NORTH SOUND MENTAL HEALTH ADMINISTRATION
ADVISORY BOARD MEETING

North Sound Mental Health Administration
Conference Room
117 North First St., Suite 8
Mt. Vernon, WA 98273
July 1, 2003
1:00 PM

Agenda

1. Call to Order - Introductions, Chair – 5 minutes

2. Revisions to the Agenda, Chair – 5 minutes

3. Approval of June 2003 Minutes, Chair – 5 minutes

4. Comments from the Public

5. Correspondence and Comments from the Chair – 5 minutes

6. Unfinished Business

a. Executive Director's Report - Chuck Benjamin – 5 minutes
b. Finance Committee – Mary Good – 5 minutes
c. Strategic Plan Committee – Janet Lutz-Smith
d. Activities and Liaison Committee
   i. Site Visitations for 2003
   ii. Consumer-Run Projects-County Reports
e. QMOC Report – Mary Good – 5 minutes

7. Items To Be Brought Forward To The Board of Directors – Charles Benjamin

   a. Consent Agenda
   b. Action Items
   c. Emergency Action Items
   d. Motions Yet to be Approved

8. New Business - 10 minutes

9. Improving Service to Special Populations – Greg Long

10. August Meeting in the San Juan's Update – Dean Stupke

11. Comments from County Advisory Board Representatives – 15 minutes

a. Island
b. San Juan
c. Skagit
d. Snohomish
e. Whatcom

10. County Coordinator Report

11. Comments from Public – 5 minutes

12. Other Business

    a. Request for Agenda Items

13. Adjournment

NOTE: The next Advisory Board meeting will be August 5, 2003, at the NSMHA Conference Room, 117 N. First Street, Suite 8, Mount Vernon.

North Sound Mental Health Administration
MENTAL HEALTH ADVISORY BOARD
June 3, 2003

Present:	Joan Lubbe, Janet Kloc, Marie Jubie, Janet Lutz-Smith, Mary Good, Tom Richardson, Jim King, Beverly Porter, John Patchamatla, Dean Stupke, Jack Bilsborough
Absent:	Kay Day
Excused:	Ian Brooks, James Vest
Staff:	Chuck Benjamin, Linda Benoit, Sharri Dempsey, Shirley Conger, Deborah Russell. Greg Long
Guests:	Jere LaFollette, Jackie Henderson, Jane Relin, Gail Barron

MINUTES

TOPIC	DISCUSSION	ACTION
CALL TO ORDER, INTRODUCTIONS		
Chair Lutz-Smith	Chair Lutz-Smith convened the meeting at 1:05 p.m., and introductions followed. Chair Lutz-Smith shared inspirational quote. She then asked the question relating to the quote, "what challenges do we face and how they can be remedied".	Informational
REVISIONS TO THE AGENDA		
Chair Lutz-Smith	NONE	
APPROVAL OF MINUTES		
Chair Lutz-Smith	The April and May 2003 minutes of the Advisory Board meeting were reviewed and were approved as written with one abstention.	Passed with one abstention
COMMENTS FROM THE PUBLIC		
Sharri Dempsey	Sharri announced a change of date of the September 13, 2003 **Craft Fair** is officially being changed to September 20, 2003. This is do to a conflict with the NAMI Conference. She shared some history about the Craft Fair and how several providers have provided their expertise and help. Sharri passed out information on the next "All Aboard" to the Behavioral Health Conference in Yakima and shared information about the MHD focus stakeholder group to be held in Olympia.	Informational
Jere LaFollette	Mr. LaFollette shared the continuing success of the Skagit Valley Farm Project. Consumers are preparing to bring their products to the Mt. Vernon Open Air Market each Saturday. The question was asked if the consumers get paid. He responded they do receive pay, but also volunteer.	Informational

CORRESPONDENCE AND COMMENTS FROM THE CHAIR

Chair Lutz-Smith	Janet Lutz-Smith would like the Executive Committee to make sure the current Advisory Board By-Laws are appropriate. The Advisory Board Executive Committee will then bring their recommendations to the full board.	Informational

UNFINISHED BUSINESS

Executive Director's Report

Chuck Benjamin	Mr. Benjamin reported on the "All Aboard" to the King County Drug Court. He shared that each person attending was able to actually go into the court and watch proceedings. He announced that QMOC needs further representation of Advisory Board Members. Mr. Benjamin also shared about the completion of the Stigma Reduction literary contest, and that the contest winners will be given their prizes during the June Board of Directors Meeting. The DBT training was completed and we have received very good feedback from providers about the training, and how they planned to implement within each individual agency.	Informational

Finance Committee Report

Mary Good		Informational

Strategic Plan Committee

Chair Lutz-Smith	Chair Lutz-Smith promoted a conference on "Mental Health in Unstable Times", June 25–27, 2003. Registration deadline for the conference is May 23.	Informational

Activities and Liaison Committee

Chair Lutz-Smith	It was noted that there is a need for more Advisory Board members on the Activities and Liaison Committee.	Informational

Site Visitations for 2003

Sharri Dempsey	Shared flyers about the Behavioral Health Conference, "All Aboard" for June 25, 26, 27 in Yakima. She shared so far 16 people who include 9 consumers will attend the conference.	Informational

Consumer Run Projects

Advisory Board Member – not appointed at this time	No report.	Informational

QMOC Report

Mary Good	Reported on the Quality Specialist activities for the month of April. Terry McDonough reported on the Compass and WCPC audit and corrective action plans. Greg Long reported on crisis concerns brought up by MHD during the audit. WCPC will submit plans on how to best correct the crisis concerns. Linda Vaughn addressed the committee about Bench Marking. Melissa DeCino addressed the QMOC about the response from WCPC response to the QRT survey. The QRT has accepted the QRT correction plan. Wendy Klamp updated QMOC on HIPAA.	Informational

ITEMS TO BE BROUGHT FORWARD TO THE BOARD OF DIRECTORS

	Consent Agenda	
Chuck Benjamin	None	
	Action Items	
Chuck Benjamin	• Extension of the PCI contract. He did share with the Advisory Board that the Raintree implementation is still scheduled for the first week in July 2003. • Monthly claims	Approved with one abstention
	Emergency Action Items	
Chuck Benjamin	None	
	Introduction Items	
Chuck Benjamin	• Revision of APN contract with the creation of the NSMHA new Management Committee and Management Council.	Informational

NEW BUSINESS

Jim King	Mr. King asked the Advisory Board if anyone else had heard of billing for transportation either to an E & T or hospital when a consumer is ITA'd. Discussion followed and concerns shared. Statement given about maximizing revenue and it is a common practice to bill for transportation.	Informational

COMMENTS FROM COUNTY ADVISORY BOARD REPRESENTATIVES

Island	New NSMHA Advisory Board member appointed and will be attending in July. The new outpatient treatment facility will be opened soon.	Informational
San Juan	New treatment facility still in planning	Informational
Skagit	Following up on concerns with termination of outpatient services and questions about continuum of care and looking at someone's life process so they will be able to stay out of the system. June 23, 2003 from 3:00 pm to 4:00 pm Skagit County will be having a *Think Tank* for consumers and advocates to talk about what local services are needed.	Informational
Snohomish	Marie Jubie reported that the County Board: • Redoing County Codes • Presentation by Chris Campbell about home school. • NAMI picnic at Forest Park on August 18, 2003.	Informational
Whatcom	Tom Richards spoke about the Western State Evaluation process and hoping to get transportation and timelines streamlined. This would stop the time of peopling sitting around in jails. Whatcom County is hoping to get their Triage Facility up and running and they are also looking at the Pierce County Drug Court System.	Informational

COUNTY COORDINATOR REPORT

Chuck Benjamin	Regional protocols will be established for CDMPH's.	Informational

COMMENTS FROM PUBLIC

John Patchamatla	Mr. Patchamatla would like to receive all the expenses not just the expense summary. Mr. Patchamatla also requested the attendance of a Board of Director during the Advisory Board Meeting. Ms. Lutz-Smith stated that a good time to look into these requests would be during the next months By-Laws Executive Committee meeting.	Informational

OTHER BUSINESS

Chair Lutz-Smith	None	

Request for Agenda Items

Chair Lutz-Smith	Request was extended.	Informational

ADJOURNMENT

Chair Lutz-Smith	Meeting adjourned at 2:55 p.m.	

MEMORANDUM

DATE: June 16, 2003

TO: NSMHA Advisory Board

FROM: **Charles R. Benjamin**
Executive Director

RE: July 1, 2003 NSMHA Board of Director's Agenda

Please find for your review and comment the following that will be discussed with the Board of Directors brought forth at the July 10, 2003 NSMHA Board Meeting.

CONSENT AGENDA

ACTION ITEMS

EMERGENCY ACTION ITEMS

ITEMS NOT YET REVIEWED BY THE ADVISORY BOARD

To review NSMHA/APN Service Providers Children's Inpatient Reduction Proposals as approved by the Board of Directors on June 12, 2003 with motion # 03-031. Total funds requested for inpatient reduction projects: $495,010

Board of Directors approved on April 10, 2003, Motion # 03-018. The NSMHA and APN Children's Service Providers have been working collaboratively to address present gaps in Children's Services and the potential impact of Fairfax Hospital discontinuing services to the Medicaid population. The biggest barrier deals with start-up funds to enhance Children's Services and to effectively divert Children's hospitalizations. It is therefore our recommendation that the FEMA funds totaling $495,010 be sent to APN per our contract but that these monies be dedicated to enhancing Children's Services and diverting hospitalizations as determined by the joint NSMHA/APN Committee.

To introduce North Sound Mental Health Administrations Improving Services to Underserved Populations in the North Sound Region.

To introduce the amended Community Mental Health Services Contract between NSMHA and APN
This provided in accordance with the Board of Directors approved Public Mental Health System Review. BOD approved on April 10, 2003, Motion # 03-020. This will add Exhibit "A" and amend the existing contract.

To introduce the following line item transfer in the NSMHA 2002 Operating Budget:
$10,600 from Administrative Budget Professional Services to the Office Machinery and Equipment. Budget is over due to updating hardware of the IS system and purchasing locking fireproof cabinets for HIPAA compliance.

If you have any questions or concerns you would like to discuss prior to the meeting, please do not hesitate to contact me.

cc: NSMHA Board of Directors
County Coordinators
NSMHA Management Team

APN Children's Service Providers
Children's Inpatient Reduction Proposals

Proposal Summary Sheet

Catholic Community Services/NW - Whatcom and Skagit Counties

CCS proposes to enhance services for high need children returning from hospital care or for children at risk of being hospitalized. Enhancements include increased availability of psychiatric services and intensive family case management services that are coordinated with other mental health providers and child serving systems in Skagit and Whatcom Counties (e.g. ICRS and Children's Crisis Response Teams). In Whatcom County CCS also proposes to provide supported foster home based planned respite with availability of daily structured activities to assist in stabilization and/or hospital diversion.

NSMHA Request: $ 114,007

Whatcom Counseling and Psychiatric Services - Whatcom County

Whatcom Counseling and Psychiatric Services is expanding Children's Crisis Outreach capacity through additional intensive case management, psychiatric service, and flex funds. These services will be delivered in conjunction with the inpatient reduction program for Whatcom County developed by Catholic Community Services NW.

NSMHA Request: $ 22,261

Compass Health - Skagit/Island/San Juan County

Services proposed would expand the Children's Crisis "Team" in Skagit County, thereby further reducing the number of hospitalizations, reducing length of stay, and providing transitional post hospital service to prevent a cycle of repeat hospitalization. While providing expanded services for all consumers in the county, this proposal also offers additional services for enrolled high risk clients at CCS and Compass Children's Services in need of day treatment, especially for those children leaving hospitalization. In addition to efforts in Skagit county, this project will offer specialized consultation and additional hours of support for behavioral aids in Island and San Juan Counties.

NSMHA Request: $ 74,241

Compass Health South - Children's Connections Project - Snohomish County

This project will delivery intensive wrap-around services to high utilizers of psychiatric hospitalization within the current level three population. Intensive case management will coordinate and wrap health and mental health educational, housing, and other social welfare services and resources around the family. Services will be delivered within the context of the family and community. The children's extended clinician working with the child on admission will continue to work with the child and family throughout the Connection Project's involvement. Services will be short-term, three to six months, and the program will serve 10 to 14 children/families at any point in time. The expectation is that between 40 and 50 children will be served through this program annually.

NSMHA Request: $ 284,501

Total Funds Requested for Inpatient Reduction Projects: $ 495,010
(This total does not include additional matching funds)

CATHOLIC COMMUNITY SERVICES NORTHWEST

INPATIENT REDUCTION PROJECT PROPOSAL – WHATCOM AND SKAGIT

I. Program Summary

CCS proposes to enhance services for high-need children returning from hospitals or children at risk of being hospitalized. Enhancements include increased availability of psychiatric services and intensive family case management services that are coordinated with other child-serving systems, including the other children's community mental health providers in Skagit and Whatcom Counties, e.g. ICRS and children's crisis response teams.

In Whatcom County, CCS also proposes to provide supported, foster-home based *planned* respite with availability of daily structured activities for limited numbers of children, to assist in stabilization and/or hospital diversion.

II. Program Objectives

CCS aims to increase community capacity to serve vulnerable, high-risk children in their own homes and communities. Specific objectives of proposed services include:

- Reducing expensive, sometimes inappropriate, out-of-community placements in inpatient care
- Increasing community responsiveness by providing more timely, flexible, and focused resources
- Increasing collaboration and capturing efficiencies of effort by interfacing with crisis response teams and other providers who serve high need, at risk children
- Adding tools to the continuum of care in each county

III. Program Components and Implementation Timelines

Whatcom:

- Intensive Family Services Case Manager (full-time)
- Carries small, short-term caseload; assists CCS primary assigned clinicians
- Focuses on hospital diversion or return to community from inpatient setting
- Supports local BRS provider(s) who serve high-need children enrolled at CCS
- Collaborates with WCPC intensive family services case manager (as proposed) to form local team, along with respite foster parent, psychiatrist, and daily activities staff

  Timeline: Position currently funded; in place since August 2002.

- Psychiatric Services (estimated 12-15 hours per month)
- Assessment, consultation, and medication services for children/families at risk of hospitalization
- Consultation with intensive family services team, as described above

Timeline: July 15, 2003

- Planned Respite Foster Home
  - Specially trained foster parent(s) who live in CCS-run home on Indian St., Bellingham
  - Capacity to provide 15 bed nights of foster care per month
  - Collaborates with Intensive Family Services Case Managers (CCS and WCPC), daily activities staff, and psychiatrist for care of high-need children in foster home

  Timeline: Indian St. house available for use July 1; foster parents available August 1.

- Daily activities ("custom day treatment") for 1-3 high-need children approximately three to four hours per day (full-time staff)
  - Based at Indian Street foster home
  - Specially trained in behavior management for children
  - Focus on stabilization and structure – de-escalation; social/recreational activities

  Timeline: July 1, or within 3-6 weeks of project funding.

Skagit:

- Intensive Family Services Case Manager (half-time)
  - Carries small, short-term caseload; assists CCS primary clinicians
  - Focuses on hospital diversion or return to community from inpatient setting
  - Supports local BRS provider(s) who serve high-need children enrolled at CCS
  - Collaborates with Children's Crisis Team, ICRS, and other children's providers

  Timeline: July 1, or within 3-6 weeks of project funding.

- Psychiatric Services (estimated 8 hours per month)
  - Assessment, consultation, and medication services for children/families at risk of hospitalization
  - Consultation with intensive family services case manager and team

  Timeline: July 1, 2003

IV. Projected Impact of Proposed Services

- Quicker identification of enrolled children at risk of hospitalization
- More effective and better coordinated intervention for children/families at risk
- More timely access to psychiatric services for high need CCS children
- Reduction in stress experienced by children and families related to diversion of hospitalizations
- Reduced hospitalization costs leading to enhanced community services through savings

V. Evaluation Summary

The primary method of evaluating effectiveness of proposed services is measuring whether hospital utilization is impacted positively, both at the individual provider and regional system levels. In addition to reporting and participating in evaluation of this data, CCS will also design methods to track access to agency psychiatric services; for example by comparing psychiatry access for children who are a focus of concern in this project with that of other children in outpatient services. Perceptions of staff satisfaction with the proposed services, as well as child/family and community collaborator satisfaction with proposed services may also be useful effectiveness measures.

CCSNW
Children's Inpatient Reduction Project
Year Ended 6/30/2004 Budget

	Whatcom	Skagit	Total
CCS In kind	24,890	18,745	43,634
NSMHA	82,407	31,600	114,007
Total Revenue	**107,297**	**50,345**	**157,642**
Direct hrs/wk	37.5	20.0	57.5
Direct Salaries	26,891	14,342	41,233
P/R Taxes & Benefits	9,277	6,847	16,124
Professional Fees	15,000	8,000	23,000
Planned Respite	17,400		17,400
Total Direct Expenses	**68,568**	**29,189**	**97,757**
Indirect Salaries	12,660	8,137	20,797
P/R Taxes & Benefits	3,650	2,250	5,900
Computer Costs	1,977	1,097	3,074
Training	245	140	385
Supplies	725	532	1,257
Telephone/Postage	1,429	672	2,101
Occupancy Cost	6,407	2,137	8,544
Equipment Expense	494	294	788
Travel	940	604	1,544
Insurance	839	125	964
Misc.	205	89	294
Admin Allocation	9,158	5,079	14,237
Total Indirect Expenses	**38,729**	**21,156**	**59,885**
Total Expenses	**107,297**	**50,345**	**157,642**
Surplus/(Deficit)	**-**	**-**	**-**

WHATCOM COUNSELING & PSYCHIATRIC CLINIC

Addendum to Proposal

By Catholic Community Services Northwest:
Inpatient Reduction Project For High Risk Children—Whatcom County

Whatcom Counseling & Psychiatric Clinic (WCPC) has formed a partnership with Catholic Community Service Northwest (CCS) to:

- Reduce expensive, sometimes inappropriate, out-of-community inpatient placement
- Increase community responsiveness by providing more timely, flexible and focused resources
- Increase collaboration and improve efficiencies by working more effectively with crisis response teams and other providers who serve high-need, at risk children
- Add resources to the continuum of care in Whatcom County

Thereby, WCPC and CCS with increase community capacity to serve this vulnerable population in their own homes and communities.

