DEPARTMENT (CSHCD)**, (hereinafter "SCRBHO"), and Contractor (hereinafter "Contractor") identified below and jointly referred to, as the "Parties" in the manner set forth herein.

CONTRACTOR INFORMATION:

Contractor Name: Pend Oreille County Counseling Services
Contractor Address: PO Box 5055, Newport WA 99156
Contractor Contact: Annabelle Payne **Phone:** (509) 447 - 5651 **Fax:** (509) 447 - 2671
Contractor E-Mail: apayne@pendoreille.org

SCRBHO INFORMATION:

Division: Spokane County Community Services, Housing, and Community Development Dept.
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Additional Contacts:

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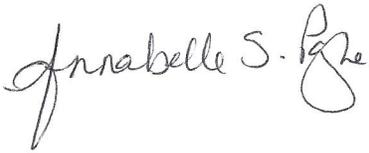
Division: Spokane County Community Services Housing and Community Development Dept.
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AMENDMENT START DATE: 02/01/17 **AMENDMENT END DATE:** 06/30/17

FUNDING:

Source: Medicaid Funds	Amount: \$1,965,693.00
Source: Non-Medicaid Funds	Amount: \$ 266,106.00
Source: Criminal Justice Treatment Account (CJTA) Funds	Amount: \$ 19,236.00
Total Funding: \$2,251,035.00	

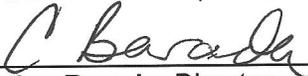
The terms and conditions of this Agreement are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings and communications, oral or otherwise regarding the subject matter for this Agreement between the parties. The parties signing below represent they have read and understand this Agreement, and have the authority to execute this Agreement. This Agreement shall be binding on CSHCD only upon signature by Spokane County.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE
	Annabelle S. Payne Director	April 19, 2017

IN WITNESS WHEREOF the Parties have signed this Agreement effective this 1st day of May, 2017.

BOARD OF COUNTY COMMISSIONERS

FOR BOARD OF COUNTY COMMISSIONERS OF
SPOKANE COUNTY, WASHINGTON



Christine Barada, Director
Community Services
Housing and Community Development

(Signing by Authority of Res. No. 2009-0290)

RECITALS: WHEREAS: For valuable consideration and the promises contained herein, Contract No. 16BHO1937, dated March 29, 2016, is hereby amended as stated below:

1. Section 5, Incident Reporting, subsection 5.1.3.5. is amended as follows:
 - 5.1.3.5. Names and ages, if known, of all individuals involved in incident. The Contractor's disclosure of Individually Identifiable Information is authorized by 42 CFR § 2.53 authorizing disclosure of the individual.
2. Section 8, Information Requirements, subsection 8.1.1. is amended as follows for the purpose of updating the language:
 - 8.1.1. Offer every Medicaid Enrollee a Washington Medicaid Behavioral Health Benefit Booklet at Intake which includes information on obtaining the booklet in alternative formats, and inform the Enrollee that the booklet is available at: <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/behavioral-health-benefits-book>, and place a link on the Contractors website to the electronic benefits booklet;
3. Section 9, Funding, subsection 9.3. is amended to replace "public behavioral health system" with "Prepaid Inpatient Health Plan":
 - 9.3. The Contractor shall use all funds provided pursuant to this Agreement including interest earned to support the Prepaid Inpatient Health Plan.
4. Section 10, Access to Care, subsection 10.1. is amended as follows for the purpose of updating the website address:
 - 10.1. The SCRBHO shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. Policies for guidelines must include all services detailed in Access to Care Standards for BHOs that now include qualifying substance use diagnoses and the American Society of Addiction Medicine (ASAM) Criteria at <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information#overlay-context=bha>.
5. Section 10, Access to Care, subsection 10.2.2. is added as follows:
 - 10.2.2. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee for Service (FFS), if the provider serves only Medicaid Enrollees.
6. Section 10, Access to Care, subsection 10.10. is renamed as follows:
 - 10.10. **Determine Individual Financial Eligibility: Low-Income Services (including SUD)**
7. Section 12, Care Management, subsection 12.8.2. is added as follows:
 - 12.8.2. Wraparound with Intensive Services (WISe) as identified in the current State Plan and defined in Section 15.3 of this contract, include:
 - 12.8.2.1. Care Coordination;
 - 12.8.2.2. Co-occurring Treatment Services;
 - 12.8.2.3. Crisis Services;

- 12.8.2.4. Family Treatment;
 - 12.8.2.5. Group Treatment Services;
 - 12.8.2.6. Individual Treatment Services;
 - 12.8.2.7. Intake Evaluation;
 - 12.8.2.8. Interpreter Services;
 - 12.8.2.9. Medication Management;
 - 12.8.2.10. Medication Monitoring;
 - 12.8.2.11. Peer Support;
 - 12.8.2.12. Psychological Assessment;
 - 12.8.2.13. Rehabilitation Case Management;
 - 12.8.2.14. Request for Services;
 - 12.8.2.15. Special Population Evaluation;
 - 12.8.2.16. Testimony for Involuntary Treatment Services; and
 - 12.8.2.17. Therapeutic Psychoeducation.
8. Section 13, Quality Management, subsection 13.9.1. is amended as follows for the purpose of revising the mandatory number of clinical Performance Improvement Projects (PIP):
- 13.9.1. For purposes of this Agreement, the SCRBHO must at all times be conducting one (1) clinical PIP, one (1) non-clinical PIP, and one (1) PIP of the SCRBHO's choosing.
9. Section 13, Quality Management, subsection 13.9.2. is deleted and replaced as follows:
- 13.9.2. Core Performance Measures (PMs): Core PMs are taken from or based on the measures identified through the House Bill (HB) 1519 and Senate Bill (SB) 5732 process (from Legislative year 2013-2014). DSHS will generate PMs statewide and by Behavioral Health Organization (BHO), on a quarterly basis with a maximum of a twelve (12) month lag. DSHS will provide baseline data for the three (3) measures listed below. Improvement targets will be provided in the July 2017 amendment.
 - 9.8.2.1. Core PM #1: Psychiatric Hospitalization Readmission Rate: Proportion of acute psychiatric inpatient stays (during the measurement year) that were followed by an acute psychiatric readmission within thirty (30) days.
 - 9.8.2.2. Core PM #2: Substance Use Disorder Treatment Initiation and Engagement (Washington Circle Adaptation): The percentage of individuals who engage in services after an admission to treatment and the percentage of individuals with continuity of care after admission to treatment.