PROGRAM SUMMARY

WCPC, in partnership with CCS, proposes to enhance service for high-need children returning from hospital or children at risk for hospitalization. Enhancements will include increased availability of psychiatric services and intensive family case management services. Such services will be coordinated with other systems helping this vulnerable population (i.e., other community mental health providers, Volunteers of America, Juvenile Justice System, DDD, DCFS, children's crisis response teams).

In Whatcom County, WCPC plans to support the CCS initiative to provide supported, foster-home based *planned* respite with availability of daily structured activities for limited numbers of children, to assist in stabilization and/or hospital diversion.

PROGRAM COMPONENTS

1. WCPC will fund a half-time position for an Intensive Family Services Case Manager, who will focus on hospital diversion activities and facilitate the return of children to the community from inpatient services. This position will serve enrolled and non-enrolled children. The WCPC Intensive Family Services Case Manager will collaborate with CCS to form a local team, working with the respite foster parents, the treating psychiatrist and the daily activities staff.

   TIMELINE: July 2003.

2. WCPC will also utilize these funds for additional psychiatric services (estimating 7 – 10 hours per month), which will provide:

- Assessment, consultation, and medication services
- Consultation with intensive family services team, as described previously

TIMELINE: JULY 2003 (When FEMA money is available.)

3. In addition, WCPC will designate flex funds for the program.

   TIMELINE: JULY 2003 (When FEMA money is available.)

PROJECTED IMPACT OF ENHANCED SERVICES

It is expected that the proposed enhancements to children's services will provide:

- Earlier identification of children at risk for hospitalization
- An increase in the effectiveness of coordinated intervention for children/families at risk
- More timely access to psychiatric services for high-need children
- A reduction in inpatient costs, allowing additional funds to be available for community services

EVALUATION

CCS will take the lead in evaluating the enhanced services; WCPC will participate in the evaluation process.

BUDGET	APPROXIMATE COST
1. Half-time position for an Intensive Family Services Case Manager (.5 FTE Clinician II)	**$21,000** (Crisis Respite Funds)
2. Enhanced psychiatric services	**$11,100** (FEMA Funds)
3. Flex Funds **$11,161**	(FEMA Funds)
	TOTAL $43,261

Proposal for Children's Inpatient Reduction Project
Compass Health—Skagit/Island/San Juan
May 14, 2003

I. Summary:

On December 1, 2002, the Children's Crisis Team in Skagit County began services with one full-time FTE. Statistical data suggests that during the following six month time period, Skagit hospitalizations significantly decreased during the hours in which the Children's Crisis Specialist responded to child/family crisis. During this time we have made discoveries as to what works best in our County regarding the response to crisis and/or possible hospitalization.

The services we are proposing would expand our concept of a children's crisis "team" in Skagit County, thereby further reducing the number of hospitalizations, reducing length of stay, and providing quality transitional post-hospital services for at least 30 days in order to prevent the cycle of repeat hospitalization. While providing expansive services for all consumers and stakeholders in the County, this proposal also provides additional services for already enrolled high-risk crisis clients at CCS and Children's Services in need of day treatment, especially coming out of hospitalization.

In addition to efforts in Skagit County, this project will offer the availability of specialized consultation and extra hours support for behavioral aids in Island and San Juan Counties.

II. Objective:

To enhance the services provided by the children's crisis program to form a true Skagit Children's Team capable of implementing high quality alternative interventions and strategies to hospitalization and to repeat hospitalization.

III. Components including staffing:

- .**8 FTE Masters Clinician III Child Specialist** to complement the hours of the already existing Clinician on the Children's Crisis Team. Hours approximately 5:30 to 12:00 midnight, Monday through Friday. This would fully cover 90-95% of children/youth crisis calls/referrals/dispatches.
- **Two: .5 FTE High Risk Interventionists (B.A.)** providing:
    1) Day treatment groups/case management for all children/youth coming out of hospitals for up to 30 days. This would be intensive work with our highest risk clients.
    2) Ability to be highly flexible and "float" between high risk situations to provide behavioral intervention, line of sight supervision in the home (or other facility), stabilization, team recommendations and follow up.
- Additional funding for mileage and additional intervention hours as needed.

IV. Projected Impact:

Projected impact would be:

- 90-95% coverage of overall children's crisis in Skagit County
- 30-40% additional reduction in hospitalization (from already decreasing amount)
- 50% reduction in length of stay by providing excellent transitional day-treatment and home-based intervention as needed.
- Integration of services for the most at risk children and youth in the County. (A children's TEAM)
- Community confidence in mental health services ability to provide quality care and after-care for its most high-risk children/youth.

V. Evaluation Summary:

Intensive daily follow-up, intervention, day treatment, and case-management has been shown around the county to be highly effective in ending the revolving cycle of hospitalizations for some children and youth and to providing the ability to shorten the length of stay during hospitalization. Flexibility in the provision of services, strategies, and interventions is also crucial. The proposed high-risk interventionist positions will provide for this crucial need.

A skilled Children's Mental Health Crisis Specialist (like Charline Cox) providing services during the crucial time between 5:30 and 12:00 midnight would cover over 90% of overall children's crisis. The extension of this current position is key to building the crisis team. The mental health expertise provided by these clinicians is the foundation for the program.

VI. Timeline for Implementation

Recruitment, hiring, training, and supervision/integration into the existing team could begin immediately with staff being on board within one month.

VII. Budget:

	Position	Approximate Cost
1.	.8 FTE Clinician III Child Crisis Specialist (Masters plus appropriate experience)	$31,000
2.	.5 FTE High Risk Interventionist (B. A. plus appropriate experience)	$16,500
3.	.5 FTE High Risk Interventionist	$16.500
4.	Additional funding for mileage	$ 5,000
	Additional funding for extra hours capacity	$ 5,000
5.	Additional Flexible funding divided between agencies	$ 241
	Total:	$ 74,241

COMPASS HEALTH SOUTH

CHILDREN'S CONNECTIONS PROJECT

i. Program Summary

The Children's Connection Project will deliver intensive wrap around services based on existing positive research findings to high utilizers of psychiatric hospitalization within our current level three population. A control group of children with the same profile will receive standard services and be compared with the project group to measure the effectiveness of the model in our community. Evaluation will include reduction of inpatient days, standardized measures of behavior/stabilization, and reduction of intervention need.

The target population will be Snohomish county children receiving Children's Extended Services (level 3 services), birth to 17 and are not in group care who meet at least *one* of the following criteria:

- have spent 30 days out of the last 180 day period in the hospital or
- have been out of the home in a juvenile rehabilitation facility with a mental disorder or
- are on the CLIP waiting list/discharging from CLIP or

All admits must be able to receive services in a home environment that does not compromise the safety of staff and are not in group care (BRS beds)

Services will be delivered based on the wrap around model that has shown positive outcomes in other geographic areas. Intensive case management will coordinate and wrap health, mental health, educational, housing, and other social welfare services and resources around the family. Services will be delivered within the context of the family and community. The Children's Extended Clinician working with the child at admission will continue to work with the child throughout the Children's Connections Project involvement as an integral part of the team. Services will be short term 3 to 6 months and the program will serve 10 to 14 children and families at a time. The expectation is that between 40 to 50 children will be served within a year.

ii. Program Objective

There are two goals for the Children's Connection Project:

1) To test a model for improving the efficiency of our community's intensive mental health services delivery system for children and families who are high utilizers of inpatient dollars.
2) To broaden the continuum of services in the community.

iii. Program Components

In addition to their existing services through Children's Extended, children and their families will have an individualized plan of family centered services based on their strengths that are drawn from the following menu of services:

- Intensive case management coordinated by case managers with low caseloads (5 to 7 families).
- Flex funds for assistance with basic needs and individualized plans
- Family centered treatment planning
- Monthly child and family team meetings for monitoring of individualized service plans.
- Home and community-based service delivery.
- Assessments of mental health, life domain needs, and long term planning
- Access to psychiatric evaluations and medication monitoring.
- Family/couples therapy
- Treatment aides
- Crisis intervention, with outreach when needed, 16 hours a day from a team familiar with the child and family
- Skills training
- Foster care and extended family/natural support respite
- Relative/natural support focus
- Continued services from the child's clinician at the time of referral throughout the Children's Connection Project wrap.

Discharge criteria will be individualized with three to six months being the average stay. Services will be titrated and transition will be coordinated with ongoing services as discharge approaches. Discharge will be a focus from the beginning of services.

Staffing: 30 hour supervisor / 2 Full Time Case Managers / 1 Full Time Treatment Aids / 3 hours Psychiatrist time a month

1v. Projected Impact

- Reduction of NSMHA funds for Snohomish county children who are high utilizers of psychiatric hospitalization dollars over the course of a year
- Improvement of short and long term stabilization outcomes for child, family and community.
- Less hospitalization and need for other community services during transition in and out of more restrictive settings such as CLIP.

V. Evaluation summary

All objectives will be evaluated by comparison of data from the control group and the group in the program before, during and after the program is completed. For each child admitted to the program a child meeting the same criteria within Children's Extended will be added to the control group. That child will be evaluated with the same admit and discharge dates into the control group as the child in the program.

The data evaluated will be: 1) days hospitalized 2) data entry records showing the number of events of each child.

Objectives will also be evaluated by a comparison of the same groups on a standardized measure such as the CAFAS or Child Behavior Checklist at admission and at discharge.

vi. Timeline for implementation

The program is projected to be fully staffed and running by July 31, 2003.

Children's Connection Project
Budget

Manager / Supervisor

Clinician I -- 1 FTE (Case Manager)
Clinician I -- 1 FTE (Case Manager
Mental Health Tech III – 1 FTE (Treatment Aid)
Secretary
Psychiatrist
Flexible Funding
Foster Home Respite
Pagers/Cell Phones
Facility/Utilities
Training

Recruitment

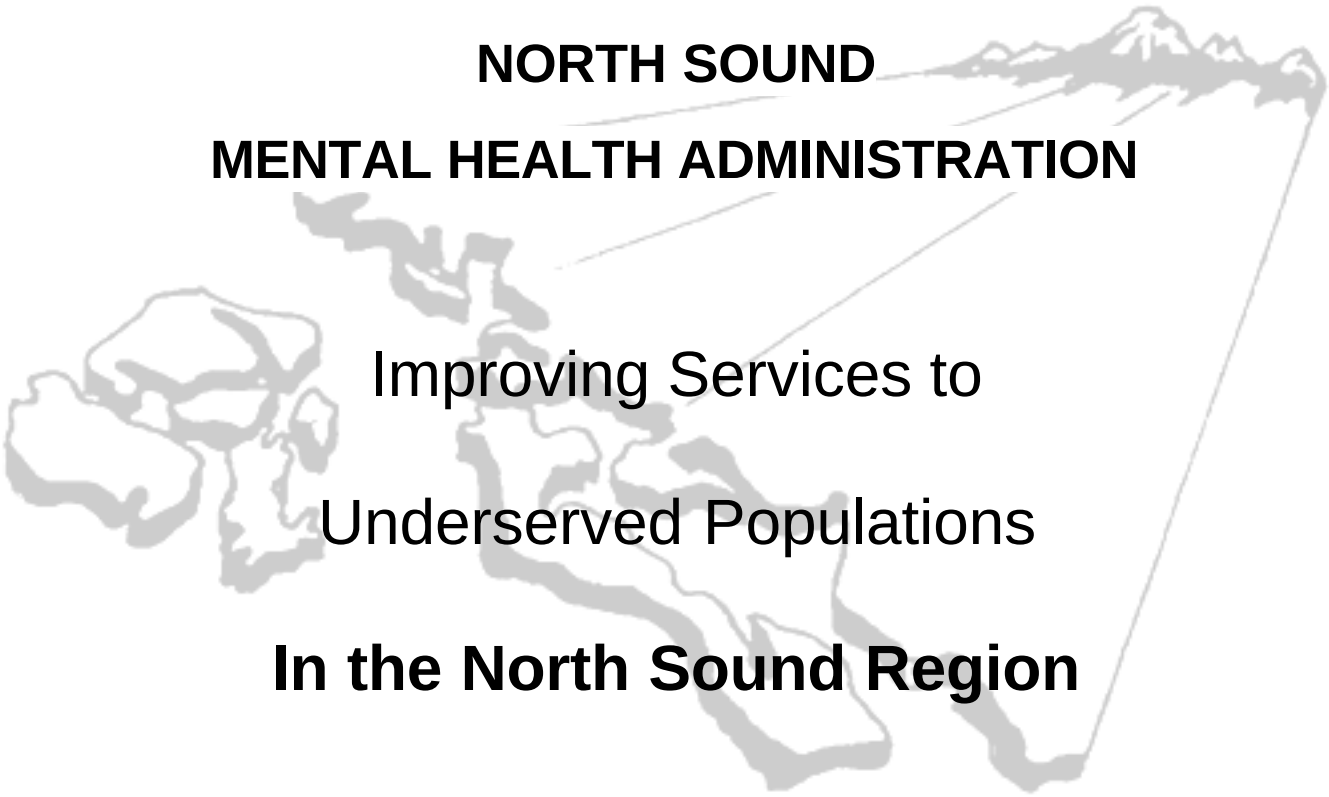
Total: $283,597

(Additional budget detail available upon request)

Category	Annual Budget	
Salaries	$	127,847
Benefits	$	30,200
Clinical Services	$	2,900
Rent	$	9,300
Communication	$	10,500
Depreciation	$	1,100
Insurance	$	2,200
supplies	$	2,400
Mileage & Travel	$	10,000
Training	$	1,250
Utilities	$	2,200
Equipment Rental	$	1,200
Recruitment	$	1,100
Foster Home Respite	$	36,000
Other Assistance to Clients	$	7,904
Misc. & Others	$	1,400
Admin	$	37,000
Total Expenses	$	284,501

NORTH SOUND

MENTAL HEALTH ADMINISTRATION



Improving Services to

Underserved Populations

In the North Sound Region

Improving Services to Underserved Populations
In the North Sound Region

Executive Summary

Across the nation, public mental health systems are striving to provide better treatment to underserved populations. The NSMHA in its Strategic Plan 2000-2003 prioritized improving services to underserved populations. The underserved groups studied in this review include racial and ethnic populations, people with head injuries and people with developmental disabilities. Better serving these populations is especially challenging in a time of major state budget deficits and reduced funding for all types of human services.

This report is based on a regional workgroup's study of these underserved populations, a study of recent literature, and a survey of professionals from the mental health system and related human service systems. The workgroup found the specialized services for underserved populations have been contracted, developed and are helping many people.

The Region meets parity for serving African Americans and American Indians/Alaskan Natives when compared to the general population. Parity is not met for Hispanic and Asian/Pacific Islanders in comparison to the general population. If the comparison is made between the underserved populations and their prevalence in the North Sound Region's Medicaid eligible population, parity is not met for any ethnic group. Services are improving for developmentally disabled adults, but there is also a need for services for developmentally disabled children. People with traumatic brain injuries can benefit from services and are underserved. The state mental health system does not prioritize them.

The workgroup makes the following recommendations, which are consistent with the national literature on underserved populations:

- Special and additional outreach and engagement efforts are needed to increase the number of underserved population consumers in community mental health services. Services to Hispanics and Asian Pacific Islanders should be emphasized at this time because these two ethnic groups have the biggest gaps in parity of services. More intensive and long-term, community-building outreach efforts are necessary to engage underserved populations than the general population.
    - Programs and clinicians specializing in working with the specific underserved populations are most likely to effectively engage and treat their target populations. Underserved population consumers are most likely to engage in treatment when they are working with a clinician of similar culture, language, and backgrounds.
    - Efforts need to continue and be increased in developing specialized programs and hiring or training of mental health clinicians who are people of color or ethnic backgrounds. The model programs operating in the North Sound Region fit the national recommendations for model programs.
    - Traditional culturally appropriate interventions as well as conventional mental health services need to be available.
    - Higher wages need to be paid to attract and retain underserved populations mental health professionals.

- All staff in the mental health system need periodic and ongoing training in cultural competency and sensitivity pertinent to their roles and responsibilities. The NSMHA needs to encourage and conduct cultural competency and training.

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Introduction

As the 21st century begins, the North Sound Region faces the growing challenge of accommodating an increasingly diverse and evolving constituency. Over 25.6% of the Medicaid eligible population that the public mental health system serves is from a non-white or Latino ethnic/racial group in the North Sound Region. Immigration is now the nation's major source of population growth. In the next 50 years, the US Census Bureau projects that 47% of Americans will be non-white or Latinos. The North Sound Region faces the challenge of providing culturally competent and effective services-regardless of color, ethnicity, language, race, disability, or sexual orientation.

This study is a continuation of the NSMHA's efforts to improve community mental health services to underserved populations. The NSHMA's Strategic Plan 2000-2003 gave the following directions for this study:

Evaluate mental health services for adequacy for ethnic minorities and special populations. *Culturally appropriate services have and continue to be an issue of concern to the NSMHA. A study will be conducted looking at current utilization patterns and gathering input from consumers, especially ethnic minority and special population consumers, advocates, mental health providers and allied system providers to these groups.*
Improve/expand services where deficiencies are found. *Services will be improved to special populations where deficiencies are identified. This work will be continued. Emphasis will also be placed on ethnic groups where numbers of clients served are not meeting parity standards.*

Children, Older Adults, and the Gay, Lesbian, Bisexual, Transgender and Questioning Community were not included in this study because the NSMHA has previously conducted studies of these underserved populations.

The NSMHA would like to thank the members of the workgroup on this project for their time and wisdom. Workgroup members were:

Dan Bilson, Advocate
Dwight Hinton, Consumer (now staff with Lake Whatcom Residential Treatment Center)
Julia Ortiz, Sea Mar Counseling
Mary Tryon, Division of Developmental Disabilities, DSHS
Chris Walsh, Delta Rehabilitation Center
Yu-Ming Zhu, Compass Health
Annette Calder, NSMHA (Staff Support)
Sharri Dempsey, NSMHA
Greg Long, NSMHA

Irina Stepanova of DSHS in Bellingham spoke with the group with passion about the needs and challenges facing the Russian and Eastern European immigrants. Janice Lovelace of Compass Health also attended the November meeting of the workgroup.

This study was comprised of four components:

- **Analysis of Demographic and Utilization Data.**
- **Review of literature-** Of special note are the recent releases of the Surgeon General's ***Report on Mental Health: Culture, Race, Ethnicity*** and the National Technical Assistance Center for State Mental Health Planning's (NTAC) *on* ***Meeting the Mental Health Needs of Asian and Pacific Islander Americans*** and ***Creating Culturally Competent Mental Health Systems for Latinos.*** These studies are national efforts that collected data, research, and expert opinions from across the nation. These taskforces are much larger, but similar processes to this regional workgroup.
- **Survey of professionals and other systems**.
- **Regional workgroup discussions-** The workgroup met four times and discussed issues for each of the underserved populations in our region. They also reviewed the design of the professional survey.

Background

The NSMHA has focused on improving services to underserved populations for years with successes and continuing challenges. All contracted community mental health centers provide counseling services to all of these underserved populations. In addition, specialized programs have been funded and developed to better meet the needs of underserved populations.

The NSMHA has had tribal representation on its Board of Directors since 1998. Snohomish County contracted for years with the Tulalip Tribes for non-traditional, culturally appropriate mental health services and NSMHA has continued this agreement since 1997. NSMHA's tribal liaison conducts monthly tribal meetings, developed and maintains a model 7.01 Plan, conducts multiple clinical trainings, and a yearly tribal conference.

NSMHA has contracted with Sea Mar Community Health Center for culturally competent services for Latinos since 1991. Sea Mar operates programs in Skagit, Snohomish, and Whatcom Counties.

In 1993, NSMHA became aware there was very low utilization of community mental health services by Asian and Pacific Islanders (API). NSMHA developed an RFP and awarded a grant to consortium of community mental health providers to develop an Asian Pacific Islander Mental Health Program. This program continues today through Compass Health as the Multi-Cultural Counseling Program.

The NSMHA has been collaborating with the Division of Developmental Disabilities for the past two years on a special program to lower the number of people with developmental disabilities at Western State Hospital. Another goal of this program is to prevent people with developmental disabilities from going to the state hospital. This program is the result of the Allen class action suit that lead to an agreed order involving both the Division of Developmental Disabilities and the Mental Health Division. These enhanced services includes more intensive case management, specialized behavior management plans, specialized crisis plans, crisis diversion beds, in-home individual crisis aids, specialized medication consultations, and extensive training for mental health, developmental disability, and adult family home providers.

A unique concentration of people with Traumatic Brain Injury (TBI) has developed in the North Sound Region. A brother of the family who owns Snohomish Chalet/Delta Rehabilitation was severely head injured in the 1980's. There was no suitable nursing home or treatment facility for him and other people with the head injuries. The family owners of the Snohomish Chalet shifted the focus of this facility into being the largest nursing home specializing in head injured people west of the Mississippi with approximately 120 head injured residents. Compass Health has a part-time mental health clinician assigned to this facility. The nursing home has also hired a private firm to provide additional mental health services. Enough of these residents become so unmanageable that the North Sound Region has 3-6 people with head injuries at Western State Hospital on a steady basis. The North Sound Region also has a number of people with head injuries living in the community and receiving mental health services.

Parity in Service to Underserved Populations For the North Sound Region

The Surgeon General's report on ***Mental Health: Culture, Race, and Ethnicity*** states that mental disorders are highly prevalent across all populations, regardless of race or ethnicity. The report also relates that within the United States the overall rates of mental disorders for most minority groups are largely similar to those for Caucasians. However, it also states that mental disorders for many smaller racial and ethnic groups, most notably American Indians/Alaska Natives and Asian/Pacific Islanders are not sufficiently studied to permit definite conclusions. Finally, this report finds that people in the lowest stratum of income, education, and occupation are two to three times more likely than those in the highest stratum to have a mental disorder. The public mental health system focuses on serving low-income people.

Prevalence of Underserved Populations

Underserved Population	U.S. Census Prevalence in North Sound Region*	Prevalence in North Sound Medicaid Eligible Population**		Prevalence in North Sound of Mental Health Consumers Receiving Services***
American Indian/Alaskan Native	1.6%	3.1%	*5,846*	2.49%
African American/Black	1.4%	2.43%	*4,470*	2.26%
Asian/Pacific Islanders	4.9%	3.95%	*7,255*	2.28%
Hispanic	5.4%	11.27%	*20,719*	4.26%
Other Race	3.1%	4.80%	*8,816*	3.54%
Eastern European/Russian/Middle Eastern	Not Reported			2.07%
White	86.5%	64.83%	*119,127*	76.1%
Not Reported/Unknown	Not Reported	9.54%	*17,522*	10.8%

* Data is from U.S. Census Bureau, Census 2000, Table DP-1 Profile of General Demographic Characteristics
**Data is from MAA Medicaid Abstract for 2000-2002. Both percentage prevalence and actual number of people who are Medicaid eligible are presented. See attachment #1 for details on Medicaid Eligibles by Race, Age, and County.
***Data is from January-June 2002 from NSMHA Data Base

The table above indicates the public mental health system in the North Sound Region is meeting parity in serving the American Indians/Alaskan Natives, African Americans, and other races when people receiving services are compared against the general population. Parity of service to the general population is not met for Asian and Pacific Islanders and Hispanics. However, the public mental health system focuses predominately on serving people who are on Medicaid so Medicaid parity comparison is an important and higher standard. The public mental health system is not meeting parity for any of these populations when comparisons are made against the Medicaid eligible population. The biggest gaps in parity occur for Hispanics and Asian Pacific Islanders.

Prevalence of developmentally disabled people with mental illnesses

There are 4,263 developmentally disabled people in the North Sound Region who are served by Developmental Disabilities Division of Aging and Disability Services. Data from the NSMHA Information System is difficult to interpret in regard to parity of service to people with developmental disabilities. This data has not been used enough to assure and refine its quality. The mental health information system's categories are overlapping. The information system does show a significant increase in the number of people with developmental disabilities being served by the mental health system in the last year.

People with Developmental Issues Served

	2001	2002
DD-Enrolled in Services	23	92
Development or Intelligence*	397	490

*Category includes (mental retardation, developmental delay, organic brain syndrome, etc.)

In 2002, the specially funded acute mental health services program for adults with developmental disabilities served 128 consumers. Extensive training was done for mental health, developmental disability, and residential staffs, which certainly contributed to this jump in services. However, this specialized program cannot serve children.

Prevalence of People with Traumatic Brain Injury and Mental Illness

Center for Disease Control sponsored studies report annual rates of Traumatic Brain Injury (TBI) of 100 per 100,000 persons based on hospital reports. This study also reports 52,000 annual deaths caused by TBI. Projecting this data over the North Sound Region's population, it can be estimated that there should be 962 people in this Region with serious brain injuries. A workgroup member estimated that 80% of brain-injured people have mental health or behavioral problems so 770 people might be expected to have TBI. However, many of these 770 people may not be eligible for public mental health services or the may not seek services. TBI is in itself not classified as a covered mental illness in the proposed new statewide Level of Care Standards. People with TBI need to have an additional covered mental illness to be eligible for public mental health services. Data on TBI in the NSMHA's Information System is very unclear for people with TBI are listed with other diagnoses. People with TBI may be listed in several different impairment categories so there is not accurate information system data.

A significant percentage of long-term patients at Western State Hospital (WSH) have TBI because their behavior is very difficult to manage. They become too difficult to be handled in nursing homes and other care programs. There is no alternative placement that will accept them. When people with TBI are placed at WSH, they become of concern to the public mental health system for they are long-term utilizers of the most expensive mental health services. Diverting people with TBI from going to WSH and finding places for individuals with TBI that are placed at WSH is an ongoing concern in the North Sound Region.

Review of National Recommendations On Improving Services to Underserved Populations

Repeated studies indicate the prevalence of mental disorders across different populations are similar. Racial and ethnic populations and other special populations consistently utilize fewer services. Shame, stigma, and discrimination are major reasons that all people avoid mental health services. The effects of these negative

public attitudes regarding mental illness is even more powerful on these special populations for they may already be struggling with stigma and discrimination because of their race, ethnicity or disability. Services need to be provided in a manner that is aligned, rather than in conflict with cultural norms. The capacity of the provider to convey knowledge, understanding and respect for the client's worldview and experiences are factors in engagement and positive outcomes. Recommendations coming from the Surgeon General's report-***Mental Health: Culture, Race, Ethnicity*** and the ***Cultural Diversity Series*** produced for the National Technical Assistance Center for State Mental Health Planning to improve services to underserved populations include:

- **Allocate sufficient funding for prevention, early intervention, and outreach programs.** Arrange for these programs to be developed and conducted in partnership with community-based non-mental health agencies serving the specific underserved populations.
- **Programs and clinical services should build on intrinsic community strengths such as spirituality, positive ethnic identity, traditional values, educational attainment and local leadership.** The resilience of many of the members of these underserved populations is a resource from which much can be learned and a strength that needs to be built upon for individuals and for each underserved population.
- **Incorporate traditional cultural treatment modalities into assessment and treatment.**
- **Use community-based family therapy interventions whenever possible.** Include family members and natural supports as appropriate in assessment and treatment.
- **Provide mental health services at convenient locations and in natural settings** (e.g. churches/temples, schools, community centers).
- **Integrate mental health and primary care.** Many underserved populations are more likely to define their illnesses in terms of physical symptoms and seek services from primary care providers. Many in these groups feel less stigma and greater trust in receiving mental health services in primary care settings.
- **Develop specialists or special programs to address problems that frequently affect the specific underserved population (**refugee trauma, co-occurring disorders, problem-gambling, etc.). A Mental Health Specialist experienced in working with the particular underserved population should conduct or oversee the assessment and treatment.
- **Ensure language access.** The ideal treatment arrangement is to have a clinician who speaks the same language and is from the same culture. The second best option is to have a mental health specialist who is knowledgeable about the individual's culture and has specialized training in working with specific underserved population. Organizations receiving federal funding legal have to provide translation services from a certified translator.
- **Partner with other agencies, such as education, rehabilitation and substance abuse, to create comprehensive, integrated service models.**

- **Recruit underserved populations professionals for clinical and leadership positions in the mental health system.**
- **Develop or obtain culturally and linguistically appropriate written mental health materials for consumers from underserved populations and their families.**
- **Empower consumers of underserved populations, their family members, and community-based organizations to lead the mental health agenda.**
- **Provide, support and encourage cultural competency training to clinical, support, and managerial staff in the community mental health system.** 3-5 hours of training each year is recommended for all staff as a minimal cultural competency standard.
- **Provide specialized training for clinical and medical staff working with underserved populations.** There is emerging evidence that underserved populations are more frequently misdiagnosed; there is differential effectiveness of treatment techniques across different populations; and there maybe differing medication dosage needs. Extensive training as well as experience in serving a specific underserved population is needed to assure cultural competency.

Satisfaction Survey

Originally in the design of this study, money was budgeted to conduct a survey of underserved populations. The workgroup decided there was likely to be little value gained by another consumer survey. The Quality Review Team (QRT), Provider agencies, and MHD regularly survey consumers. In addition, the workgroup's thinking was that cultural traditions and trust make it unlikely that consumers from underserved population in these programs would openly express dissatisfaction with these programs. Many of the consumers that would be surveyed are getting services from specialized programs designed to serve them.

QRT have surveyed 32 individuals who are specifically identified as African American/Black, American Indian/Alaskan Native, Asian/Pacific Islander, and Hispanic/Latino. The average consumer satisfaction score for this group was 74% mostly or completely satisfied. That score is very similar to the overall averages of consumer satisfaction scores for all consumers in the North Sound Region. QRT also surveyed 50 people identified as developmental disabled. Their average satisfaction score was slightly higher at 76%. 29 consumers from these underserved populations who are living in mental health residential facilities were surveyed. Their average satisfaction scores were slightly lower at 68%.

Sea Mar conducted a 32-question client satisfaction survey in 2002. 44 consumers were surveyed in Snohomish County and Whatcom County. Satisfaction scores of satisfied or very satisfied were in the high 80s or 90s percentages on most scales. The only low scores were in the high 70s. The low scores were on the following questions:

- The services provided to me are helpful and effective 77%

- I am aware of how to file for a grievance 77%

On average, underserved population consumers seem to be as satisfied or more satisfied with public mental health system services as all other consumers.

Survey of Professionals and Other Systems

A survey of all stakeholders was constructed by the workgroup and circulated to mental health consumers, mental health advocates and professionals. Professionals working in the mental health, schools, Children's Administration, Division of Developmental Disabilities, Division of Alcohol and Substance Abuse systems received surveys. Over 600 surveys were distributed. The majority of respondents answered the survey on our website. There were 187 responses and 6 that had to be disregarded because they were not filled out appropriately. People affiliated with the mental health system completed 108 of the surveys and 79 people identified themselves as being connected with other systems. The questionnaire had eleven scales to rate their satisfaction and an area for comments.

Stake Holders' Survey Questions	Very or somewhat Satisfied	Somewhat or Dissatisfied
How satisfied are you that consumers in underserved populations can easily obtain services?	**51.2 %**	**37.42%**
How satisfied are you that case managers, therapists or counselors are willing to help as often as consumers in underserved populations need?	**54.01%**	**35.83%**
How satisfied are you that case managers, therapists, or counselors are willing to help consumers in underserved populations with whatever they need? *(Social Security applications/spend-downs, housing, return phone calls, referrals for legal services, etc.)*	**54.01 %**	**33.16%**
How satisfied are you that case managers, therapists or counselors for consumers from underserved populations have the skills themselves or make reasonable accommodations for consumers' special needs? *(Interpreter, TTY, Specialist Consultations, etc)*	**58.29%**	**28.87%**
Have consumers you worked with from underserved populations ever contacted the Crisis Line?	**Yes: 66.31%**	**No: 9.09%**
How satisfied were you with the services that consumers from underserved populations receive from the mental health crisis line?	**48.12%**	**20.32%**
How satisfied are you that the crisis line staff has the skills or made reasonable accommodations for consumers special needs? *(Interpreter Services, TTY, Special Consultations, etc.)*	**37.70%**	**15.51%**
How satisfied are you that mental health services help consumers from underserved populations reach their goals of a meaningful life? *(Independent living, employment, improved family and social relationships, etc.)*	**51.33%**	**38.5%**
As a whole, how satisfied are you that the mental health services are helping consumers from underserved populations to manage their illness, feel better about themselves and have hope for the future?	**52.51%**	**40.11%**
As a whole, how satisfied are you that all mental health staff, including case managers, therapists, prescribing physicians and nurses are courteous and treat consumers from underserved populations with dignity and respect.	**70.06%**	**21.93%**

Discussion of Survey

Generally, these satisfaction scores are fairly low as compared with consumer satisfaction scores which rate in the 70% or above ranges. The NSMHA has found from previous studies that scores are lower in cross-system evaluations such as the cross-system evaluations of NSMHA and APN as well as the Access Review and the nursing home satisfaction with crisis services review. Some of this frustration from staff in allied systems may stem from the increasingly restrictive eligibility criteria for the public mental health system. The growing number of consumers who need services but don't qualify has to be frustrating to other systems. Staff of other systems may also have to accept the limitations of the effectiveness of current mental health treatments. Mental health treatments are effective on many people, yet a significant number of people do not respond rapidly.

The Multi-Cultural Counseling Program at Compass Health in Everett, Sea Mar's programs and the Acute Services for the people with developmental disabilities programs have features of model national programs. The sophisticated multi-cultural mental health program in Everett is not available in all areas of the Region. The low score for the Crisis Line is also surprising for this program generally gets high ratings and is well regarded. It is important that people believe that the underserved populations are treated with dignity and respect. This is a critical value to build upon. These scores mean there is significant room for improvement in services or people's perceptions of these services. These scores will be reviewed with providers and suggest a need for further inquiry and possible quality improvements.

Open-ended Questions from the Survey

What would you change about the way mental health services for consumers from underserved populations are provided?	Percentage of Votes
More awareness about the availability of mental health services	52.41%
Counselors need to know more about the consumers' special needs or culture.	48.66%
More services in the consumers' home or in the community	47.59%
Services more rapidly available	45.99%
Greater sensitivity to individual's needs rather than paperwork requirements	42.25%
More involvement of consumer's family in treatment	37.97%
Better transportation	33.16%
More frequent appointments	31.02%
More counselors speaking consumers' native language	31.02%
More traditional holistic services	27.27%

The survey indicates a range of ideas on how to improve services with no issue getting significantly over half of the respondents support. The greatest needs identified were for greater awareness of services, greater availability of services, and more services in the home or community also support the notion of more outreach and community involvement. This fits the national recommendations and the recommendations of the workgroup. The low level of support for holistic and traditional treatment approaches is surprising and runs counter to the recommendations in the national literature and the

workgroup. Concerns about the burden of paperwork emerged in this survey and in the workgroup. The NSMHA has already committed to conducting another review to see what paperwork can be reduced.

Comments Section of the Survey
In the written comments, again no issues emerged as top priority recommendations. The re-occurring themes were:

- More specialized services are needed for these and other underserved populations (Older adults, 0-3 year old kids, and PTSD consumers)
- More intensive services are needed.
- Case managers need to have smaller caseloads.
- More outreach is needed and services offered at more sites.
- More housing is needed.
- Less paperwork. The paperwork is counterproductive with these underserved populations.

Issues Emerging from the Workgroup

Several overarching themes emerged from this group as well as issues for each of the specific group. The workgroup emphasized that all of the groups face significant stigmatization on a daily basis due to their race, ethnicity, culture, or disability. Many consumers from underserved populations approach mental health treatment struggling with these prejudices and the further stigma of being poor. If they admit to having a mental illness, they face another layer of stigmatization. It is understandable that a relationship must be established and high degree of trust must be developed before people will engage in mental health treatment.

More outreach is needed to engage underserved populations. Workgroup members believe outreach and community-building efforts builds the trust and credibility that is a prerequisite before underserved populations will engage in treatment. Examples of this type of community building outreach include the yearly tribal gathering that community mental health funding has helped support on the Tulalip Tribes Reservation, family support and resource groups for Hispanics lead by Sea Mar in the Bellingham schools and cooking groups as well as cultural holiday celebrations supported by the Multi-Cultural Program staff at Compass Health. Workgroup members fear that the pressures of scarce and declining funding along with the pressures from organizations in this era of managed care for productivity will lead to declining commitment to outreach when increased levels of outreach are needed to achieve parity.

Language barriers and getting good interpreters is a challenge. The NSMHA's contract with MHD and federal requirements mandate that certified interpreters be used when working with a person of another language. The best solution is to have a clinician who speaks the language of the consumer and knows their culture. All of Sea Mar's clinical staff speak Spanish fluently. Clinical staffs speak more than twelve languages across the Region. However, there are so many languages spoken across our Region, it is not practical to have clinicians fluent with the many languages of people requesting services from providers across the Region, especially at the multiple service locations. Compass Health alone is averaging spending more than $5,000 per month for interpreters. Working with interpreters is challenging for they are not mental health professionals.