- 9.8.2.3. Core PM #3: Behavioral Health Access Monitoring: A monthly unduplicated count of the number of individuals (child/youth and adults) who received a mental health service and an unduplicated count of individuals (child/youth and adult) who received a substance use disorder treatment in the SCRBHO Region of Care.
10. Section 18, Services, subsection 20.8.3.3. is added as follows:
- 20.8.3.3. CJTA for Treatment in the Jail. Criminal Justice Treatment Account (CJTA) funds may be used, in a limited capacity, to provide substance use disorder (SUD) assessments, engagement, referral, transition planning and outpatient treatment services in jail.
- 20.8.3.3.1. The Contractor must identify and provide transition services to persons with substance use disorder, who meet the CJTA requirements as defined in [RCW 71.24.580](#), to expedite and facilitate their return to the community.
- 20.8.3.3.2. Continue treatment services with individuals who were engaged in community-based treatment prior to their incarceration, with the intent to complete the outpatient treatment episode.
- 20.8.3.3.3. Initiate outpatient treatment services with individuals who will be released and transition into community-based treatment.
- 20.8.3.3.4. The Contractor may provide eight (8) sessions per individual, the sessions may include:
- 20.8.3.3.4.1. Engaging individuals in SUD treatment;
- 20.8.3.3.4.2. Referral to SUD services;
- 20.8.3.3.4.3. Coordinating care;
- 20.8.3.3.4.4. Continuity of care; or
- 20.8.3.3.4.5. Transition planning.
11. Section 21, Community Coordination, subsection 21.1.1. is amended to replace “public behavioral health system” with “Prepaid Inpatient Health Plan”:
- 21.1.1. Attend DSHS/DBHR-sponsored training regarding the role of the Prepaid Inpatient Health Plan in disaster preparedness and response;
12. Section 22, Tribal Relationships, is deleted and replaced as follows:
- 22.1. Should the SCRBHO contract or a Contractor subcontract with a Federally Recognized Tribe or RAIO, the SCRBHO or the Contractor shall comply with the terms and conditions of the current DSHS/DBHR Contracts with the SCRBHO.
- 22.2. The Contractor shall adhere to all formal plans between the SCRBHO and Tribal Authorities.

- 22.3. The SCRBHO's Integrated Behavioral Healthcare Manager will be the main BHO contact for tribal communication/service coordination. The DBHR Tribal Liaison will be notified of the main BHO contact for tribal communication/service coordination. DBHR will provide the name and contact information to local Tribes, and RAIOS.
- 22.4. **Tribal Coordination Implementation Plan.**
- 22.4.1. The SCRBHO must develop or attempt to develop a Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan in partnership with each Federally Recognized Tribe and RAIO within its service area as defined in this Agreement. The SCRBHO must provide documentation of attempts to develop a plan if any Federally Recognized Tribe or RAIO declines to participate. The SCRBHO will invite contracted providers who provide crisis services, ITA evaluations and outpatient treatment within the county of each Tribe within the SCRBHO region to participate in the Coordination Implementation meetings. The DBHR Tribal Liaison is available to assist in the partnership and creation of the Coordination Plan between the SCRBHO and the Federally Recognized Tribes and RAIOS within its service area.
- 22.5. In the event the Contractor is aware that the Individual receiving behavioral health services is a Federally Recognized Tribal Member, or receiving behavioral health services from a Tribal Behavioral Health Program, and the Individual or their legal representative consents, efforts must be made to notify the SCRBHO and Tribal Authority or RAIO to assist in discharge planning and transition for the Individual. If the Individual chooses to be served only by the Tribal Behavioral Health Program, and is not under a Less Restrictive Alternative order requiring them to receive treatment from a BHO provider, a referral to a contracted network BHA is not required.
- 22.6. If an Individual of a Federally Recognized Tribe is referred to or presents for non-crisis services and they, or their legal representative, completes a Release of Information and requests coordination with a Washington State Tribal Authority or RAIO; the Contractor must make documented efforts to fulfill the request and seek assistance in treatment planning and service provision for the Individual from the identified Tribal Authority or RAIO. If the Individual chooses to be served only by the Tribal Behavioral Health Program a referral to a contracted network BHA is not required.
- 22.7. Tribal Coordination for Crisis, Voluntary Inpatient, and Involuntary Commitment Evaluation Services.
- 22.7.1. The SCRBHO must work with the DBHR Tribal Liaison to develop and maintain a tribal crisis coordination plan. The plan shall outline details for providing crisis, ITA-MH and ITA-SUD evaluations, voluntary inpatient authorization and discharge planning services on Tribal Lands within the BHO service area. With the consent of the Tribe, the SCRBHO will invite contracted providers who provide crisis, ITA-MH and ITA-SUD evaluations, voluntary inpatient authorization and discharge planning services within the county of the Tribal lands to participate in development of the tribal crisis coordination plan.

- 22.7.2. The plan shall be developed in partnership with the affected Federally Recognized Tribal and RAIO entities within the SCRBHO region.
- 22.7.3. The plan shall identify a procedure and timeframe for evaluating its efficacy and a procedure and timeframe for modification to the satisfaction of all parties at least once per year.
- 22.7.4. If the SCRBHO and the Federally Recognized Tribal or RAIO entity are not able to develop a plan or the Tribe or RAIO does not respond to the request, DBHR will work with the Tribe and/or RAIO and the SCRBHO to reach an understanding. These meetings will be conducted in a manner which comports with the DSHS government-to-government relationship with Washington State Federally Recognized Tribes, and the collaborative relationship with RAIOs. If a Tribe or RAIO declines to develop a plan, the documentation of attempts to engage must be attached to the plan. The documentation must include the date of the decline, method of communication for the decline (email, telephone, or in-person), and contact information of the person at the Federally Recognized Tribe or RAIO who was delegated authority by the Federally Recognized Tribe or RAIO's governing body to make the decision to decline.
 - 22.7.4.1. Those Federally Recognized Tribes, whose Tribal lands lie within multiple BHOs, may develop joint plans with those BHOs. If a BHO has multiple Tribal lands within its service region, one (1) plan may be developed for all Tribes if all parties agree.
 - 22.7.4.2. The plan must include a procedure for crisis responders and DMHPs (non-Tribal) to access Tribal lands to provide requested services, including crisis response, and ITA evaluations.
 - 22.7.4.3. Any notifications and authority needed to provide services including a plan for evening, holiday, and weekend access to Tribal lands if different than business hours.
 - 22.7.4.4. A process for notification of Tribal authorities when crisis services are provided on Tribal land, especially on weekends, holidays, and after business hours. This must identify the essential elements included in this notification, who is notified and timeframe for the notification.
 - 22.7.4.5. A description of how non-Tribal crisis responders and DMHPs will coordinate with Tribal behavioral health providers and/or others identified in the plan for, including a description of how service coordination and debriefing with Tribal behavioral health providers will occur after a crisis service has occurred.
 - 22.7.4.6. The plan must include the process for determining when a non-Tribal DMHP is requested and a timeframe for consulting with Tribal behavioral health providers regarding the determination to detain or not for involuntary commitment.
 - 22.7.4.7. Include a planned response to Tribal ITA court orders for SUD Treatment ITA Evaluation Services.