Much can be lost in the interpretation and even more in the subtleties of intonation and non-verbal communications as well as unique cultural and familial considerations.

Providers are having difficulty hiring special population mental health professionals. Salaries in human services and mental health are so low that many people from these groups or with specialized language skills choose to work in other industries. Mental health training programs across the nation are not attracting or graduating enough people committed to working with these underserved populations. Creative approaches are needed to hire and retain these scarce professionals. Group members believe wage differentials need to be paid to attract and retain underserved population professionals as an initial effort.

African American Issues

- African American mental health issues can only be understood in light of both the history of discrimination and the appreciation of the ongoing daily subtle discriminations. The impact of discrimination on the African American family shapes the relationships and mental health of all African Americans.
- African Americans are likely to be under diagnosed and underserved for both physical and mental health disorders.
- In light of this, African American's are more likely to trust and want to work with other African Americans.

American Indians/Alaskan Native Issues

- More traditional healing services should be offered. The small traditional healing funding that is received by the Tulalip Tribes should be replicated for other tribes.
- Mainstream community mental health provider clinicians need to understand the value of traditional healing and make referrals for it.
- Tribes feel strongly that specialists with documented experience working with American Indians and Alaskan Natives should be the standard of care.
- The 7.01 Plan in the North Sound Region is a model one for the State and appreciated by the tribes. Future 7.01 Plans will have tighter and stronger language. This will place more demands on the public mental health system.
- American Indians and Alaska Natives believe that more of their people need to be hired by community mental providers to make these organizations more sensitive to the needs of American Indians and Alaska Natives.
- American Indians and Alaska Natives are plagued by high rates of suicide, homicide, accidental deaths, domestic violence, child abuse and alcoholism as well as other social problems. It has been suggested in many studies that racism and oppression, including internalized oppression are continuous forces, which exacerbate these destructive behaviors. It has also been documented these social ills are primarily the product of a legacy of chronic trauma and unresolved grief across generations that has been undiagnosed or under diagnosed.

Asian and Pacific Islander Issues

- There is enormous diversity in the different Asian and Pacific Islander cultures so grouping them together is a major oversimplification.

- Mental Health is a foreign concept in many Asian and Pacific Islander cultures. Frequently, psychiatric problems will be experienced or voiced as physical health problems. This means that much outreach is needed to engage this group in treatment. Treatment also needs to be in collaboration with primary health care providers.
- Family is a very strong value in Asian and Pacific Islander cultures. Thus, families should be incorporated in treatment when ever possible and appropriate. Engaging these families is difficult for mental health treatment may not be part of their culture and may even be a taboo concept.
- Asian children and adults feel tremendous respect, responsibility, and pressure to honor their elders. This is a major factor in treatment.

Issues for People with Developmental Disabilities

- More services are needed for children with developmental disabilities. These services work well if they are provided in conjunction with schools.
- Developmental disability professionals still believe that mental health clinicians too rapidly discount unusual or aggressive behavior as "DD" rather than assessing for underlying mental illnesses. This issue has gotten much better with the special acute mental health services program, but the issue remains a concern.
- Depression is a common diagnosis among people with developmental disabilities and may be under-diagnosed.
- People with developmental disabilities need more time for sessions and more frequent sessions.
- People with developmental disabilities feel like they are outsiders frequently in their lives. Hence, they value get-togethers and community-building activities.
- People with developmental disabilities do well in groups. They want and need life skill classes to grow.

Issues for People with Head Injuries

- Short-term memory loss is one of the most common symptoms of Traumatic Brain Injury. This means that traditional counseling techniques may not be effective. Specialized mental health treatment approaches are being developed.
- People with head injuries require more time and repetition in treatment.
- People with head injuries require much cueing. Eventually they can learn to cue themselves.
- The general population needs to be educated about brain injuries. People need to know about the problems of brain injury so they take appropriate precautions for themselves and loved ones. People also need to know about brain injuries so they relate effectively to the increasing numbers of people with brain injuries.

Hispanic Mental Health Issues

- There is enormous diversity in the different Hispanic cultures so grouping them together is a major oversimplification.
- Mental health organizations and clinical staff have to become part of the Hispanic community before many Hispanic people will engage in counseling services. This

type of community involvement does not directly produce clinical hours of services and thus not valued as an essential part of providing counseling services to Hispanics.

- Engaging Hispanic people in mental health services takes much time in building trust and developing relationships. This process takes time and money. Helping people with practical problems such as food, housing, and legal problems needs to occur before people will engage in mental health treatment.
- A majority of Hispanic people who enter mental health services engage briefly to resolve a crisis or problem.
- Family is a strong value in Hispanic cultures. Thus, families should be incorporated in treatment when ever possible and appropriate. Engaging these families is difficult for mental health treatment may not be part of their culture.
- Psychiatric problems may be experienced or voiced as physical health problems more frequently amongst Hispanic people. Treatment needs to be in collaboration with primary health care providers. This also means that much outreach is needed to engage this group in psychiatric treatment.

Recent Immigrants and Their Mental Health

In the last twenty years, many immigrants have come to the United States and this Region from Spanish-speaking countries, Asian, and more recently from Eastern Europe, Russia, and the Middle East. Major problems facing these immigrants are culture shock, poverty, and the language barrier. The children frequently pick up the language in school or from peers. However, for adults over 40 years of age the language barrier is difficult and many never quite adjust. Immigrants tend to view their mental health problems as physical health problems. Depression and adjustment disorders are common but not often viewed as mental health problems. Mental illnesses are viewed as diseases of the rich or a weakness. Immigrants tend to turn to their religious leaders for help with these problems rather than seek public mental health services.

Conclusion and Recommendations

Sea Mar's services for Hispanic people, the Multi-Cultural Counseling Program at Compass Health in Everett, and the acute care services for people with developmental disabilities are model programs, which meet many of the national recommendations for model programs. Considerable effort and resources have been committed to developing services for underserved populations.

The following recommendations are based on best practices reported in the national literature on underserved populations and on the opinions of local professionals specializing in serving these populations. These recommendations outline best practice ideals and are not constrained by financial considerations. These recommendations will

have to be considered, prioritized, and implemented under the current shadow of enormous financial deficits for mental health services:

- Special and additional outreach and engagement efforts are needed to increase the number of underserved population consumers in community mental health services. *More intensive and long-term, community-building outreach efforts are necessary to engage underserved populations than the general population. Outreach can be accomplished by partnering with agencies well established and accepted in serving the underserved group's community. Providing services in community settings trusted by members of the underserved population is another recommended strategy.*
- Services to Hispanics and Asian Pacific Islanders should be emphasized at this time because these two ethnic groups have the biggest gaps in parity of services.
- Services are best provided by programs and clinicians specializing in working with the specific underserved population. Underserved population consumers are most likely to engage in treatment when they are working with a clinician of similar culture, language, and backgrounds.
- Efforts need to continue and be increased in hiring or training of mental health clinicians who are people of color or ethnic backgrounds.
- Traditional cultural interventions as well as conventional mental health services need to be available to these people from underserved groups.
- Creative approaches are needed to attract and retain underserved population mental health professionals. This includes but cannot be limited to wage differentials for these scarce professionals.
- All staffs in the mental health system need periodic and ongoing training in cultural competency and sensitivity pertinent to their roles and responsibilities. The NSMHA needs to encourage and conduct cultural competency and training. 3-5 *hours of training is recommended per year for all staff as a minimal cultural competency standard.*
- There are a significant but undetermined number of people with head injuries in the Region who might benefit from mental health services. This group has not been prioritized in the state service priorities. This deficit in services may have to be addressed at some time in the future.

Exhibit 1: Count of Medicaid Eligibles by Race, Age Group, and County for 2002

Sum of CountOfPIC		County							
Race	Age Group	ISLAND	Out Of RSN	Out of State	SAN JUAN	SKAGIT	SNOHOMISH	WHATCOM	Grand Total
Afric Amer	0-17	168	407	20	1	91	1634	167	2488
	18-59	109	337	24	4	70	1122	195	1861
	60+	6	8			2	98	7	121
Afric Amer Total		283	752	44	5	163	2854	369	4470
Amr Indian	0-17	42	291	18	9	414	1335	1159	3268
	18-59	28	208	8	12	323	862	844	2285
	60+	1	7	1	1	60	102	121	293
Amr Indian Total		71	506	27	22	797	2299	2124	5846
Asian Amer	0-17	113	197	27	9	92	2959	382	3779
	18-59	78	162	10	3	69	1485	226	2033
	60+	57	69	7		27	1160	123	1443
Asian Amer Total		248	428	44	12	188	5604	731	7255
Caucasian							1		1
	0-17	3257	4596	500	911	7457	33721	11214	61656
	18-59	2300	4719	355	491	5766	23956	8691	46278
	60+	563	492	42	143	1415	6239	2298	11192
Caucasian Total		6120	9807	897	1545	14638	63917	22203	119127
Hispanic							1		1
	0-17	437	825	127	86	4587	5703	2483	14248
	18-59	218	427	51	36	1759	2224	1172	5887
	60+	13	16	7	4	164	223	156	583
Hispanic Total		668	1268	185	126	6510	8151	3811	20719
Other	0-17	152	326	46	46	778	3331	1100	5779
	18-59	67	196	25	12	242	1494	426	2462
	60+	3	34	2	2	46	401	87	575
Other Total		222	556	73	60	1066	5226	1613	8816
Unknown							1		1
	0-17	503	270	60	80	576	3368	1665	6522
	18-59	390	434	221	213	1198	3975	4165	10596
	60+	21	17	29	2	28	208	98	403
Unknown Total		914	721	310	295	1802	7552	5928	17522
Grand Total		8526	14038	1580	2065	25164	95603	36779	183755

NORTH SOUND REGIONAL SUPPORT NETWORK

COMMUNITY MENTAL HEALTH PROGRAM SERVICES CONTRACT

WITH

ASSOCIATED PROVIDER NETWORK

JANUARY 1, 2002 TO DECEMBER 31, 2003

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AGREEMENT FOR THE PROVISION
OF
OUTPATIENT MENTAL HEALTH REHABILITATION SERVICES,
INTEGRATED CRISIS RESPONSE SERVICES
AND
COMMUNITY PSYCHIATRIC INPATIENT CARE

BETWEEN

NORTH SOUND REGIONAL SUPPORT NETWORK (NSRSN)

AND

ASSOCIATED PROVIDER NETWORK (CONTRACTOR)

THIS MENTAL HEALTH SERVICES AGREEMENT (the "Agreement"), pursuant to Chapter 71.24 RCW and all relevant and associated statutes, as amended, is made and entered into by and between the NORTH SOUND REGIONAL SUPPORT NETWORK ("NSRSN"), 117 North 1st Street, Suite 8, Mount Vernon, Washington 98273, and ASSOCIATED PROVIDER NETWORK ("CONTRACTOR") L.L.C., 413 Gates Street, Suite A, Mount Vernon, Washington 98273.

The effective date of this Agreement is January 1, 2002 through December 31, 2003.

A. BACKGROUND, MUTUAL COMMITMENTS AND PURPOSE

Background. The NSRSN is a group of county authorities (recognized and certified by the Secretary of DSHS) which have entered into joint operating agreements to contract with the Secretary pursuant to RCW 71.24.025(13), to operate a single managed system of services for persons with mental illness living in the service area covered by Island, San Juan, Skagit, Snohomish and Whatcom Counties. The NSRSN is party to an interagency agreement with the State of Washington Department of Social and Health Services ("DSHS"), pursuant to which the NSRSN has agreed to provide integrated community support, crisis response and inpatient management services to people needing such services in its Service Area. The NSRSN, through this agreement, is subcontracting with CONTRACTOR specific integrated community support, crisis response, and inpatient management services. CONTRACTOR, by signing this agreement, attests that they are willing and able to provide such services in the NSRSN Service Area.

Mutual Commitments: The parties to this Agreement are mutually committed to the development of an efficient, cost effective, integrated, consumer-driven, recovery model approach to the delivery of quality community mental health services. To that end, the parties are mutually committed to maximizing the availability of resources to

provide needed mental health services in the Region, maximizing the portion of those resources used for the provision of direct services and minimizing needless duplication of effort.

Purposes. The purposes of this Agreement are for the CONTRACTOR to:

1. Provide in the NSRSN Service Area age, culturally, and linguistically competent community mental health services for consumers who experience mental disorders or who are severely emotionally disturbed; and those they define as family (e.g. parents, foster parents, assigned/appointed guardians, siblings, caregivers and significant others) pursuant to:
   - RCW 38.52, 70.02, 71.05, 71.24, and 71.34, or their successors;
   - WAC 388-865 or any successors;
   - Federal Public Law 102-321 (Federal Block Grant), or their successors;

2. Provide outpatient mental health rehabilitation services, crisis response services, and community psychiatric inpatient care services, under a Prepaid Health Plan managed care system to eligible Medicaid recipients.

3. Services shall be provided in an efficient and effective manner so as to demonstrate sufficient amount, intensity, duration, and scope to assist and support consumers to function at their highest possible level, given the severity of their disorder, in the least restrictive setting of their choice.

4. Comply with all applicable law and standards including, but not limited to: WAC 388-865-0200, -0210, -0220, - 0222, -0230, -0250, -0255, -0260, -0275, -0280, -0284, -0350, -0410, -0438; 42 CFR 434. (a-e), .4,.6,.32,.36,.53,.70,455,.456; 42CFR 422.28,; 42CFR 455.1, 42 CFR 489, SMD 12/30/97; SMM 2081.2, 2087.4, 2088.7, 2090.1; ADA; the Waiver, or their successors.

5. Provide a system that promotes rapid and successful integration of services and supports and provides for continuity of care.

6. Ensure service recipients and advocates are represented in the ongoing process of planning, implementation, operation and evaluation of CONTRACTOR's system.

7. Provide an integrated, coordinated and seamless voluntary and involuntary[1] crisis response system for the NSRSN and its member counties in accordance with, RCW 71.24, , RCW 71.05 ,RCW 71.34 and WAC 388-865 or their successors.

8. To evolve the public system to national standards for behavioral healthcare and a state of the art system through incorporation of private sector business and managed care practices

[1] Excludes Snohomish County ITA, VOA Care Crisis System

9. To assure the State of Washington mental health system mission statement, value statement and the guiding principles for the system, attached hereto as Attachment I, are recognized as the basis of all aspects of service delivery, system capacity building, and implementation of this Agreement.

10. To assure that the NSRSN Core Values and Principles attached hereto as Attachment II are recognized and apparent in all aspects of service delivery system, capacity building and implementation of this Agreement.

Any provision of this contract which conflicts with federal Medicaid statutes, regulations, CMS (formerly known as HCFA) policy guidance, or minimum requirements of DSHS/MHD Integrated Services Contract with NSRSN is hereby amended to conform to the provisions of the laws, regulations, federal policy and minimum DSHS/MHD Contract obligations. Such amendment of this Agreement will be effective on the effective date of the statutes, regulations or DSHS/MHD contract 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. The NSRSN may require the CONTRACTOR to perform obligations in addition to and/or at a higher standard than federal Medicaid statutes, regulations, CMS policy guidance or the minimum requirements of DSHS/MHD Integrated Services Contract with NSRSN. Such additional obligations and standards shall not be misconstrued as conflicts with the statutes, regulations, etc. stated in this paragraph.

All rights and obligations of the parties to this agreement shall be subject to and governed by the terms and conditions contained in the text of this Agreement, including exhibits and attachments.

B. CONTRACTOR DUTIES AND RESPONSIBILITIES

Throughout the entire term of this Agreement (unless otherwise expressly provided herein), including any extension or renewal, CONTRACTOR shall furnish, either directly or through subcontract, the necessary personnel, materials and/or services and otherwise do all things necessary for, or incidental to, the performance of the following duties and responsibilities, including all exhibits and attachments provided herein.

CONTRACTOR shall include community and county input into planning and access to services.

CONTRACTOR shall be held fully responsible for the contractual obligations and performance by its members, affiliates and subcontractors.

- **Provider Network.** CONTRACTOR shall have and maintain an effective, efficient adequate and accessible provider network that is licensed/certified, monitored and capable of providing comprehensive services and be able to demonstrate its ability to carry out the functions required by this Agreement.

- **Covered Services.** CONTRACTOR shall provide to Medicaid Recipients and Other Eligible Recipients in the Service Area those medically necessary mental healthcare services in accordance with this Agreement and the NSRSN Standards of Care, Exhibit H, that are requested by or on behalf of such individuals in accordance with the benefit package and eligibility provisions of Table A, page 10. Such services shall include but not be limited to those services described in WAC 388-865 and the integrated community mental heath services detailed in the State Medicaid Plan.

Covered Lives

CONTRACTOR shall provide services to the following groups of persons:

- Medicaid enrollees of all ages including but not limited to:
  - Medicaid special health care needs populations defined by CMS
    - SSI beneficiaries of all ages
    - Children including:
      - ✓ foster children
      - ✓ children in adoption support
      - ✓ children who are blind
      - ✓ children who are disabled
      - ✓ children on Title V
    - Adults 65 years of age or older
  - Enrollees who reside within the CONTRACTOR's service area
  - Children who are Medicaid enrollees with "D" coupons or its legal substitute, or other evidence of placement by DSHS, without regard to the child's original residence
  - Enrollees identified pursuant to RCW 72.09.370 or any successor as Dangerous Mentally Ill Offenders (DMIO).
- "Priority populations: Acutely mentally ill individuals, chronically mentally ill adults, severely emotionally disturbed children, and seriously disturbed children" as defined in RCW 71.05, 71.24, 71.34; WAC 388-865-0215; or their successors. This includes persons identified as meeting the priority population definitions who are also identified pursuant to RCW 72.09.370 as Dangerous Mentally Ill Offenders (DMIO).

Table A, page 9, defines the types of services that are to be available in accordance with NSRSN Standards of Care Manual.

Table A

POPULATIONS TO BE SERVED

I. All Persons As Needed	***Medicaid Enrollees***	***Non-Medicaid, Low Income Persons with Chronic & Serious Mental Illness***
Emergency Crisis Intervention *Disaster Mental Health Services* *ITA Administration*	*Emergency Crisis Intervention* *Disaster Mental Health Services* *ITA Administration*	*Emergency Crisis Intervention* *Disaster Mental Health Services* *ITA Administration*
Involuntary Hospitalization: ♦ *State Hospitals* ♦ *Community Hospitals*	*Involuntary Hospitalization:* ♦ *State Hospitals* ♦ *Community Hospitals*	*Involuntary Hospitalization:* ♦ *State Hospitals* ♦ *Community Hospitals*
	PLUS: *Community Support Services* *Voluntary Hospitalization* ♦ *State Hospitals* ♦ *Community Hospitals* *Rehabilitation/Support Services Including:* ♦ *Housing* ♦ *Employment* *Engaging High Need Populations*	*PLUS (Within Available Resources):* *Community Support Services* *Voluntary Hospitalization* ♦ *State Hospitals* ♦ *Community Hospital* *Rehabilitation/Support Services Including:* ♦ *Housing* ♦ *Employment* *Engaging High Need Populations* *Assisting with Entitlements*

Non-Medicaid service recipients shall be defined as those who are acutely or chronically mentally ill adults, children/youth who are severely emotionally disturbed and individuals at risk for hospitalization, jail, losing their homes or access to basic human needs (food, clothing, warmth).

1. OUTPATIENT/COMMUNITY SUPPORT SERVICES

   CONTRACTOR shall provide Outpatient/Community Support Mental Health Services as required in this Agreement and in the NSRSN Standards of Care, or its successor, in compliance with: WAC 388-865- 0200, -0225, -0230, -0235, -0240, --0255, -0286 -0320, -0363, -0425,- 0430, -0452; RCW 38.52, 71.05, 71.24.025(7), 71.34; 42 CFR 434.25 (b), .27 (a-c), .30 (b-c), 42 CFR 436(6)(a)(2); 42 CFR 456.150-160; SMM 2080.6, 2088.2, 2088.3, 2090.4, 2090.12; the Waiver; or their successors.

The CONTRACTOR agrees to:

a. Provide for reasonable and adequate hours of operation including 24-hour, 7 days per week availability of information, referral, and emergency services.

b. Report each biennial quarter (July 1, 2002; January 1, 2003; July 1, 2003; January 1, 2004) the number of known consumers or parents of consumers employed by the CONTRACTOR and/or providers;

c. Report each biennial quarter (July 1, 2002; January 1, 2003; July 1, 2003; January 1, 2004) CONTRACTOR/provider opportunities for volunteer work for youth, adults, and older adults who are consumers;

d. Ensure that when Medicaid consumers must travel to service sites, they are accessible per the following standards:

   1. in rural areas, service sites are within a 30-minute commute time;
   2. in large rural geographic areas (e.g. ferry transportation areas), service sites are accessible within a 90-minute commute time;
   3. in urban areas, service sites are accessible by public transportation.

   Travel standards do not apply: a) when the consumer opts to use service sites that require travel beyond the standards; b) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, delayed ferry service).

e. Ensure that qualified professional personnel, including mental health specialists, are involved at critical treatment junctures.

f. Pay for consumer's medically necessary services outside of the service area in a timely manner if the provider network is unable to provide the services covered under the Agreement. The CONTRACTOR shall continue to pay for services outside the service area until the CONTRACTOR is able to provide them within its service area. CONTRACTOR, its members and affiliates shall abide by NSRSN complaint and grievance determinations

g. Pay for half of the fair hearing cost when the ruling favors the CONTRACTOR, its member or affiliate. Pay for 100% of the cost of any fair hearing when the ruling favors the consumer.

h. Pay for half of the NSRSN grievance settlement when the ruling favors the CONTRACTOR it's member or affiliate. The CONTRACTOR shall be responsible for paying 100% of cost of NSRSN's grievance settlement when the ruling favors the consumer request.

i. Fraud and Abuse
Develop and implement administrative and management procedures that are designed to guard against fraud and abuse including:

   1. A mandatory compliance plan;

2. Written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable federal and state standards;
3. Designation of a compliance officer or a compliance committee that is accountable to the CONTRACTORs;
4. Effective training and education for the compliance officer and the CONTRACTOR's providers, members and affiliates;
5. Effective lines of communication between the compliance officer and the CONTRACTOR's network of providers, members and affiliates;
6. Enforcement of standards through well-publicized disciplinary guidelines;
7. Provision of internal monitoring and auditing;
8. Provision for prompt response to detected offenses and for development of corrective action initiatives;
9. Participation by the CONTRACTOR and subcontractors in Medicaid fraud and abuse training conducted by the Washington State Attorney General's Medicaid Fraud Unit.
10. Submit CONTRACTORs compliance plan, policies and procedures to the NSRSN by July 1, 2002.
11. Report fraud and/or abuse information of the CONTRACTOR its members, affiliates or subcontractors to NSRSN as soon as it is discovered or suspected, including the consumer name/ID number if applicable, the source of the complaint, type of provider, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

j. Implement effective policies and procedures that ensure consumers and their families are free from retaliation (or the perception of retaliation) for accessing services and protections outlined in this Agreement. Submit CONTRACTOR's policies and procedures to NSRSN by April 1, 2002. In collaboration with NSRSN, consumers, advocates, and other NSRSN contracted providers develop and implement effective policies and procedures that ensure consumers and their families are free from retaliation (or the perception of retaliation) for accessing services and protections outlined in this Agreement by October 1, 2002.

k. Ensure Healthy Options enrollees are informed of their choice to receive mental health services either through the CONTRACTOR or the Healthy Options enrollee's managed care plan. The enrollees shall be informed in a manner that in no way limits or directs their choice. The CONTRACTOR or its subcontractors may refer and transition those consumers who are enrolled in Healthy Options (H.O.) Plans when: a) the consumer is stabilized; b) their needs can be covered with services available from the H.O. Plan (e.g. medication management).

l. Ensure consumers, and families of children under age 18, receive assistance to obtain state and federal entitlement programs.

m. Notify the NSRSN of any incident where the potential for negative media coverage exists, including the unexpected death of a consumer served by the CONTRACTOR and as required in the NSRSN Critical Incident Policy, Attachment IV. Phone notification shall be made to the NSRSN Executive Director or his/her designee on the day the CONTRACTOR becomes aware of such an event. Notification shall include a description of the event, the actions taken for what purpose or end, implications to the service delivery system, and efforts designed to prevent or lessen the possibility of future similar incidents.

n. Submit a report to the NSRSN by July 15, 2002 and 30 days prior to implementation and/or public notice when the CONTRACTOR, members and/or affiliates add, change location, or close a facility, and when the number of staff type/specialty changes at any CONTRACTOR facility by 10% or more. The report shall identify each CONTRACTOR, including member and affiliate, facility location/address and the number and F.T.E. of individuals providing direct services who are employed or contracted at each location by type/specialty (e.g. PCP, MHP, MHS-child, MHS-DDD, MHS, older adults, psychiatrist, etc.)

o. It is the responsibility of the CONTRACTOR to ensure a sufficient number, mix and geographic distribution of direct service providers and PCPs to meet access, age, cultural, quality of care, range of services – including preventative care, case management, and specialty services.

p. Participate with the NSRSN in the development of service delivery protocols for the coordination and integration of services for consumers with multiple needs including:

    - Children (including, but not limited to, Native American/Indian children and children served by DSHS Juvenile Rehabilitation Administration and Children's Administration);
    - Adults and older adults served by DSHS Aging and Adult Services Administration.

q. Notify the NSRSN 30 days in advance of public notice if the CONTRACTOR terminates any of its direct care mental health services subcontracts.

r. Submit data on the number and disposition of complaints and grievances in accordance with Attachment XVI or its successor. The report for July through December is due to the NSRSN by February 1 of 2002 and 2003; the report for January through June is due by August 1 of 2002 and 2003.

s. Provide immediate on-site disaster mental health services to the community at large in the event of a community crisis (e.g. series of suicides or deaths or acts of terrorism) or disaster (e.g. earthquake, flood). The CONTRACTOR shall begin assessing the local need for post-disaster needs (e.g. emergency counseling, support services) while out in the service area and through key informant interviews with disaster responders. The CONTRACTOR shall coordinate and document efforts with the NSRSN, MHD, emergency management, FEMA, American Red Cross, and other volunteer organizations when those agencies are involved in the local area.

t. In the event of a State of Emergency or disaster proclamation by the President and/or Governor the CONTRACTOR shall provide to the NSRSN the name and contact information for person(s) coordinating each NSRSN county response and provide information on those local needs and preliminary plans to address them. The CONTRACTOR shall coordinate and document efforts with the NSRSN, MHD, emergency management, FEMA, American Red Cross, and other volunteer organizations when those agencies are involved in the local area.

2. INITIAL AUTHORIZATION and CONTINUED SERVICE AUTHORIZATION

a. In accordance with NSRSN Standards of Care Manual CONTRACTOR shall:

1. Provide the Initial Authorization, Continued Service Authorization and ITCP approval process for CONTRACTOR service recipients consistent with NSRSN Standards of Care, or its successor.
2. Provide access and assessment services consistent with the delivery system requirements in the NSRSN Standards of Care.
3. Implement operational policies, procedures and protocols that meet the requirements of NSRSN Standards of Care that are consistently implemented throughout the CONTRACTOR provider network.

b. Notify the NSRSN in writing of those authorized by CONTRACTOR to serve as contact person(s) with NSRSN for purposes of CONTRACTOR service authorization.

c. Ensure data pertaining to all clients triaged and accepted for services has been entered into the NSRSN MIS System within 5 working days of contact.

d. Ensure CONTRACTOR reports monthly to the NSRSN aggregate data pertaining to all clients triaged and not accepted for services. This data shall be documented at the CONTRACTOR/subcontractor level and audits shall be performed by the NSRSN.

3. ACCESS AND ASSESSMENT SYSTEM

CONTRACTOR shall provide a regionally managed integrated access and assessment system with region-wide standardized initial screening, assessment, service authorization, level of care assignment and linkages to crisis services, and:

a. Provide Medicaid consumers access to services upon request and ensure they are not placed on waiting lists.

b. Ensure medically necessary services are not contingent upon full completion of intake evaluations.

c. Ensure: 1) routine care is offered to occur within 10 working days, but not to exceed 14 calendar days; 2) emergent care occurs within 2 hours; 3) urgent care occurs within 24 hours from the request for services.

d. Ensure emergency requirements are met in accordance with 42 CFR;

e. Ensure prior authorization is not required for emergency services;

f. Pay for up to 2 hours of emergency mental health services when/if Medicaid eligible individuals residing within the NSRSN service area receives said service outside of the service area when:

    1. Services are needed immediately due to sudden psychiatric illness
    2. There is inadequate time to reach CONTRACTOR's facilities or services
    3. The facilities of the provider would mean risk of permanent damage to health

g. Ensure emergency crisis intervention services are provided in collaboration with allied systems, including physical health, law enforcement, consumers, and their families, for multiple needs consumers of all ages;

h. Ensure County Designated Mental Health Professionals, crisis intervention staff, consumers and their families (when authorized) have 24-hour, 7 days per week access to current crisis plans;

i. Ensure ITA services comply with all applicable law and standards including, but not limited to: RCW 71.05; WAC 388-865-0245, -0468; Exhibit A-1 (The County Designated Mental Health Professionals Protocol); or their successors.

j. Ensure that each Medicaid consumer (including parents/foster parents, assigned/appointed guardians of children, and youth) is able to choose a participating mental health PCP to comply with WAC 388-865-0345, or its successor, and in accordance with the approved Medicaid waiver or its successor

k. Provide a region-wide integrated access and assessment system for new consumers.

l. Provide a region-wide phone access and seamless triage service system.

4. CARE MANAGEMENT

CONTRACTOR's care management responsibilities shall include the following:

a. Ensure accessibility, engagement and utilization of mental health services for individuals who are high need, resistant to treatment, or homebound due to medical or psychiatric conditions. Provide crisis intervention, case management and treatment services on an outreach basis. Implementation of outreach and engagement services shall include: 1) locating consumers in need of services; 2) engaging consumers in services; 3) assessing needs; 4) linking consumers to appropriate level of support services; 5) purchasing or providing follow-up services.

b. Consumers, including children and their families, have voice in developing tailored services for individual service plans, advance directives, and crisis management by accessing a range of community support services to meet their needs reflecting: 1) consumer/family-defined treatment goals, provided in a language or format they understand; 2) that services are informed by, and coordinated with, other formal and informal service system(s), including physical health care, for consumers served by multiple systems.

c. Strength-based services: 1) are designed creatively and flexibly to meet the unique needs of the consumer and their family in support of consumer recovery, rehabilitation, and community reintegration; 2) ensure consumer, family, formal and informal natural supports, and community strengths are incorporated into the individual service plan; 3) are not hindered by defined services or programs; 4) represent a blend of service dollars and community resources.

d. Maintenance of a skilled care coordination process that promotes rapid and successful reintegration of consumers back into the community from long-term placements (e.g. juvenile facilities, state hospitals, nursing homes, children's long-term inpatient facilities). The process shall ensure the following:

Designation of a mental health PCP as primarily responsible for coordinating the mental health care services provided to the consumer;

Providers have the information necessary for effective continuity of care and quality improvement;

Coordination of services the CONTRACTOR provides to the consumer with the services the consumer receives from any other Managed Care Organizations (MCO) and PHPs;

An appointment is offered to each consumer for a face-to-face contact within seven days of discharge from community inpatient care and state hospitals;

Children/foster children receive continuity of care (i.e. same case manager and/or therapist) including transition planning when changes in residential placements occur (e.g. in and out of home care, community placements including outside of the CONTRACTOR's service area) as requested by and negotiated with a Children's Administration social worker. In situations where the consumer has been placed outside of the CONTRACTOR's service area, the CONTRACTOR is not required to take services to the new community and any necessary transportation of the consumer to the CONTRACTOR's service site is not the responsibility of the CONTRACTOR. Transportation and service delivery may be negotiated with the Children's Administration social worker.

CONTRACTOR shall ensure children with multiple service needs who meet the requirements of Early Periodic Screening Diagnosis and Treatment (EPSDT) shall receive services that comply with Exhibit L and collect, track, and report to the NSRSN upon request, the following EPSDT data:

1. Number of unduplicated children
2. Level of service each child assigned
3. Types of services provided
4. Utilization
5. Costs associated with each child

f. Provide assistance to older adults with mental illness to maintain or restore their ability to function at the highest level of independence that their mental condition permits, as required in this Agreement and the NSRSN Standards of Care Manual, or its successor.

g. Ensure that services are available to eligible service recipients within seven (7) days of receiving a copy of a PASARR evaluation, which indicates a need for mental health services.

h. Participate in continuum of care planning that provides for housing and supportive services leading to permanent housing with the highest level of self reliance in independent or interdependent living service recipients may achieve.

i. Coordinate the necessary services for service recipients who may need specialized disability services in order to utilize mental health treatment (e.g. sight and hearing impaired, developmentally disabled).

j. Each consumer's medical record content at a minimum is consistent with the Code of Federal Regulation Utilization Control Requirements, Attachment XXIII.

k. Provide or obtain services to enable service recipients to become employed. These services include assistance in obtaining a GED, or other supported education and/or training options.

l. Provide all necessary services to assist in obtaining State and Federal entitlement for eligible service recipients.

m. Resources and/or technical assistance are provided or purchased to support consumer- operated businesses, peer support, consumer involvement, and/or drop-in centers for adults and youth.

n. Notify service recipients in writing of changes in service, PCP denials and/or changes, or termination in services at least 30 days prior to the effective date whenever possible.

o. Assure that mental health care is coordinated for service recipients. Coordination of care may be delegated to the service recipient's PCP, however the CONTRACTOR shall be ultimately responsible to assure coordination of care occurs. The CONTRACTOR shall:

1. Coordinate services to meet the service recipient's mental health care needs. Referrals to other providers shall be documented in the service recipient's records, whether or not services are provided;

2. Provide facilitated referrals for community health and social programs;

p. Ensure representative payee services are available for those who need them. When provider agency performs representative payee services, it shall be at no cost to all NSRSN-enrolled consumers.

q. Ensure involvement of primary clinicians with Crisis Respite Services to improve continuity of care

r. Ensure emphasis on skills training for parents. Skills training should empower parents, reduce their anxiety, and increase their sense of competence, and confidence in their ability to manage their own children, and reduce their reliance on formal system intervention.

s. Ensure mental health services proactively follow mental health consumers, regardless of setting, in the mental health or physical health system.

5. RESIDENTIAL TREATMENT AND HOUSING SUPPORT SERVICES

CONTRACTOR shall provide residential treatment and housing support services, consistent with WAC 388-865,and the NSRSN Standards of Care, or their successor. Residential treatment and housing supports shall emphasize least restrictive, stable living situations appropriate to age, cultural, linguistic and residential/housing needs of each service recipient. CONTRACTOR shall actively promote consumer access and choice in safe and affordable independent housing. CONTRACTOR shall monitor and report all residential housing programs and utilization identifying current and new capacity by January 15, 2002 and an update report by January 15, 2003.

CONTRACTOR shall provide timely residential services and placement where necessary within the NSRSN Service Area to meet a consumer's special needs. It is the intent of the NSRSN that CONTRACTOR shall commit to increasing adult residential capacity within the five (5) county area by prioritizing the development of the appropriate mix of licensed Adult Family Homes, use of boarding homes, nursing homes and Adult Residential Rehabilitation Centers (ARRCs), to meet special needs. CONTRACTOR shall maintain at a minimum the current residential capacity of:

- Adult Residential Rehabilitation Center (ARRC) – 20 beds
- Boarding Home – 159 beds

- Adult family home – 40 beds

The CONTRACTOR shall make a good faith effort to at a minimum, maintain the current low-income housing capacity of 685 beds and increasing subsidized housing options within the five county area.

CONTRACTOR may use an administrative process to alter the minimum mix of residential resources stated in the above paragraphs. The Administrative process must be approved by the NSRSN; include community planning; and focus on consumer and community safety, security and least restrictive alternatives.

CONTRACTOR shall maintain separation whenever possible between providers of housing and providers of mental health services. A service recipient's housing shall not be dependent on his/her willingness to participate in mental health services, except where required by source(s) of housing subsidy funding.