- 22.7.4.8. The plan shall include procedures for coordination and implementation of ITA-MH and ITA-SUD evaluations on Tribal lands, including whether or not non-Tribal DMHPs may conduct ITA evaluations on Tribal lands.
- 22.7.4.9. If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom Individuals will be transported to non-Tribal lands for ITA-MH and ITA-SUD evaluations and detentions.
- 22.7.4.10. If DMHP evaluations cannot be conducted on Tribal Land, the plan shall specify how and by whom Individuals will be transported off of Tribal Land to the licensed Evaluation and Treatment (E&T) facility.
- 22.7.5. The plan shall specify where Individuals will be held and under what authority, if no E&T beds are available.
- 22.7.6. Voluntary Hospital Payment Authorization
 - 22.7.6.1. The plan will include specifics as to how the SCRBHO would like Tribal behavioral health providers to request voluntary psychiatric hospitalization and substance use residential payment authorizations for Medicaid-eligible Individuals.
 - 22.7.6.2. The SCRBHO shall provide to the Federally Recognized Tribes information on how to request for voluntary payment authorization, appeals and expedited appeals. The plans shall reiterate that only a psychiatrist or a doctoral level psychologist may issue a denial and that denials may only be issued by the SCRBHO and not the crisis provider.
- 22.7.7. Inpatient Discharge Planning. The plan shall address procedures and protocols for coordinating discharge planning and discharge activities with Tribal behavioral health providers. The plan shall address hospitals, freestanding evaluation and treatment centers, and substance use disorder residential facilities.
- 22.8. The plan shall address a process for identifying the Tribal behavioral health provider as the liaison for inpatient coordination of care when the Individual is an identified Tribal member and has not expressed a preference regarding involvement by the Tribe in their care.
- 13. Exhibit B-1 is deleted and replaced with Exhibit B-1 Scope of Work, attached hereto and incorporated herein by reference.
- 14. This amendment shall be effective as of February 1, 2017.

Except as specifically amended by this amendment to the agreement, all terms of the agreement shall remain in full force and effect.

BEHAVIORAL HEALTH SERVICES AGREEMENT

EXHIBIT B - 1

SCOPE OF WORK

PEND OREILLE COUNTY COUNSELING SERVICES: CRISIS AND OUTPATIENT SERVICES (MENTAL HEALTH)

1. PURPOSE

- 1.1. The purpose of this Agreement is for the Contractor to provide services to promote recovery and resiliency for seriously mentally ill adults and seriously emotionally disturbed children and adolescents. Recovery means the processes through which people are able to live, work, learn, and participate fully in their communities. Resiliency means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stressors, and to live productive lives.
- 1.2. The Contractor shall provide behavioral health services as described in this Scope of Work, Contractor Policy and Procedures, and recognized professional practice standards, in conformance with federal and state legislative, and administrative regulations, and as required by the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR), behavioral health contracts.
- 1.3. Individuals authorized and reimbursed through a Health Plan for Healthy Options may not be authorized or reimbursed for the same time period by Spokane County Regional Behavioral Health Organization (SCRBHO) and the accounting of personnel, direct and indirect costs must be delineated clearly in the general ledger.

2. SERVICE ENCOUNTER REPORTING

- 2.1. The Contractor shall follow the DSHS/DBHR Service Encounter Reporting Instructions (SERI), the DSHS/DBHR Consumer Information System (CIS), SCRBO Data Dictionary, and any attendant updates and will report all individuals and services funded in part or wholly by SCRBO to the SCRBO Information System (IS). The SCRBO IS System is called "Raintree."

3. OUTPATIENT ALLOWABLE SERVICE MODALITIES

- 3.1. Brief Intervention Treatment – See SERI
- 3.2. Child & Family Teams – H0032, Modifier HT. additional Clinicians – C2015 (Native only S9482)
- 3.3. Community Support – H2015
- 3.4. Crisis Services - H2011
- 3.5. Family Psychotherapy – Client Present – 90847, Client Not Present - 90846

- 3.6. Group Treatment – 90853, Multi Family Group - 90849
- 3.7. Individual Treatment Services – See SERI
- 3.8. Individual Treatment Services CPT – H0046
- 3.9. Intake – Without physician present H0031, with physician – CPT codes
- 3.10. Interpreter Services – T2038
- 3.11. Medication Management –Evaluations and Management (E&M) codes
- 3.12. Medication Monitoring - H0033, if education & support – H0034
- 3.13. Peer Support – H0038
- 3.14. Rehabilitation Case Management (RCM) and/or Engagement – H0023
- 3.15. Request for Service – Raintree Generated from Episode - H0046
- 3.16. Special Population Consultation – H2014 by phone; H2014 Face to Face with Provider and Specialist
- 3.17. Special Population Evaluation by Specialist – T1023 Face to Face with Client
- 3.18. Testimony for Involuntary Treatment - 99075
- 3.19. Therapeutic Psychoeducation – H0025, H2027 & S9446

4. **SERVICES**

- 4.1. Services shall consist of the following programs:

- 4.1.1. **Outpatient Services**

- 4.1.1.1. Outpatient Services for individuals of all ages offering a range of individual and group mental health and/or co-occurring services. Treatment is brief and episodic, solution focused and based on functional problems and individual needs. Services focus on symptom reduction, promoting recovery from addiction, the restoration of self-esteem, access to available resources, and the attainment of independent functional and meaningful roles in the community through the recovery process.
- 4.1.1.2. Community Support Services provides treatment to individuals using a recovery model of care for individuals with severe and persistent mental illness. Treatment is community based and focuses on assisting individuals to increase their ability to manage their illness and improve the quality of their lives while residing in their own community. Clinicians help individuals access needed entitlements, acquire or maintain housing, and develop the necessary skills to manage symptom of their illness with the focus on independent living and vocational or volunteer participation.
- 4.1.1.3. The contractor will expand outpatient services to include providing school-based mental health services within the Newport School District with one Full-Time Equivalent (FTE) Mental Health Professional (MHP) who will also be a Designated Mental Health Professional (DMHP). Services will be provided to Medicaid enrolled students in Kindergarten through 12th grade who meet

access to care guidelines. Services may include screening, intakes, individual, family and group treatment, case management support, coordinated planning with community supports, and consultation and training. Services will be provided year around, including a summer program, at a community location the individual or family chooses.