6. COMMUNITY PSYCHIATRIC INPATIENT SERVICES MANAGEMENT

CONTRACTOR shall coordinate an integrated system of access to all inpatient services, whether care is provided on a voluntary or involuntary basis and shall comply with all applicable law and standards including, but not limited to: NSRSN Standards of Care Standards of Care Manual, RCW 71.24.300 and WAC 388-865-0229,-0500 through -0565, or their successors. In addition, the CONTRACTOR shall provide Voluntary Inpatient Certification and Involuntary Payment Authorization Numbering services as required in attached Exhibit B, Inpatient Certification Services. Specific inpatient management services shall include:

a. Provision of resource management of community hospital care for consumers.

b. Compliance with federal requirements in 42 CFR 150-441-182; state requirements in RCW 71.05, 71.24, and 71.34; WAC 388-865, 388-550, 246-320, and 246-322; DSHS Memorandum 01-03 pertaining to Revised Procedures regarding Psychiatric Hospitalization; or any successors, and all pertinent Medical Assistance Administration (MAA) Billing Instructions, or their successors.

c. Ensure that a CONTRACTOR's clinician contacts the inpatient staff within two (2) business days of a child's admission to an inpatient facility.

d. For any hospitalization exceeding five (5) days, ensure that a child's primary care clinician be present for at least one face-to-face meeting with the child and their treatment team before the child's discharge from any inpatient facility.

e. Responding to all calls requesting certification of the need for psychiatric inpatient care for eligible consumers in community hospitals within two

hours. A decision concerning certification of the need for inpatient care shall be made within twelve hours of the initial call.

f. If the CONTRACTOR denies a request for authorization of an inpatient stay, ensure a physician reviews denial and determines clinical appropriateness within three workdays.

g. Implementation of NSRSN approved plan for authorizing community inpatient extensions. Any modifications to the plan shall be submitted to NSRSN for review and approval. CONTRACTOR shall implement modified plan(s) within 30 days of NSRSN approval.

h. Coordination with crisis response system pre-hospital emergency assessment for voluntary hospitalizations.

i. The provision of resource management services in compliance with the Working Agreement between the NSRSN and WSH (attached as Attachment X) and perform the following functions with respect to clients receiving services at WSH:

1. Assure that a medical clearance is performed by a licensed physician or ARNP prior to the transfer of any service recipient to WSH from other hospitals, emergency rooms, E&T facilities or nursing homes;
2. Provide an admission packet to the state hospital at or before the time of transfer from other hospitals, emergency rooms, evaluation and treatment centers, or nursing homes. The CONTRACTOR shall ensure admission information for consumers coming from other living situations is provided to the hospital within 3 working days of admission.
3. Assure contact with the WSH treatment team within three (3) working days of the service recipient's admission to WSH to participate in treatment and discharge planning;
4. Provide input for court proceedings in compliance with the WSH/NSRSN Working Agreement; and
5. Respond to state hospital census alert notifications by: a) diverting state hospital admissions; b) expediting consumer discharges from the state hospital using alternative community resources and services.

j. CONTRACTOR shall coordinate and actively participate with hospitals and residential care providers in discharge planning designed to maximize use of least restrictive care alternatives.

CONTRACTOR shall provide appropriate and timely community mental health services and supports to service recipients upon discharge from inpatient services:

- **Participating Hospitals and NSRSN Evaluation and Treatment Facilities.** Contact facility within (3) three working days of a consumer's admission to

actively participate with hospitals in the development and implementation of an inpatient plan of care in accordance with applicable standards and written agreements with the inpatient facility. Ensure that each service recipient's community plan of care is integrated with the inpatient plan of care jointly developed with the inpatient facility. Ensure that an appropriate and timely discharge plan is jointly developed and implemented, as required in this Agreement and the NSRSN Standards of Care Manual. Designate a PCP and supply name to facility. Ensure a direct contact occurs, prior to discharge from an inpatient setting for consumers and their families seeking community support services.

- **Western State Hospital.** CONTRACTOR shall actively work with NSRSN WSH Liaison, to ensure timely community residential placement and implementation of mental health services to individuals discharged from Western State ("WSH") on a no decline policy, regardless of recipient's Medicaid eligibility.

- **CLIP Program.** CONTRACTOR shall actively work with NSRSN CLIP Committee, to ensure the provision of medically necessary mental health services to individuals discharged from CLIP programs on a no decline policy, regardless of recipient's Medicaid eligibility.

- **Residential Providers.** Coordinate with residential providers regarding admission, course of treatment and discharge planning to maximize use of least restrictive care alternatives, as required in this Agreement and the NSRSN Standards of Care Manual.

7. ***DISENROLLMENT***

The CONTRACTOR shall comply with all applicable law and standards including, but not limited to WAC 388-865-0255-0330, -0340; or its successors. In addition, the CONTRACTOR shall:

a. Provide written notification to the NSRSN on the first day the CONTRACTOR receives any enrollee disenrollment request. The CONTRACTOR shall include the reason for the disenrollment request and verification that disenrollment is not due to adverse change in Medicaid enrollee's health.

b. Provide written notification to the NSRSN on the first day the CONTRACTOR receives a grievance that relates to any disenrollment

c. In the event the Medicaid enrollee requests disenrollment after the grievance process is complete, the CONTRACTOR shall immediately transmit a copy of the entire grievance record to the NSRSN.

d. Ensure mental health services to the enrollee are continued during any disenrollment process.

e. Ensure enrollees who wish to transfer to another RSN or contracted provider within the NSRSN service area may do so at any time without cause. The CONTRACTOR shall notify the NSRSN within four (4) working days when an enrollee transfers from one service area to another.

8. MANAGEMENT INFORMATION SYSTEM

The CONTRACTOR shall be responsible for assuring the timely, accurate and uniform collection, documentation and reporting of integrated community mental health program services data as required by NSRSN Reporting requirements, NSRSN MIS Data Dictionary (Attachment XIV) and MHD CIS Data Dictionary (Attachment XV). The CONTRACTOR shall comply with all applicable law and standards including, but not limited to: WAC 388-865-0275; SMM 2080.13, 2087.8; or their successors. In addition, the CONTRACTOR shall:

a. Provide to the NSRSN all data described in the North Sound RSN Data Dictionary, or its successor, incorporated herein by reference.

b. Provide to the NSRSN all data described in the data dictionary for the Mental Health Division Consumer Information System (MHD-CIS) (Data Dictionary), or its successor, incorporated herein by reference.

c. Ensure all data elements defined in the NSRSN core data dictionary are transmitted daily to the NSRSN, including adds, edits, and deletes. Ensure non-routine/exceptional data is transmitted within 60 days of the close of each calendar month. Transmission will retain the Provider's location identifiers.

d. Remedy all data errors within 25 calendar days of the receipt of an error report. The NSRSN will monitor the quality of the data across the fiscal year.

e. If the NSRSN receives a state request to explain significant differences in reported data, the CONTRACTOR shall cooperate fully with the NSRSN in responding to the request. The CONTRACTOR agrees to respond in a manner that allows the NSRSN to meet its 30-day obligation.

f. Every effort shall be made to ensure that all transactions are final 180 days after the close of the submission month. Any data corrections, additions, edits or deletions after 180 days must be submitted to the NSRSN. The CONTRACTOR shall be liable for any costs associated with submitting the updated data to the MHD if MHD charges the NSRSN.

g. Ensure the data transmitted to the NSRSN is timely and accurate as defined in the NSRSN-Regional MIS Quality Assurance/Quality Control Plan (QA/QC) or its successor.

h. Ensure the existence and operation of a single integrated information system. It shall have the ability to collect, use internally and report data as required by the NSRSN in order to provide a centralized, seamless system of mental health services and to provide timely monitoring. This data shall be useable as management data for audit purposes, and contain sufficient information to track termination from services (42-CFR 434.53c).

i. Develop a plan to implement an online clinical record for all service recipients and submit the plan to the NSRSN for approval by September 30, 2001.

j. Participate in the NSRSN CIS Workgroup.

k. Ensure core data based on any new state and/or NSRSN criteria is recognized as Minimum Data Set. Direct and oversee implementation and documentation of technical changes to CONTRACTOR data, collection software and procedures, assuring all required modifications will be accomplished within 110 days of written notification from the NSRSN.

l. Cooperate fully with NSRSN and MHD data audits.

m. Collaborate with the NSRSN in the development and implementation of an NSRSN-Regional MIS Quality Control and Quality Assurance plan that verifies data accuracy. This plan shall be completed with implementation beginning no later than January 1, 2003.

n. Archive documentation on CONTRACTOR information system tests showing year 2000 compliance until the year 2010.

o. Submit all data indicating the provision of any emergency service component within three (3) working days from the completion of that service;

p. Comply with HIPAA implementation requirements and standards (e.g. data collection, submission, privacy, and security).

q. Ensure that the NSRSN receive requested information in a manner that will allow for a timely response to inquiries from MHD, CMS, the legislature, and other parties about system operations. Such data shall be provided in the time frame indicated by the NSRSN at the time of the request.

9. NON-MEDICAID RECIPIENTS

CONTRACTOR shall implement the NSRSN approved plan for the provision of medically necessary services to Non-Medicaid eligible recipients in accordance with the requirements of this agreement and the NSRSN Standards of Care Manual. The CONTRACTOR shall submit any requested modifications to the approved plan within 60 days of contract execution. The approved plan shall be implemented by CONTRACTOR within 30 days from NSRSN approval date.

10. SERVICE RECIPIENTS WHO HAVE A MENTAL ILLNESS AND ARE HOMELESS

With respect to service recipients who have a mental illness and are homeless, CONTRACTOR shall:

Engage homeless mentally ill by providing:

a. Active outreach
b. Screening
c. Assessment Services
d. Treatment services
e. Medication monitoring
f. Information and referral services, i.e. food and clothing banks, shelters, mental health centers and other needed services;
g. Facilitate access to: Safe havens, drop-in centers, clubhouse services and supports, crisis residential services, residential services and emergency (temporary) housing
h. Assistance with Medicaid and other public entitlement applications

11. SERVICE RECIPIENTS WHO DUE TO A MENTAL ILLNESS ARE INVOLVED IN THE **CRIMINAL JUSTICE SYSTEM**

CONTRACTOR shall provide mental health services to eligible persons of all ages who have a mental illness and are involved in the criminal justice system per the following terms:

a. Implement policies and procedures that are consistently applied throughout the CONTRACTOR provider network that ensures:

1. Assistance to law enforcement and the criminal justice system, upon request by providing:
2. Relevant information and referral services, within legal limits
3. In-jail screening and assessment services
4. Court ordered mental health treatment planning
5. Sentencing alternatives

b. Discharge planning for individuals returning to the community, including medication monitoring, residential treatment consistent with residential licensing

requirements, housing support services, linkage with community supports and medically necessary mental health services.

c. Mental health services brochures and educational materials are prominently displayed and available to individuals and their family members/advocates at jails, juvenile detention facilities, prisons and juvenile rehabilitation facilities reception areas.

d. Actively work and collaborate with the Division of Developmental Disabilities (DDD), The Children's Administration, Juvenile Rehabilitation Administration (JRA), Educational Service Districts (ESD), Division of Alcohol and Substance Abuse (DASA) and other agencies and stakeholders when people with mental illness are in the criminal justice system and the above stakeholders are integrally involved in providing services to such persons.

CONTRACTOR shall enter data into the NSRSN MIS that allows the following reports to be generated:

a. Number of mentally ill individuals involved in the criminal justice system who are provided emergency mental health system services at jails, or at other locations in conjunction with law enforcement consultations, (including service type, i.e. emergency services or ITA investigations).

b. Number of mentally ill individuals involved in the criminal justice system receiving ITA investigations, which resulted in placement;
   - To voluntary outpatient services
   - To crisis bed placement
   - To inpatient services
     - Detention to hospital or E&T for 72 hour hold
     - Voluntary hospitalization

c. Number of mentally ill offenders provided with discharge planning services prior to release from prison, jail or community detention.

d. Number of mentally ill individuals involved in the criminal justice system who are provided with mental health assessments, screenings and/or diagnostic services while in jail or detention.

12. CULTURAL COMPETENCE AND SENSITIVITY

CONTRACTOR shall provide competent and culturally sensitive services to all people, of diverse cultures, Tribal communities and ages in all areas of the system. Competent and culturally sensitive services as required in NSRSN Standards of Care Manual include:

a. staffing and staff development;

b. clinical supervision;
c. peer review;
d. access;
e. client satisfaction;
f. management policies;
g. consultation services, e.g. Tribal GLBT, hearing impaired, ethnic minority, developmentally disabled, etc.
h. language appropriate services

13. QUALITY MANAGEMENT

The CONTRACTOR shall ensure their Quality Management (QM) activities comply with all applicable law and standards including, but not limited to: WAC 388-865-0280, -0425 and the NSRSN QM Plan, Standards of Care Manual; or their successors. In addition:

a. CONTRACTOR shall assign two (2) individuals to actively participate on NSRSN's Quality Management and Oversight Committee (QMOC).

14. STAFF COMPETENCY AND TRAINING

The CONTRACTOR must ensure that all staff are qualified for the position they hold and have at a minimum the education, experience and skills to perform their job requirements, per WAC 388-865.

a. The CONTRACTOR shall collaborate with the NSRSN to design and implement a regional training plan by January 1, 2003.

b. Each member and affiliate shall have a training plan that at a minimum complies with the NSRSN-Regional Plan.

c. CONTRACTOR and its members and affiliates shall participate in any NSRSN-sponsored trainings.

d. CONTRACTOR shall ensure Adult Family Home Providers and Residential Managers complete specialty care training before providing services to our mentally ill recipients. (Attachment XIII).

In addition, each direct service staff, including case managers, supervisors, MHP, MHS, CDMHP, therapists, psychiatrists, etc., must implement an annual training plan that is pertinent to their position, improves quality of care and incorporates a recovery, strength-based system of care.

All direct service staff shall have competency trainings as determined by the NSRSN-Regional training plan. The plan shall address:

a. Customer service and consumer satisfaction utilizing consumers and family members whenever possible.

b. Contractual requirements to assure knowledge of contract elements pertinent to their position by April 20, 2002.

c. Crisis management pertinent to their position.

d. De-escalating and handling of "out-of-control children" for all staff working with children. This training shall cover how to use these acute incidents for positive change for the child and family.

e. Cultural, Tribal, and disability sensitivity.

f. Case manager core competencies to assure uniform and quality case management throughout the region.

g. Individualized and tailored service plans.

h. Benefits of utilizing natural supports and community capacity building.

i. Best practices in clinical services to GLBT, hearing impaired, ethnic minority, developmentally disabled, etc.

j. Trauma-based illnesses and effective treatments.

k. Clinical risk assessment and risk management.

l. Co-occurring Disorder/Mentally Ill Chemical Abuse training for all direct service staff. All staff shall have additional specialized COD/MICA assessment training. Training shall encompass a minimum of 15 hours over the next 2 years.

m. Community-based cross system training. How to effectively work with cross- systems and what services cross-systems provide within each community (i.e., DASA, DDD, criminal justice, DCFS, etc.).

CONTRACTOR shall provide training to staff **and** the community relevant to provision of crisis response services. This training shall include:

a. How staff develops meaningful and effective Individual Crisis Plans and Alerts.

b. How staff access and effectively utilize flex funds for crisis response staff.

c. Community-based cross system training and protocol implementation. How to effectively work with cross- systems and what services cross-systems provide within each community (i.e., DCFS, HCS, DDD, DASA, etc.).

d. Access & Triage training and education within each local community. This training shall be accomplished in partnership with VOA.

e. Integrated Crisis Response Standards of Care Training for all CONTRACTOR Crisis Response staff. The goal of this training shall be to develop and implement consistency of Standards of Care throughout the NSRSN service area.

f. Co-occurring Disorder/Mentally Ill Chemical Abuse training for all direct service staff. All staff shall have additional specialized COD/MICA assessment training.
Training shall encompass a minimum of 15 hours over the next 2 years.

g. Consumer and family issues and perspectives on crisis services.

15. RESOURCE MANAGEMENT

CONTRACTOR shall conduct resource management activities in compliance with all applicable law and standards, including but not limited to 42 CFR 434, 404, 456; WAC 388-865-0225, 0255, 0320, 0405, 0530; or their successors in accordance with an ongoing CONTRACTOR Resource Management Plan

CONTRACTOR shall cooperate and coordinate their resource management efforts with NSRSN Clinical/Quality Management staff.

The CONTRACTOR's documented and implemented resource management program shall include the following:

–

g. Assure mental health specialists are involved at critical treatment junctures.

h. Ensure participation and compliance with grievance, fair hearings, and disenrollment determinations. In cases where determinations have broader system implications, those determinations shall be the basis for system quality improvements.

i. Ensure a standard authorization decision and provide notice as expeditiously as the consumer's mental health condition indicates for routine care within 10 working days, emergent care within 2 hours and urgent care within 24 hours of the request for

services. The CONTRACTOR shall ensure routine care is initiated no later than 14 calendar days after receipt of the request for services. An extension of up to 14 additional calendar days is possible if the CONTRACTOR provides prior written justification to the NSRSN regarding the need for additional information and how the extension is in the consumer's interest. The NSRSN reserves the right to deny the extension.

j. Ensure expedited authorization decisions for cases in which a provider indicates or the CONTRACTOR determines that following the standard timeframe could seriously jeopardize the consumer's life, or health, or ability to attain, maintain, and function at their highest possible level, given the severity of their disorder. The CONTRACTOR shall implement a process to provide for the CONTRACTOR to make an expedited authorization decision and provide notice as expeditiously as the consumer's mental health condition requires.

k. Ensure that mental health professionals: a) furnish information about service options (including the option of no services) in a culturally-competent manner; b) ensure that consumers with disabilities have effective communication with all service providers.

l. Provide for a second opinion regarding service options from a qualified mental health professional within the contracted network. If an additional qualified mental health professional is not currently available within the Network, the CONTRACTOR shall provide or pay for a mental health professional outside the Network, at no cost to the consumer.

16. LOCAL RESPONSIVENESS AND COMMUNICATIONS

CONTRACTOR shall cooperate with the NSRSN and the Counties in the Service Area to provide a locally responsive delivery system by doing the following:

a. Ensuring that consumer, advocate and family representatives are included in its ongoing process of decision-making and policy setting in the planning, implementation, operation and evaluation of CONTRACTOR network.

b. Attending all meetings of the NSRSN Board of Directors, county and regional advisory boards to ensure incorporation of an effective voice for the full range of local community stakeholders.

c. Create an ongoing work group that focuses on involvement of consumers, advocates and family members and evaluates their current involvement.

d. Implementing within each county of the NSRSN Service Area a minimum of two APN providers initiated face-to-face meetings during each school year. The purpose is to establish an APN and School District contact person, improve communications, exchange information regarding access and available services (including crisis services) for school age children, consultations specific to

individual children, etc. APN Provider maintained minutes/logs of all school district meetings shall be reviewed as part of the NSRSN's annual review process.

e. Providing ongoing information to referral sources to inform them of such matters as service availability, referral process and common mental health symptoms.

f. Posting and making known to service recipients their rights (including complaint, grievance, fair hearing procedures, and the availability of Ombuds services) and their responsibilities.