4.1.2. **Outpatient Psychiatric Services**

4.1.2.1. Contractor shall provide outpatient psychiatric services to all enrolled eligible individuals who are in need of such care. Access to psychiatric care must be provided no more than thirty (30) days of request, as staff resources allow, and in accordance with Washington Administrative Code (WAC) and Revised Code of Washington (RCW) requirements. Outpatient psychiatric care will include at a minimum the following:

- 4.1.2.1.1. Psychiatric evaluation, diagnosis, and treatment;
- 4.1.2.1.2. Psychiatric consultation including outpatient emergencies;
- 4.1.2.1.3. Medication prescription and management including clinic, laboratory and pharmacy services in accordance with WAC 388-865-0458 or any of its successors; and
- 4.1.2.1.4. Referral for non-psychiatric medical problems.

4.1.3. **Crisis Response Services**

4.1.3.1. The Contractor shall provide integrated crisis response services to persons on a twenty-four (24) hour, seven (7) day per week basis, including, but not limited to:

- 4.1.3.1.1. Crisis Hotline: Telephone service provided by trained personnel or qualified staff. Services include triage, referral and telephone based support to individuals experiencing a mental health crisis. Crisis hotlines operate on a twenty-four (24) hour basis. This service will be accessed via a published local or toll free number. Crisis Hotline services may be provided without an intake evaluation for mental health services. The Crisis phones shall be answered by qualified persons who are proficient, or can immediately access personnel proficient in the use of TTD/TTY and alternate languages, for the hearing impaired and limited English proficient population(s). Contractor will assure that policies and procedures are in place;
- 4.1.3.1.2. Availability. The Contractor shall provide for reasonable and adequate hours of operation including twenty-four (24) hour, seven (7) days per week availability of information, referral, and emergency services;
- 4.1.3.1.3. The status presented by an individual and the coordination of care documents, shall indicate appropriate treatment modalities to meet individual

need, and shall include, but not be limited to the behavioral health services identified in the State Plan and listed below, to be provided by the Contractor directly.

- 4.1.3.1.4. Assurance that individuals who are referred or present themselves for emergency or crisis services receive face-to-face contact when appropriate by qualified staff;
- 4.1.3.1.5. For each call that requires clinical intervention, provide documentation, of the date, time and duration. In addition, the Contractor will report to the SCRBHO the total number of calls received on an annual basis.

5. INVOLUNTARY TREATMENT ACT (ITA) / LESS RESTRICTIVE ALTERNATIVE (LRA) MONITORING SERVICES

5.1. The Contractor shall:

- 5.1.1. Provide appropriately credentialed staff to ensure that individuals are appropriately assessed for involuntary commitment, extensions or revocations under RCWs 71.05 and 71.34. The Contractor shall also ensure that all outpatient providers court ordered to provide treatment services to Pend Oreille County individuals being released on a least restrictive alternative court order from the community or state hospital are monitored for compliance with said order;
- 5.1.2. Obtain written documentation of SCRBHO approval of individuals as DMHPs;
- 5.1.3. Provide community based DMHP evaluation when requested and in compliance with applicable laws and protocols;
- 5.1.4. Utilize Peer Support Counselors whenever appropriate to accompany the DMHPs in order to assist with the de-escalation of individuals in crisis situations;
- 5.1.5. Arrange transportation to inpatient facilities for involuntarily detained persons. Reimbursement from DSHS shall be pursued by Contractor when required;
- 5.1.6. Facilitate, when appropriate, admissions of persons enrolled at any Behavioral Health Organization (BHO), who is voluntarily or involuntarily admitted from a Pend Oreille County location, pursuant to RCW 71.05 and 71.34, to an inpatient psychiatric facility. Ensure communication about hospitalization occurs with BHO of origin prior to admission;
- 5.1.7. All persons considered for psychiatric hospitalization shall first be considered for a less restrictive alternative to hospitalization. It shall be documented as to why the person required hospitalization rather than a community inpatient diversion alternative in the medical record;
- 5.1.8. When known, ensure communication about when and where the hospitalization occurs, with BHO of origin prior to admission; and

- 5.1.9. When known, ensure communication occurs with individual's BHO of origin prior to inpatient or Evaluation and Treatment (E&T) admission.

5.2. **Coordination**

- 5.2.1. The Contractor shall:
- 5.2.1.1. Coordinate with community inpatient psychiatric providers for admissions;
 - 5.2.1.2. Ensure, through documented efforts, linkage to services on behalf of persons that may require other services and/or services of other BHO contractors;
 - 5.2.1.3. Contact any agency necessary when LRA individuals not served by a SCRBHO contracted provider to ensure agency receives information about statutory requirements for providing outpatient services;
 - 5.2.1.4. Ensure coordination with the SCRBHO Integrated Care Coordinators and the SCRBHO Authorized Service Organization (ASO) as applicable; and
 - 5.2.1.5. Collaborate with SCRBHO Leadership to determine any changes or modifications to the SCRBHO Crisis system of care.

6. **CRISIS PLAN**

(SCRBHO is not ready to receive crisis plan data in Raintree for Pend Oreille County Counseling Services, but a crisis plan should be kept in the individual medical record if the individual meets one of the categories)

- 6.1. Contractor will create and submit a crisis plan for required individuals in treatment beyond thirty (30) days who meet clinical appropriateness for a plan.
- 6.2. An individual **will** require a Crisis Plan under the following circumstances:
- 6.2.1. LRA orders;
 - 6.2.2. Psychiatric hospitalization within the past six (6) months (state hospitals, E&T facilities, Children's Long Term Inpatient Program (CLIP), community psychiatric hospitals);
 - 6.2.3. Frequent crisis service contacts;
 - 6.2.4. Current suicidal/homicidal ideations or attempts;
 - 6.2.5. Allen/Marr members;
 - 6.2.6. Currently enrolled in a SCRBHO funded residential placement;
 - 6.2.7. Non-Medicaid High Utilizer individuals in mental health treatment; and
 - 6.2.8. Current self-injurious and/or assaultive behavior.

- 6.3. The crisis plan will be developed collaboratively with the individual (including parents for those twelve (12) and under) and the Mental Health Care Provider (MHCP). The crisis plan will be provided to residential facilities where the individual resides and to any SCRBHO contractors that also provide services to the individual.

7. LEVEL OF CARE ASSIGNMENT

- 7.1. For all SCRBHO enrolled individuals that the Contractor serves:
- 7.1.1. The Contractor will participate in the assignment of the SCRBHO Level of Care Guidelines to provide coordination and prior authorization of medically necessary services for eligible children, youth, adults and older adults receiving behavioral health treatment for psychiatric disorders per SCRBHO policy.

8. INDIVIDUALS ON A LRA

- 8.1. All active individuals that are assigned to the agency as enrolled responsible for the case will be provided outpatient behavioral health services by the agency while on a LRA. The assigned provider agency is responsible for fulfilling all requirements of the LRA court order, including providing the required periodic LRA status report regarding the LRA to the LRA Monitoring provider staff, in accordance with WAC requirements.
- 8.2. If the individual requests psychiatric services from a professional not funded by the SCRBHO, then the MHCP assigned to the individual, will be responsible to notify Superior Court and LRA Monitoring provider staff that the individual has chosen to receive psychiatric services with another community provider not originally indicated on the court order. The individual's MHCP is responsible for ensuring that the required periodic psychiatric LRA Status Report is completed by the community psychiatric provider, in accordance with WAC requirements and submitted to the LRA Monitoring provider staff.

9. LEAST RESTRICTIVE ALTERNATIVE TREATMENT – OUTPATIENT TREATMENT

- 9.1. The Contractor must provide specified services to individuals ordered by the court to LRA treatment, who:
- 9.1.1. Are enrolled in Medicaid and meet the Access to Care Standards for BHO's; or
- 9.1.2. Are not enrolled in Medicaid and do not have other insurance to pay for services, if the BHO has adequate available resources to provide the services.
- 9.2. The Contractor must follow Adult Outpatient Treatment (AOT) caseload and treatment guidelines for Care Coordinators and AOT response times guidelines during and immediately following periods of hospitalization or incarceration. Guidelines must be within the DBHR-required range of guidelines.

- 9.3. LRA treatment must be administered by a provider that is certified or licensed to provide or coordinate the full scope of services required under the less restrictive alternative order and that has agreed to assume this responsibility.
- 9.4. Duration of LRA Orders (per RCW 71.05.320(7)). When entering an LRA order for a person eligible for up to one hundred eighty (180) days of involuntary mental health treatment, a court may enter an order for up to one year of treatment, rather than for up to one hundred eighty (180) days, if the Individual's previous commitment term was for inpatient treatment in a state hospital. Subsequent orders are for up to one hundred eighty (180) days.
- 9.5. Enforcement of LRA Orders and Early Release. Facilities and agencies overseeing treatment and DMHPs are authorized to take Responsive Actions to enforce compliance with an LRA or Conditional Release order.
- 9.6. Definitions
- 9.6.1. Assisted Outpatient Treatment (AOT) means an order for LRA Treatment for up to ninety (90) days from the date of judgement. AOT must not order inpatient treatment.
- 9.6.2. Care Coordinator means a clinical practitioner who coordinates the activities of LRA treatment. The Care Coordinator coordinates activities with the designated MHP's necessary for enforcement and continuation of LRA orders and is responsible for coordinating service activities with other agencies and establishing and maintaining a therapeutic relationship with the Individual on a continuing basis.
- 9.6.3. In Need of Assisted Outpatient Treatment (AOT) means that a person, as a result of a mental disorder:
- 9.6.3.1. Has been committed by a court to detention for involuntary mental health treatment at least twice during the preceding 36 months; or, if currently committed, has been committed at least once during the thirty-six (36) months preceding the date of initial detention of the current commitment cycle;
- 9.6.3.2. Is unlikely to voluntarily participate in AOT without an order for LRA treatment in view of the individuals' treatment history or current behavior;
- 9.6.3.3. Is unlikely to survive safely in the community without supervision;
- 9.6.3.4. Is likely to benefit from LRA treatment;
- 9.6.3.5. Requires LRA treatment to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time. (Time spent in a mental health facility or in confinement as a result of a criminal conviction is excluded from thirty-six (36) month calculation); and
- 9.6.3.6. When DMHP conducts investigation for likelihood of serious harm or grave disability, if DMHP determines individual is in need of AOT.
- 9.6.4. Involuntary Outpatient Evaluation means an evaluation conducted by any combination of licensed professionals authorized to petition for

involuntary commitment under RCW 71.05.230 and that includes involvement or consultation with the agency or facility providing monitoring or services under the proposed LRA Treatment order. The evaluation must analyze the individual's condition and determine whether or not that condition is caused by a mental disorder and results in a likelihood of serious harm, results in the Individual being gravely disabled, or results in the Individual being in need of assisted outpatient mental health treatment.