17. CROSS-SYSTEM WORKING RELATIONSHIPS

CONTRACTOR shall actively work with allied community providers, including providing mental health education and supports to ensure that service recipients receive a balanced, coordinated and individualized array of quality supports and services. The CONTRACTOR shall work with service recipients and their caregivers to prevent inappropriate hospitalization and to provide cross-system individualized support and cost sharing. Such allied community providers shall include at least the following organizations:

a. Tribal authorities;
b. The covered counties' Alcohol and Substance Abuse program;
c. The DSHS regional office of the Division of Developmental Disabilities;
d. The DSHS regional office of the Division of Aging and Adult Field Services, including the regional office of Residential Care Services;
e. The local AIDS Network;
f. Area Agency on Aging;
g. The DSHS regional office of the Division of Children and Family Services;
h. State psychiatric hospitals;
i. Free-standing E&T facilities;
j. Local schools;
k. Local Medicaid medical managed care plans, including Healthy Options and Basic Health Plan Plus;
l. The DSHS Division of Vocational Rehabilitation;
m. County jails and County Department of Corrections;
n. The State Department of Corrections
o. The DSHS Juvenile Rehabilitation Administration;
p. The county juvenile court;
q. Local hospitals; and
r. Nursing homes.

This shall be accomplished through documented working agreements and implemented protocols as well as demonstration of working partnerships that:

a. Assure that mental health care is coordinated for service recipients. Coordination

of care may be delegated to the service recipient's PCP, however the CONTRACTOR is ultimately responsible to assure coordination of care occurs.

b. Facilitate referrals to non-mental health care providers shall be documented in the service recipient's records, whether or not services are provided; and
c. Ensures appropriate facilitated referrals for community health and social programs

18. VOLUNTARY AND INVOLUNTARY CRISIS RESPONSE SERVICES

As required in the NSRSN Standards of Care and Exhibit A of this Agreement.

19. VOLUNTARY INPATIENT CERTIFICATION AND INVOLUNTARY PAYMENT AUTHORIZATION NUMBER SERVICES

As required in Exhibit B of this Agreement.

20. EVALUATION AND TREATMENT SERVICES & FACILITIES

As required in Exhibit C of this Agreement.

21. CHILDREN'S HOSPITAL ALTERNATIVE PROGRAM AND CONTINUUM OF CARE SERVICES

As required in Exhibit D and CHAP Standards of Care Addendum of this Agreement.

22. IV-E WAIVER SERVICES

As required in NSRSN Standards of Care Manual, Exhibit H of this Agreement, and NSRSN Standards of Care.

23. TRIBAL CONSULTATION SERVICES

Pursuant to the Centennial Accord (Attachment VII), between the Washington State government and the Washington Tribes, CONTRACTOR shall recognize the unique social/legal status of Indian nations and the tribes under the Supremacy clause and the Indian Commerce Clause of the United States Constitution, federal treaties, executive orders, Indian Citizens Act of 1924 and other statutes and State and Federal Court decisions and must maintain compliance with DSHS policy 7.01, or its successor, (Attachment VIII) and NSRSN 7.01 plan, or its successor, (Attachment IX).

24. OPERATING POLICIES

CONTRACTOR shall implement operational policies, procedures and protocols that ensure compliance and meet the requirements of WAC 388-865 and the NSRSN Standards of Care Manual and ensure consistent application within the NSRSN service area.

a. CONTRACTOR shall ensure a drug-free work place, and shall so indicate by signing the form attached as Attachment XVIII and returning it with the Agreement for execution.

b. Advance Directives for psychiatric care in accordance with 42-CFR-434.28 subpart I of part 489, for service recipients who have created this directive for mental health care. This includes providing written information to adult individuals concerning policies on advance directives. CONTRACTOR shall comply with, respect and utilize Advanced Directives for psychiatric care for service recipients who are experiencing situations for which they have planned in advance and created this directive so long as they are clinically appropriate and legally enforceable.

c. Service recipients, including parents or guardians of children, have the right to choose a participating primary care provider (PCP). If the service recipient does not make a choice at the time of intake and assessment, CONTRACTOR shall assign a PCP within reasonable proximity to the service recipient's home. CONTRACTOR shall assign PCPs no later than ten (10) days after intake and assessment of such individual. CONTRACTOR shall allow a service recipient to change PCP in the first thirty (30) days of service and once during a twelve-month period for any reason. Any subsequent change of PCP during the twelve-month period may be made for documented good cause at the service recipient's request.

d. Service recipients have equitable access to services covered by this Agreement, directly with CONTRACTOR and through its subcontractors. This shall occur in the same manner and according to the same standards, as individuals enrolled under other CONTRACTOR payer contracts, except to the extent that the amount, duration, and scope of covered services are different.

e. Services shall be offered in convenient locations (e.g. homes, out of facility) to the service recipient that are responsive to needs, in the least restrictive manner, allowing the greatest possible opportunity for recovery and normalized living as determined with the service recipient.

f. Service recipients shall receive services and supports that help maintain them in their natural home environment whenever clinically possible.

g. Reasonable accommodations shall be made for service recipients with disabilities (Americans with Disabilities Act) for all covered services and shall assure that physical and communication barriers shall not inhibit people with disabilities from

obtaining covered services.

h. Access for limited English proficient service recipients and service recipients who are deaf, hard of hearing or blind will be provided and that:

- In the absence of certified bilingual staff, certified interpreter services to include certified signers are provided for service recipients with a primary language other than English for all interactions between the service recipient and CONTRACTOR or any of its providers including, but not limited to, all appointments with any provider for any covered service, emergency services, and all steps necessary to pursue complaint and grievance procedure.
- **Written materials generally available to service recipients shall be translated and made available in the languages and/or alternative formats (for those with visual/hearing impairments) when there is a need for the translation. CONTRACTOR shall work with NSRSN and its other contracted providers to develop translation materials and make available, as needed, i.e. consumer rights, complaints and grievances, service benefit package.**
- CONTRACTOR is responsible for translation of eligibility determinations, materials related to complaints and grievances, and for any other written communication from CONTRACTOR to the service recipient. In addition, for any service recipient whose primary language is other than English or for whom language translation is required, CONTRACTOR shall assure that a certified staff or interpreter translates other written materials either orally or in writing in accordance with DSHS Administrative policy 7.21 or its successor.
- Communication capacity including AT&T or Washington Telecommunications Relay Services and other electronic devices shall be available, including DSHS' Language Interpreter Services and Translations (LIST) and their registry of certified and qualified interpreters. CONTRACTOR shall cooperate with NSRSN, which shall monitor adherence through both concurrent and annual reviews. CONTRACTOR shall guarantee consumer access in all cases of need, by requiring providers of services (urgent and non-urgent) to have in place a formal agreement with AT&T Language Line Interpreter Services, in accordance with this Agreement and the Standards of Care Manual, during the performance period.

k. Subcontractors will be used in a manner that supports provider flexibility in the design, selection and delivery of individualized services to service recipients and all subcontracts shall be in writing and adhere to the Subcontract requirements required in this Agreement.

25. MARKETING/OUTREACH & RECIPIENT EDUCATION

CONTRACTOR shall work with NSRSN and its other contracted providers to develop and implement an NSRSN marketing /education plan. The written educational materials shall be distributed on an annual basis to all NSRSN Medicaid enrollees within the NSRSN Service Area, and such materials shall be

at a minimum readily available and accessible at all CONTRACTOR, member, affiliate, and sub-CONTRACTOR facilities. The CONTRACTOR shall, work with the NSRSN and its other contracted providers to assure that marketing plans, procedures and materials are accurate and do not mislead, confuse or defraud either the recipient or the agency. All written materials shall be translated and available in the languages required by MHD as defined in Exhibit K

26. FINANCIAL MANAGEMENT

General Fiscal Assurances. The CONTRACTOR shall maintain financial management to comply with all applicable law and standards including, but not limited to: WAC 388-865- 0203, -0280; RCW 71.24; 42 CFR 422.208, and 42 CFR 422.210. In addition, the CONTRACTOR shall abide by all Budgeting, Accounting and Reporting System (BARS) Manual and BARS Supplemental Instructions; Office of Management and Budget (OMB) Circulars; the Waiver; Generally Accepted Accounting Principles; or any successors. At a minimum, the financial management system shall:

Be a viable, single, integrated system with sufficient sophistication and capability to effectively and efficiently process, track and manage all of CONTRACTOR's fiscal matters and transactions;

Demonstrate the capacity to reimburse the Member Agencies, Affiliate Members or other subcontractors, and emergency service providers accessed by current or potential service recipients while outside of the contracted service area, within 60 days following the date of service, using methods consistent with generally accepted accounting practices;

Comply with the requirements of law regarding the purchase of goods and services from certified and non-certified Minority and/or Women Business Enterprises and Community Based Organizations ("CBO") and reporting of expenditures thereon;

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

e. Ensure and maintain records in such a manner as to reasonably ensure that all third-party resources available to consumers are identified and pursued in accordance with the reasonable collection practices which the CONTRACTOR or its subcontractors apply to all other payors for services covered under this Agreement.

f. Provide financial reports in accordance with generally accepted accounting principles that comply with the fiscal reporting requirements of this Agreement;

g. Assure that funds are expended and/or removed from operating, capital and/or risk reserves in compliance with the authorization of CONTRACTOR's governing council, and that all revenues earned pursuant to this Agreement are utilized by CONTRACTOR in a manner consistent with the provisions of this Agreement;

h. Comply with the requirements of section 1128(b) of the Social Security Act, which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to recipients;

i. Ensure that Medicaid recipients shall not be charged for services covered under the terms of this agreement (42 CFR 447.15);

j. Ensure CONTRACTOR and its provider network has a sliding fee scale, which is posted and accessible to staff and service recipients, and does not require payment from service recipients with income levels equal to or below the grant standards for the general assistance program of the State of Washington;

k. The CONTRACTOR shall provide the Aging and Adult Services program local funds equal to the general-fund state cost of Medicaid Personal Care Services used by the CONTRACTOR for consumers who are disabled (as per the Comprehensive Assessment) due solely to a psychiatric disability when such payments have been authorized by the CONTRACTOR.

L Ensure services are provided in the most cost effective and efficient manner possible.

m. Ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system. Savings generated under the capitation rate may be used to provide innovative and needed services beyond those described in this Agreement.

n. Ensure that the total amount of money set aside in the CONTRACTOR's reserve accounts and in unobligated mental health fund balance accounts does not exceed 10 percent of the annual revenue supporting the public mental health system operated by the CONTRACTOR.

o. If the CONTRACTOR has reserve and unobligated mental health fund balance accounts at the beginning of the period of this Agreement that exceed 10 percent of the annual revenue supporting the mental health system operated by the CONTRACTOR, the CONTRACTOR is required to comply by June 30, 2003.

p. Limit administration costs and increases in reserve accounts incurred by the CONTRACTOR and by all providers under contract or subcontract to the CONTRACTOR to no more than 15.25 percent of the annual revenue supporting the public mental health system operated by the CONTRACTOR. Administration costs shall be measured on a fiscal year basis according to the reported information submitted by the CONTRACTOR in their reports.

Financial Reporting

CONTRACTOR shall provide the following reports to the NSRSN:

Within 15 days from the effective date of this Agreement, a program-specific budget that demonstrates to NSRSN’s reasonable satisfaction, compliance with direct service and indirect cost requirements. (Attachment XIX).

Annual audited financial statements for CONTRACTOR and each of its participating provider agencies. These shall be submitted by each such entity, respectively, no later than 180 days following the end of its fiscal year.

CONTRACTOR shall maintain necessary records to document third-party resources and report to the NSRSN fiscal section on a biennial quarterly basis or upon the reasonable request of the NSRSN, the amount of such third-party resources collected for all service recipients during the quarter, by source of payment.

A calendar quarterly report of revenue received, indirect costs incurred by CONTRACTOR and its participating provider agencies, direct service expenditures, and all reserve activity, demonstrating compliance with the financial limitations of this Agreement regarding such costs. This report, Attachment XIX, shall be submitted within 30 days following the end of each calendar quarter during the term of this Agreement. Should corrective action be required, NSRSN shall notify CONTRACTOR within 30 days of report receipt. Any additional analysis, monitoring and/or reporting requirements of the NSRSN related to such costs shall be satisfied in a manner consistent with the provisions of this Agreement.

Report the level of reserve accounts and unobligated mental health fund balances to the NSRSN according to the BARS Supplemental Instructions issued by the State Auditor.

Report revenue, expenditure, and fund balance information to the NSRSN on a biennial quarter basis. Reports must comply with the provisions in the BARS Supplemental Instructions for Mental Health Services promulgated by the Washington State Auditor's Office and Attachment XIX. Reports are due within 30 days of the biennial quarter end (December and June of each year).

C. PERFORMANCE INDICATORS

The NSRSN has implemented an outcome-based contracting model for the purchase and evaluation of Community Support, Integrated Crisis Response and Inpatient Management Mental Health Services. This outcome-based evaluation is a systematic approach to assessing program achievements. It is the intent of this Outcome-Based Evaluation to:

1. Provide accountability
2. Improve program quality
3. Support decision-making about resource allocation
4. Help programs market themselves

The CONTRACTOR shall report information to the NSRSN for the implementation of performance indicators to be used to monitor the performance of the public mental health system. Additional Outcomes and Performance Indicators not represented herein, may be added as required by MHD/CCS.

Definitions for the performance indicators are included in Exhibit K (Definition of Terms):

1. Penetration rates for services by race/ethnicity, age, gender, and Medicaid eligibility.
2. Utilization rate for services by race/ethnicity, age, gender, and priority population.
3. Percent of consumers age 16 and above who are employed.
4. Average annual cost per consumer served.
5. Average annual cost per unit of service.
6. Percent of revenues spent on direct services.
7. Percent of consumers who were homeless in the last 12 months by age and priority population.
8. Percent of children who live in family-like settings.
9. Percent of children and adolescents receiving services in natural settings (e.g. out of clinician office).

The CONTRACTOR shall provide consumer contact information to support MHD completion of an annual Mental Health Statistics Improvement Project (MSHIP) survey for children and families and a biennial MSHIP survey for adults for the following three Performance Indicators to be used to monitor the performance of the public mental health system:

1. Consumer perception of access.
2. Consumer perception of quality/appropriateness of services.
3. Consumer perception of active participation in decision-making regarding services.

The following measures will be under development during this Agreement period and are included for gathering and reporting data throughout the Agreement period and work in refining the indicators:

1. Percent of consumers who are maintained in the community without a psychiatric hospitalization during the last 12 months.
2. Percent of consumers who receive services by both MHD and Division of Alcohol and Substance Abuse (DASA) in the previous 12 months.
3. Percent of consumers who access physical health care.
4. Percent of consumers living in stable environments.

In addition, CONTRACTOR agrees to implement the NSRSN approved Information Technology System-wide Performance Management Plan and Performance Measurement Reports.

D. NSRSN DUTIES AND RESPONSIBILITIES

1. Provide independent utilization management process that monitors provider network to ensure services provided are sufficient, but not excessive and which

are predicated on the individual needs of the recipient with respect to that person's age, culture, language and abilities.

2. Perform clinical system monitoring and continuous quality improvement process according to NSRSN Concurrent and Selective Review protocols. This shall include performing concurrent and urgent reviews, which will be based on ten (10) percent or 500 cases minimum. This number shall be increased as deemed necessary or appropriate by NSRSN.

3. Monitor CONTRACTOR's compliance utilizing the Washington State Performance and Outcome Indicators, outcome-based evaluation, NSRSN Quality Management Plan; monthly reporting requirements; NSRSN Standards of Care Manual Requirements; on-site reviews; QRT & Ombuds reports/findings and CONTRACTOR's Operating Policies, procedures and protocols.

4. Coordinate and oversee the Quality Review and Ombuds programs.

5. The NSRSN Quality Review Team and Ombuds staff shall provide reasonable prior notice when requesting direct access to CONTRACTOR provider network

6. Responsible for coordinating, staffing and overseeing the Regional NSRSN Advisory Board.

7. Ensure the existence of an advisory committee(s) for children, older persons, and ethnic minorities, which meet quarterly.

8. Ensure the existence of oversight committee(s) for crisis services and Information Services, which shall meet regularly and include CONTRACTOR participants.

9. Maintain during the term of this Agreement a working agreement with WSH and shall timely furnish to CONTRACTOR a copy of said working agreement and all amendments thereto. Among other provisions, the working agreement shall address continuity of care to assure a seamless discharge process including, but not limited to, roles and process for referrals, involuntary admissions, court proceedings, treatment and discharge.

10. Provide discharge-planning coordination services with WSH for all Service Area residents in designated wards and shall ensure the provision of appropriate intensive case management community transition services and nursing home treatment coordination and support to persons discharged from WSH. NSRSN shall provide discharge planning for all residents on the geriatric wards of WSH on an ongoing basis. NSRSN shall identify these residents and assess the appropriateness of their continued hospitalization. With local planning and community input, NSRSN shall coordinate for those who are appropriate for discharge with assistance in obtaining community residential placement in accordance with their level of care needs. NSRSN shall perform the geriatric

mental health specialist liaison function with the State Hospital Geriatric Mental Health Unit.

11. Develop and maintain documented NSRSN marketing plans and procedures and ensure distribution of written educational materials.

12. Establish interagency agreements with Department of Alcohol and Substance Abuse and County Substance Abuse authorities to promote cost sharing and system efficiencies for persons with co-occurring mental health and substance abuse related disorders.

13. Upon notification from government, NSRSN shall timely notify CONTRACTOR in writing of changes/modifications in Medicaid status, regulations, CMS policies, DSHS/MHD contract requirement changes, etc.

14. Chair and staff the NSRSN Service Area CLIP Committee and perform CLIP hospital liaison responsibilities.

15. Provide CONTRACTOR with timely notification of Medicaid Personal Care authorizations.

16. Manage the NSRSN MIS Database.

17. Work with MHD in development of statewide performance indicators and outcomes.

18. Facilitate and lead in collaborating with consumers, advocates, and all NSRSN contracted providers to develop and implement effective policies and procedures that ensure consumers and their families are free from retaliation (or the perception of retaliation) for accessing services and protections outlined in this Agreement by October 1, 2002.

19. Shall perform a biennial satisfaction survey of NSRSN provider network, including allied systems and local stakeholders. The NSRSN will include data from the satisfaction survey for planning and system improvement.