- 9.6.5. LRA Treatment (per RCW 71.05.858) means a program of individualized treatment in a less restrictive setting that includes the following services:
- 9.6.5.1. Assignment of a Care Coordinator;
 - 9.6.5.2. An intake evaluation with the provider of the LRA treatment;
 - 9.6.5.3. A psychiatric evaluation;
 - 9.6.5.4. Medication management;
 - 9.6.5.5. A schedule of regular contacts with the provider of LRA Treatment for the duration of the order;
 - 9.6.5.6. A transition plan addressing access to continued services at the expiration of the order;
 - 9.6.5.7. An individual crisis plan; and
 - 9.6.5.8. LRA Treatment may additionally include requirements for an Individual to participate in the following services:
 - 9.6.5.8.1. Psychotherapy;
 - 9.6.5.8.2. Nursing;
 - 9.6.5.8.3. Substance abuse counseling;
 - 9.6.5.8.4. Residential treatment; and
 - 9.6.5.8.5. Support for housing, benefits, education, and employment.
- 9.6.6. Less Restrictive Alternative Treatment Provider means a provider agency that is licensed by DBHR to monitor, provide/coordinate the full scope of services required for LRA Treatment, agrees to assume this responsibility, and houses the Care Coordinator.
- 9.6.7. Peer Support Services includes those services that serve to validate Individuals' experiences, provide guidance and encouragement to Individuals to take responsibility for and actively participate in their own recovery, and help Individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce Individuals' self-imposed stigma. Such services also include counseling and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness.
- 9.6.8. Person-Centered Treatment Plan is the culmination of a continuing process involving each Individual, their family and/or natural supports in the community, and the LRA Treatment team, which individualizes

service activity and intensity to meet the Individual's specific treatment, rehabilitation, and support needs. The written treatment plan documents the Individual's strengths, resources, self-determined goals, and the services necessary to help the Individual achieve them. The plan also delineates the roles and responsibilities of the team members who will work collaboratively with each Individual in carrying out the services.

- 9.6.9. Responsive Actions may include, but are not limited to:
- 9.6.9.1. Counseling, advising, or admonishing the person as to their rights and responsibilities under the order and offering compliance incentives;
 - 9.6.9.2. Increasing the intensity of services through more frequent provider contacts, referral for assessment for assertive community services, or by other means;
 - 9.6.9.3. Requesting a court hearing for review and modification of the order;
 - 9.6.9.4. Causing the person to be transported by a peace officer, DMHP, or other means to the facility providing services or to another facility for up to twelve (12) hours to determine whether modification, revocation, or commitment proceedings are appropriate. Detention is intended to occur only after a pattern of noncompliance or failure of reasonable attempts at engagement and is only permitted upon a clinical determination that temporary detention is appropriate; and
 - 9.6.9.5. Initiating revocation proceedings if the Individual is on an LRA. Revocation must be based on violation of LRA orders conditions, not violations of AOT conditions.
- 9.6.10. Service Coordination is a process of organization and coordination within the transdisciplinary team to carry out the range of treatment, rehabilitation, and support services each Individual expects to receive per his or her written Person-Centered Treatment Plan and that are respectful of the Individual's wishes. Service coordination also includes coordination with community resources, including Consumer self-help and advocacy organizations that promote recovery.
- 9.7. The Contractor must provide for the services and staff, and otherwise do all things necessary for or incidental to the performance of work as set forth herein.
- 9.7.1. Care Coordinator Caseload Size. The case mix must be such that the Care Coordinator can manage and have flexibility to be able to provide the intensity of services required for each Individual, according to the Medical Necessity of each Individual.
 - 9.7.1.1. LRA Treatment must have the capacity to provide multiple contacts per week with Individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in a living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two (2) to three (3)

- times per day, seven (7) days per week, and depend on individual need and a mutually agreed upon plan between the individual and program staff. Many, if not all, staff must share responsibility for addressing the needs of all individuals requiring frequent contact.
- 9.7.1.2. LRA Treatment must have the capacity to rapidly increase service intensity to an individual when his or her status requires it or an individual request's it.
 - 9.7.1.3. Operating as a continuous treatment service, LRA Treatment must have the capability to provide comprehensive treatment, rehabilitation, and support services.
 - 9.7.2. LRA Treatment must have a response contact time of no later than seven calendar days:
 - 9.7.2.1. Upon commencement of the order for the Individual to receive services; or
 - 9.7.2.2. Upon discharge from hospitalization and/or incarceration (whichever is later).
 - 9.7.3. Services must minimally include the following:
 - 9.7.3.1. Hospital Liaison Role. The BHO's hospital liaison must actively coordinate the transition of Individuals from Hospital/Evaluation and Treatment Center discharge to LRA Treatment in order to minimize gaps in care.
 - 9.7.3.2. Service Coordination. Service coordination must incorporate and demonstrate basic recovery values. The individual will have ownership of his or her own treatment, will be expected to take the primary role in Person-Centered Treatment Plan development, and will play an active role in treatment decision-making.
 - 9.7.3.2.1. Each individual will be assigned a Care Coordinator who coordinates and monitors the activities of the individual's participation in LRA Treatment. The primary responsibilities of the Care Coordinator are to work with the individual to write a Person-Centered Treatment Plan, provide individual supportive counseling, offer options and choices in the Person-Centered Treatment Plan, ensure immediate changes are made as the individual's needs change, and advocate for the individual's treatment needs, rights, and preferences. Service coordination also includes coordination with community resources, including Consumer self-help and advocacy organizations that promote recovery.
 - 9.7.3.3. Crisis Assessment and Intervention. Crisis assessment and intervention must be provided twenty-four (24) hours per day, seven (7) days per week through the BHO's crisis system. Services must be coordinated with the assigned Care Coordinator. These services include telephone and face-to-face contact.

- 9.7.3.3.1. Each individual receiving LRA Treatment must have an individualized, strengths-based crisis plan. As with the treatment planning process, the individual will take the lead role in developing the crisis plan.
- 9.7.3.4. Medication Prescription, Administration, Monitoring and Documentation. The LRA Treatment physician or psychiatric ARNP must:
 - 9.7.3.4.1. Establish a clinical relationship with each individual;
 - 9.7.3.4.2. Assess each individual's mental illness symptoms and provide verbal and written information about mental illness. The physician or psychiatric ARNP will review that information with the individual, and, as appropriate, with the individual's family members or significant others.
 - 9.7.3.4.3. Make an accurate diagnosis based on direct observation, available collateral information from the family and significant others and the comprehensive assessment.
 - 9.7.3.4.4. In collaboration with the individual, assess, discuss and document the individual's mental illness symptoms and behavior in response to medication and monitor and document medication side effects. Review observations with the Individual.
- 9.7.4. Services may include the following, as determined by medical necessity:
 - 9.7.4.1. Education Services. Supported education related services are for individuals whose high school, college or vocational education could not start or was interrupted. Services include providing support to enrolling and participating in educational activities.
 - 9.7.4.2. Vocational Services. These services may include work-related services to help individuals value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers.
 - 9.7.4.3. Activities of Daily Living Services. Services to support activities of daily living in community-based settings include individualized assessment, problem solving, skills training/practice, sufficient side-by-side assistance and support, modeling, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), environmental adaptations to assist to gain or use the skills required to access services, and provide direct assistance when necessary to ensure that individuals obtain the basic necessities of daily life.
 - 9.7.4.4. Social and Community Integration Skills Training. Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skill training and include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and

assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure Individuals' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support.

9.7.4.5. Peer Support Services. These include services to validate individuals' experiences and to guide and encourage Individuals to take responsibility for and actively participate in their own recovery, as well as services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma. Peer Support and Wellness Recovery Services include:

9.7.4.5.1. Peer counseling and support services, including those which:

9.7.4.5.1.1. Promote self-determination; and

9.7.4.5.1.2. Encourage and reinforce choice and decision-making.

9.7.4.5.2. Introduction and referral to individual self-help programs and advocacy organizations that promote recovery.

9.7.4.5.3. Sharing the journey (a phrase often used to describe Individuals' sharing of their recovery experience with other peers).

9.7.4.5.4. The Peer Specialist will serve as a consultant to the LRA Treatment team to support a culture of recovery in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, support, and community activities.

9.7.4.6. Substance Use Disorder Treatment. If clinically indicated, the Care Coordinator may refer the individual to a DBHR-licensed SUD treatment program. The Care Coordinator shall use a LRA/AOT referral form, as provided by DBHR.

10. REHABILITATION CASE MANAGEMENT AND ENGAGEMENT SERVICES

10.1. Rehabilitation Case Management (RCM)

10.1.1. The usage of RCM is limited by SCRBHO to inpatient, Jail and Juvenile Detention facilities. These facilities are: Eastern State Hospital (ESH), Community Hospitals, Sunshine Health Adult Residential Treatment Facility (ARTF), E&T facilities, CLIP facilities (McGraw, Child Study and Treatment Center, Pearl Street, and Tamarack Center), Jails, and Juvenile Detentions. **An exception to this rule is Community Hospitals: use the RCM code H0023 when the individual is not Medicaid eligible; however, use H2015 Community Support when the individual has Medicaid coverage.**

- 10.1.2. The RCM encounter code may be used by agencies that have either an Enrolled Responsible or an Enrolled Ancillary relationship with the individual. If the individual is unknown to the agency, a Registered episode must be created. Refer to SCRBHO Data Dictionary for Episodes.
 - 10.1.3. RCM is to be utilized to provide liaison activities outlined in the description of the DSHS/DBHR Service Encounter Reporting Instructions for Behavioral Health Organization (BHO). The primary purpose of RCM is to provide case management services, care coordination services, and services that promote continuity of behavioral health care, appropriate discharge planning to maximize the benefits of the placement, and to minimize the risk of unplanned readmission.
 - 10.1.4. RCM should not be used for therapeutic services as these are the responsibility of the hospital, ARTF, E&T, Jail, or Juvenile Detention.
 - 10.1.5. An intake is not required prior to performing RCM services, however the individual must have an existing open Enrolled Responsible, Ancillary, or new Registered episode in the SCRBHO information system.
 - 10.1.6. RCM services may be provided regardless of individual financial eligibility or Contractor's source of funding provided in the SCRBHO contract with the provider.
- 10.2. **Required RCM Services**
- 10.2.1. The Contractor will ensure that the assigned case manager/clinician will provide appropriate RCM to all active individuals admitted to a psychiatric state or community hospital, Sunshine ARTF, E&T, CLIP facility, and/or Jail and Juvenile Detention facilities for purposes of discharge planning.
 - 10.2.2. The assigned case manager/clinician in collaboration with the SCRBHO Integrated Care Coordinator will provide RCM services for all individuals admitted to ESH, Community Hospital, E&T, or the CLIP facility. This will be accomplished by:
 - 10.2.2.1. Serving as the primary case contact for hospital program staff;
 - 10.2.2.2. Providing individual case management from pre-admission to discharge;
 - 10.2.2.3. Active participation in person or via phone conferencing in scheduled treatment team meetings and discharge planning with ESH, the community psychiatric hospitals, and the CLIP treatment teams;
 - 10.2.2.4. Facilitating discharge transition to community outpatient services that support hospital discharge recommendations to include medication management;
 - 10.2.2.5. Providing an enrollment intake during the hospitalization upon individual, hospital, or BHO request; and
 - 10.2.2.6. Providing ongoing communication and collaboration with the SCRBHO Integrated Care Coordinator on behalf of the individual from the point of hospital admission through discharge to outpatient treatment.

10.3. Engagement Services

10.3.1. The Contractor will ensure that the assigned case manager/clinician will provide appropriate Engagement Services to all individuals assigned to the Contractor after discharge from a psychiatric state or community hospital, CLIP facility, Sunshine ARTF, E&T, Detoxification Programs, Spokane County Jail, or Juvenile Detention for admission to community mental health care. These services are necessary when there are difficulties with the individual engaging in treatment.

11. WASHINGTON STATE CHILDREN'S MENTAL HEALTH SYSTEM PRINCIPLES AND CORE PRACTICE MODEL

11.1. Contractor shall embrace 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 I.

12. CHILDREN'S LONG TERM INPATIENT PROGRAM (CLIP)

12.1. For all enrolled individuals admitted to a CLIP facility the Contractor must ensure:

12.1.1. The assigned case manager/clinician in collaboration with the SCRBHO Integrated Care Coordinator will provide RCM in or with the facility to include a range of activities for the direct benefit of the admitted youth including:

- 12.1.1.1. Serve as the primary case contact for CLIP program treatment staff;
- 12.1.1.2. Provide individual case management from pre-admission to discharge;
- 12.1.1.3. Provide regular active participation in person or via audio or video conferencing in formal treatment team meetings and discharge planning with the CLIP treatment team;
- 12.1.1.4. Maintain monthly contact with admitted youth to preserve and maintain treatment relationship;
- 12.1.1.5. Facilitate discharge transition to community outpatient services that support CLIP discharge recommendations to include medication management;
- 12.1.1.6. Provide an outpatient service within seven (7) days of discharge from CLIP; and
- 12.1.1.7. Provide ongoing communication and collaboration with the SCRBHO Integrated Care Coordinator on behalf of the youth from CLIP admission through the inpatient discharge to outpatient treatment.

12.2. The primary assigned case manager/clinician will participate in the local Children's Intensive Task Force meetings to assist in assessing the needs of the children or youth being considered for voluntary CLIP and/or to coordinate the referrals from the task force.

13. CARE COORDINATION WITH RESIDENTIAL FACILITIES AND STEP DOWN HOUSING PROVIDERS

- 13.1. For all individuals placed in residential housing and/or step down housing to facilitate progress towards achieving living in independent housing in the individual's outpatient treatment plan.
- 13.2. Participate in regular meetings with the residential facility providers to review progress towards increased development of independent living skills and ability to transfer to a less restrictive environment.
- 13.3. Collaborate with the residential provider and the SCRBHO Integrated Care Coordinator to review the residential/step down reauthorization requests in order to determine if the individual is in the appropriate care setting.

14. COORDINATION WITH OTHER CONTRACTED BEHAVIORAL HEALTH PROVIDERS

- 14.1. The Contractor will provide the following documentation to other SCRBHO providers when an individual is referred for behavioral health treatment and services and Contractor is the responsible agency for the enrollment of the BHO individual:
 - 14.1.1. Current Agency Intake;
 - 14.1.2. Most Recent Treatment Plan;
 - 14.1.3. Agency Release of Information (ROI) (to ancillary program);
 - 14.1.4. GAINS-SS (if applicable);
 - 14.1.5. Most recent crisis plan (if applicable);
 - 14.1.6. Most recent psychological assessment (if applicable);
 - 14.1.7. Most recent psychiatric evaluation (if applicable);
 - 14.1.8. Specialty consultation (if applicable);
 - 14.1.9. Guardianship and Power of Attorney paperwork (if applicable);
 - 14.1.10. Medical advance directive (if applicable);
 - 14.1.11. Mental health advance directive (if applicable); and
 - 14.1.12. LRA court order and LRA Treatment Plan.
- 14.2. SCRBHO providers are required to make every effort to obtain guardianship and Power of Attorney paperwork from individuals they serve when the primary agency assigned to the individual is unable to obtain it.

15. FACILITY LOCATIONS

- 15.1. Upon execution of the Agreement, the Contractor shall provide to SCRBHO a written list that specifies:
 - 15.1.1. The physical address for each facility;
 - 15.1.2. The type(s) of programs provided by facility; and

15.1.3. The ages of the individuals served by each program.

16. MAINTENANCE OF EXISTING SITES

- 16.1. The Contractor shall be required to maintain primary and out-station sites existing as of the date of the full execution of this Agreement, unless written approval for modification to the out-stationed behavioral health services is obtained from the SCRBHO.
- 16.2. The Contractor shall notify the SCRBHO within ninety (90) days prior of moving and/or closing any office locations.

17. ACCESS TO CARE

- 17.1. The Contractor shall provide a mutually acceptable intake appointment to the eligible individual within ten (10) working days of an individual's request. Contractor shall provide an intake evaluation at the location requested by the individual.
- 17.2. The Contractor shall make available to the individual, a community based intake appointment if the individual has significant barriers that will impede their ability to keep a clinic based appointment.

18. PERFORMANCE GOALS

18.1. Required State Core Performance Measures

- 18.1.1. The Contractor must comply with the appointment standards identified in the contract under the Section entitled Appointment Standards.

18.2. Management Information System Data Submission Compliance

- 18.2.1. The Contractor understands and will comply with Management Information Systems standards for compliance with mandatory data submissions of demographics and service encounters.
- 18.2.2. The Contractor's data submissions will be complete, accurate and timely for the production of reliable and accurate Business Day Submission Reports that guide performance outcome goals and meet state and SCRBHO requirements.

18.3. Required Off-Site Services to Enrolled BHO Individuals

- 18.3.1. Contractor must have the capacity to provide off-site services to any individual; meeting at a mutually agreeable location rather than automatically designating that the service will be provided at the case manager/clinician's office. There is an expectation that when an individual does not show for an appointment (including intakes that a follow up call or actual outreach will be performed to re-engage the individual.

18.4. Active Participation in SCRBHO Quality and Clinical Leadership Committees

- 18.4.1. The agency will designate a representative for attendance in all assigned SCRBHO Committees, to include:

18.4.1.1. Spokane County Providers:

- 18.4.1.1.1. Mental Health (MH) only contracted providers must attend the MH Director's Meeting, MH Information Systems meetings, and any other meetings identified as mandatory;
 - 18.4.1.1.2. Substance Use Disorder (SUD) only contracted providers must attend the System of Care (SOC) Meeting, SUD Information Systems meetings, and any other meetings identified as mandatory;
 - 18.4.1.1.3. Co-Occurring Services providers must attend all meetings listed above in 18.4.1.1. and 18.4.1.2.;
 - 18.4.1.2. Northeast (NE) County providers must attend the NE Quality Meeting, SOC Meeting, MH and SUD Information Systems meetings, and any other meetings identified as mandatory; and
 - 18.4.1.3. Out of Region providers are not required to attend meetings.
 - 18.4.2. These meetings will serve as the oversight forums for the behavioral health system of care.
 - 18.4.3. Meetings shall be attended by the agency Director, County Coordinator, or their designee, who shall be knowledgeable and authorized to make decisions on behalf of that agency. Agency staff attending must communicate the information shared at meetings with the appropriate and applicable agency staff. Compliance with this requirement will be a significant factor considered in the evaluation of contract performance.
 - 18.4.4. Representative(s) will attend, on time, to every assigned committee meeting and fully participate in the committee agenda and is responsible to inform Contractor leadership of the outcome of each meeting.
 - 18.4.5. Missed attendance of more than two (2) meetings within three (3) months may be subject to a Corrective Action Plan and may result in termination of contract.
 - 18.4.6. Complete monthly Service Denial and Contract Compliance reports.
- 19. PARTICIPATION IS ONGOING WITH OTHER PROVIDERS IN THE SCR BHO SYSTEM OF CARE TO IDENTIFY INDIVIDUAL'S NEEDS IN THE COMMUNITY AND TO COLLABORATE REGARDING SPECIFIC CHILDREN AND ADULTS IN INPATIENT OR IN NEED OF DIVERSION IN ORDER TO DEVELOP A PLAN FOR THOSE INDIVIDUALS AND FAMILIES.**
- 20. CONTRACTOR WILL INCLUDE PEER SUPPORT COUNSELOR EMPLOYEES AND SERVICES WITHIN THEIR AGENCY**