20. The NSRSN shall take the lead and facilitate a collaborative process with NSRSN provider network to design and implement a regional training plan by January 1, 2003.

21. The NSRSN shall take the lead and facilitate a collaborative process with its contracted providers to develop and implement an NSRSN marketing /education plan. The written educational materials shall be distributed on an annual basis to all NSRSN Medicaid enrollees within the NSRSN Service Area, and such materials shall be at a minimum readily available and accessible at all contracted provider facilities throughout the NSRSN service area. The NSRSN shall work

with its contracted providers to assure that marketing plans, procedures and materials are accurate and do not mislead, confuse or defraud either the recipient or the agency. All written materials shall be translated and available in the languages required by MHD as defined in Exhibit K

The plan and written materials shall include:

- Service recipients' rights and responsibilities, cross-system linkages, and access to services for diverse populations and locations, including other languages than English.
- Use of media and stigma reduction;
- Subcontractor(s) participation/involvement;
- Scope of available services (e.g., inpatient, community support, residential, crisis response, employment, community support);
- Major mental illnesses and the range of options for treatment, supports available in the system, including medication and formal psychotherapies, as well as alternative approaches that may be appropriate to age, culture and preference to the service recipient;
- Service locations, and
- Service recipient's responsibilities with respect to out-of-area emergency services; unauthorized care; non-covered services; complaint process, grievance procedures; and other information necessary to assist in gaining access.
  Consumer training on how to participate in a consumer driven model of care.

E. SHARED DUTIES AND RESPONSIBILITIES - SERVICE AREA CENSUS AT WSH

The parties shall work together to assure that the non-forensic census of Service Area residents at WSH does not exceed the respective maximum numbers permitted by the MHD.

F. PARTICIPATION IN MHD'S INDEPENDENT DATA COLLECTION AND ANALYSIS

The CONTRACTOR shall cooperate with the NSRSN to meet MHD's requirements with respect to its independent data collection, analysis, evaluation and publication of reports thereon, including but not limited to:

1. Reasonable participation in all reviews, a yearly medical audit, financial audits, program audits, surveys, and research conducted by the NSRSN, MHD or other Department(s) of the State of Washington.

2. Allow and facilitate access to service recipients and records in conjunction with the integrated review process, the Mental Health Outcome Project, the Consumer Access, Voice and Ownership Survey (CAVO) and any other evaluation, monitoring and corrective action efforts, and respond to questions and issues raised in connection therewith.

3. Provide access to CONTRACTOR's provider network for the purpose of confirming consumer and provider satisfaction.

G. CLINICAL REVIEW ACTIVITIES

The CONTRACTOR shall work with the NSRSN to:

1. Implement a region-wide recovery oriented service delivery system.

H. FINANCIAL PROVISIONS - REIMBURSEMENT REQUIREMENTS

The consideration to be paid by the NSRSN for the work to be provided by CONTRACTOR pursuant to this Agreement shall consist of the available amount from primary funding sources as described in Exhibit I of this Agreement.

Depreciation and Depreciation Funding: Depreciation expense included in CONTRACTOR's operating statements in accordance with generally accepted accounting principles shall be fully recognized as operating expenses. CONTRACTOR shall have the right but not the obligation to fully fund depreciation expense.

Funding Utilization: The parties agree to fully cooperate to maximize the availability of funding for direct services and minimize the use of funding for indirect services, and to work cooperatively to allocate available funding for indirect costs between them proportionately, in accordance with the costs of their respective responsibilities.

Protection of County Funding: Funds received by CONTRACTOR and/or its participating member providers from any one or more of the Service Area's counties specifically for the purpose of providing services to individual county programs during the term of this Agreement are in addition to the consideration described in Exhibit I and are not intended to reduce such consideration, but are to be used as additional funds in furnishing those additional local services for which such county funds were provided.

Payment Methodology: The consideration by NSRSN to CONTRACTOR pursuant to this Agreement shall be paid monthly within ten (10) working days of NSRSN's receipt of payment by DSHS/MHD, when the conditions described below are met.

Mental Health Services: Outpatient/Community Support, Psychiatric Inpatient Care Management and Crisis Response Mental Health services shall be paid to CONTRACTOR in accordance with Exhibit I upon the demonstration of meeting the following requirements:

a. NSRSN Service Area and County specific program budget submitted within 15 days of effective date of this contract.

b. Detailed organization chart listing all staff / F.T.E.s allocated by program submitted within 15 days of effective date of this contract.
c. Services have been performed in accordance with the requirements of this Agreement and all Exhibits and Attachments.
d. Financial reporting requirements have been met.
e. MIS data entry and transmission to NSRSN data base requirements have been met.

I. OTHER PROVISIONS

1. TERMS AND CONDITIONS

All rights and obligations of the parties with respect to this Agreement shall be subject to and governed by the terms and conditions contained in the text of this Agreement, including exhibits and attachments incorporated by reference.

2. ASSIGNMENT

Except as otherwise provided within this Agreement, this Agreement may not be assigned, delegated or transferred by either party without the express written consent of the other party, and any attempt to transfer or assign this Agreement without such consent shall be void.

The terms “assigned”, “delegated” or “transferred” shall include change of business structure to a limited liability company, of any CONTRACTOR Member Agency.

3. TERMINATION

Except as otherwise provided in this Agreement, NSRSN may terminate this Agreement upon thirty (30) days written notice in the event that NSRSN receives notice of termination of its contract with MHD. Otherwise, NSRSN or CONTRACTOR may terminate this Agreement by providing to the other party ninety (90) days written notification, provided that the effective date of termination shall be the ninetieth day after notification or the last day of a calendar month in which the ninetieth day occurs, whichever is later. If this Agreement is so terminated, then each party shall be responsible only for the performance in accordance with the terms of this Agreement rendered prior to the effective date of termination. CONTRACTOR shall assist in the orderly transfer/transition of the service recipients served under this Agreement. CONTRACTOR shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

4. TERMINATION FOR DEFAULT

The NSRSN may terminate this Agreement for default, in whole or in part, by written notice to the CONTRACTOR, if NSRSN has a reasonable basis to believe that the CONTRACTOR has:

a. **Failed to ensure the health or safety of any client for whom services are being provided under this Agreement;**

b. **Violated any law, regulation, rule, or ordinance; and/or**

The NSRSN may terminate this Agreement for default without such written notice and without opportunity for correction if NSRSN has a reasonable basis to believe that the CONTRACTOR has failed to ensure the health or safety of any client for whom services are being provided under this Agreement or the CONTRACTOR has violated any law, regulation, rule or ordinance.

c. **Otherwise breached any provision or condition of this Agreement.**

Before NSRSN may terminate this Agreement for default as described in item c. above, the NSRSN shall provide the CONTRACTOR with written notice of the CONTRACTOR's noncompliance with the contract and provide the CONTRACTOR an opportunity to correct the CONTRACTOR's non-compliance. If the CONTRACTOR has not corrected the CONTRACTOR's noncompliance within the period of time specified in the written notice of noncompliance, the NSRSN may then terminate this Agreement.

5. RENEWAL

This Agreement may be renewed for one additional year by mutual written agreement of the parties on or before April 30, 2003, subject to the approval of the NSRSN Board of Directors.

6. ONGOING SERVICES

CONTRACTOR assures that in the event of labor disputes or job actions, including work slowdowns, so called "sick outs", or other activities, within its service provider network, uninterrupted services shall be available as required by the terms of this Agreement.

7. EXTRAORDINARY OCCURRENCES

CONTRACTOR shall ensure that providers comply with NSRSN Critical Incident Reporting Policy and Procedure (Attachment IV) regarding extraordinary occurrences and shall advise the NSRSN of all extraordinary occurrences the same day as information is received from providers.

8. COMPLIANCE REVIEW PROCESS

The processes for compliance review contained in this section shall only apply where

the issues under review do not present a clear and imminent danger to the health and well-being of service recipients under this Agreement, a clear violation of applicable State and Federal laws or regulations specifically found to be of imminent concern and requiring immediate corrective action, a clear violation of deadlines specified in this Agreement, or imminent loss of Federal financial participation for payments under this Agreement.

If a dispute exists between the MHD and/or the NSRSN and CONTRACTOR as to whether non-compliance exists, the matter may be submitted to arbitration according to this Agreement for binding resolution.

In the event CONTRACTOR fails to comply with any of the terms and conditions of this Agreement and that failure results in an overpayment, NSRSN may recover the amount due the Department. In the case of overpayment, CONTRACTOR shall cooperate in the recoupment process and return to NSRSN the amount due upon demand.

Nothing in this section shall preclude audits or actions based on audit findings by the NSRSN, Department, State or Federal government.

9. SUBCONTRACTS

All subcontracts held between CONTRACTOR and its Member Agencies, Affiliate Members and other subcontractors for the provision of community support mental health and crisis response services as required in this Contract, shall be in writing and fulfill the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract terminates the legal responsibility of CONTRACTOR to the NSRSN to assure all activities under this Agreement are carried out. Subcontractors shall comply with all applicable state regulations and federal statute and laws.

a. CONTRACTOR may enter into subcontracts with persons, partnerships, or corporations, after notifying the NSRSN of its intent to subcontract with such entity. Upon NSRSN's reasonable request, CONTRACTOR shall promptly furnish to NSRSN a complete list of its subcontractors.
b. CONTRACTOR shall establish and maintain a formal complaint process for the subcontractor. CONTRACTOR shall ensure that the complaint by the subcontractor is acted upon and that there is documentation on file for review.
c. CONTRACTOR shall ensure subcontracts, including its subcontractor subcontracts, contain, at a minimum, the following requirements:

1. For services for which state or federal laws require licensure, the proper Department/Agency must license those providing service. Verification of subcontractor license shall be on-site and a copy provided to the NSRSN;
2. Access to services under this Agreement are equal to or greater than access for

non-public pay service recipients;
3. Compliance with the nondiscrimination clause in this Agreement and allowance for monitoring;
4. Subcontractors must abide by the requirements of Section 1128A(b) of the Act prohibiting CONTRACTORs 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;
5. Service recipients rights and responsibilities are posted in all areas which are open to service recipients and potential services recipients;
6. Documents for Certificates of Insurance and endorsements are provided to the NSRSN within 15 days of execution of the subcontract;
7. A complaints resolution process consistent with that of CONTRACTOR's across the service area for service recipients, including assurance of adherence;
8. Facilitation of access for Ombuds and Quality Review Team services including but not limited to access to physical property, assistance in meeting directly with consumers and Ombudsman access to records with client consent;
9. Demonstrate how Ombuds, Quality Review Team and Advisory Board recommendations are received analyzed and decisions are made regarding action to be taken. Demonstrate how issues raised are addressed and incorporated into on-going operations and Quality Improvement Plan, and how approved Ombuds, Quality Review Team and Advisory Board recommendations are implemented.
10. Compliance with grievance and fair hearing determinations;
11. Maintain records in accordance with the terms in this Agreement.
12. Financial funding pools, if any, may be created by the subcontractor around natural clusters of expense which allow for financing flexible, individualized plans of care;
13. Make all efforts to collect and report third party reimbursement;
14. Secure a financial audit yearly by an independent CPA firm;
15. Compliance with MIS requirements this Agreement, including participation in the independent audit for integrity and accuracy of data;
16. Participation in NSRSN and MHD monitoring, evaluation and facilitate access to service recipients, their families, and their clinical records. The subcontractor shall also provide access to on-site inspections as described in this Agreement;
17. Develop and implement cross system relationships with allied social services and informal community resources;

All other relevant parts of this Agreement pertaining to subcontracted activities.

10. REMEDIAL ACTION

The CONTRACTOR agrees that NSRSN may initiate remedial action as outlined below if the NSRSN or MHD determines any of the following situations exist:

a. A problem exists that negatively impacts consumers;

b. The CONTRACTOR has failed to perform any of the services required in this Agreement;

c. The CONTRACTOR has failed to develop, produce, and/or deliver to the NSRSN or MHD any of the statements, reports, data, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement;

d. The CONTRACTOR has failed to perform any administrative function required under this Agreement. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of services;

e. The CONTRACTOR has failed to resolve identified situations to the satisfaction of and within NSRSN prescribed time frames.

The NSRSN may impose any of the following remedial actions in response to findings of situations as outlined above:

a. Planning of and corrective action that resolves identified situations. Corrective action plans shall include a brief description of the finding, the specific steps to be taken to correct the situation, a timetable for performance of specified corrective actions steps, a description of the monitoring to be performed to ensure that the steps are taken, and a description of the monitoring to be performed that will reflect the resolution of the situation. Corrective action plans developed by the CONTRACTOR must be submitted to the NSRSN within 30 calendar days of receipt of the notice of the situation. The NSRSN may extend or reduce the time allowed for corrective action depending upon the nature of the situation and the existence of an emergency as determined by the NSRSN or MHD. Corrective action plans shall be subject to approval by the NSRSN, which may accept the plan as submitted, accept the plan with specified modifications, or reject the plan;

b. Modification of any policies or procedures of the CONTRACTOR relating to the fulfillment of its obligations pursuant to this Agreement;

c. Withhold one percent of the next monthly capitation payment for each remedial action and each monthly capitation payment thereafter until the situation(s) has been resolved.

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

e. The NSRSN may retain, at its sole discretion, all or a portion of withheld funds for consumer oriented projects and the enhancement of mental health services.

f. Terminate this Agreement as per the General Terms and Conditions of this Agreement.

The NSRSN will notify the CONTRACTOR of situations requiring remedial action, define the remedial action to be implemented, and provide a time frame for action by both parties.

No payment will be reduced or withheld until CONTRACTOR has been provided with written notification of the pending reduction or suspension, stating the reason(s) therefore, and a thirty-day period of corrective action. Exceptions to the preceding statement include liquidated damages imposed by MHD, and CONTRACTOR initiated Evaluation & Treatment Facility(s) closure.

11. LIQUIDATED DAMAGES/SANCTIONS

Financial sanctions shall be utilized when CONTRACTOR fails to meet contractual obligations.
State Mental Health Division Imposed Sanctions
Liquidated damages under this section of the Agreement will be imposed upon CONTRACTOR by NSRSN only if MHD first imposes such sanctions:

a. Payments to CONTRACTOR will be reduced by its share of the applicable daily WAC rate $365.00 per client per day, at WSH for the period of January 1, 2002 to December 31, 2003, as liquidated damages whenever the daily census utilization by the RSN-C at Western State Hospital exceeds the maximum census of 777. No period for corrective action is applicable under this Section unless authorized by the Director of the Mental Health Division.

b. Unpaid assessments, penalties, damages, and other payments made by the MHD and reduced from NSRSN payment, which are the CONTRACTOR's responsibility/liability.

c. Liquidated damages will be assessed to a maximum of $5,000 per month for all costs related to services provided to Medicaid enrollees disenrolled from services who were enrolled with the CONTRACTOR at the time they disenrolled. These costs will include, but are not limited to, the costs of provider procurement, contract development, legal advice, transportation, and assessment and services deemed necessary and appropriate by the MHD or its designee. Recovery costs shall be based on the total amount of FTE time expended by the MHD staff at a fixed rate of $80 per hour, provider billed costs for the MHD attorneys' fees and costs charged by the Attorney General's Office, Medicaid eligibles' attorneys' fees and costs if required by settlement or court order, transportation and services, and any other costs related to serving the consumer. Any costs beyond the $5,000 per month for each disenrolled enrollee across the state will be accrued by the MHD. Periodically, the MHD will reduce payments to all CONTRACTORs by an amount necessary to retire the accrual. The payments will be allocated to each CONTRACTOR according to the number of Medicaid enrollees residing in each CONTRACTOR's service area in the month the payment was made.

d. The NSRSN will also pass on MHD liquidated damages being assessed for the

following:

- Hospital bed day rate for every consumer from the CONTRACTOR's service area starting seven calendar days after hospital determination that the consumer is ready for discharge and continuing until the consumer is discharged;
- Costs associated with additional data processing as outlined in this agreement, Section 8, Management Information System.

NSRSN Imposed Sanctions
NSRSN may withhold payments to CONTRACTOR in each of the following circumstances:

a. Clinical review (e.g. Integrated Review, NSRSN Review, Medical Review) finds CONTRACTOR has failed to maintain reasonable and competent clinical care; to ensure access to services, including Ombuds Services as described in Exhibit E and effective Quality Review Team performance in conformity of Exhibit F; to ensure services are age, culturally and linguistically appropriate for service recipients; to provide individualized tailored care when requested; and, to ensure service recipients have voice in their treatment.

   The amount withheld will be 2 percent of the monthly capitated payment for all service recipients, including all fund sources whether State or Federal, for each month CONTRACTOR fails to meet these terms and conditions. Payments will be released as soon as it is determined by peer review that reasonable and competent clinical care, appropriate services, and service recipients' consumer voice, etc. have been restored if within three months. After three months, liquidated damages will be equal to one half of the amount of withheld payments for every calendar quarter except the current calendar quarter and will not be released to CONTRACTOR.

b. A required report, including electronic data has not been accurately or timely submitted and/or data errors have not been remedied within contractual time requirements.

   The amount withheld will be 1 percent of the monthly capitated payment for all service recipients, including all fund sources whether State or Federal, for each month the required report or electronic data is not properly completed and filed. Payments will be released as soon as a properly completed report or electronic data is received if received within three months. After three months, liquidated damages will be equal to the full amount of withheld payments for every calendar quarter except the current calendar quarter and will not be released to the CONTRACTOR.

c. Failure to provide face-to-face crisis response evaluation or stabilization services as requested by VOA's Care Crisis Response.

The amount withheld will be 1 percent of the monthly capitated payment for all service recipients, including all fund sources whether State or Federal, for each month CONTRACTOR continues to not provide face-to-face crisis response evaluation or stabilization services as requested by VOA's care crisis response. Payments will be released as soon as CONTRACTOR provides face-to-face crisis response evaluation or stabilization services as requested by VOA's care crisis response within three months. After three months, liquidated damages will be equal to the full amount of withheld payments for every calendar quarter except the current calendar quarter and may not be released to the CONTRACTOR.

d. Payments to CONTRACTOR will be reduced by $7,500 per day per facility whenever the CONTRACTOR fails to provide two (2) 15 bed Evaluation & Treatment Facilities as a result of CONTRACTOR initiated bed reduction and/or closure of one or both facilities. No period for corrective action is applicable under this Section unless authorized by the Executive Director of the NSRSN.

e. Payment upon termination - The NSRSN shall release only 50 percent of the final payment under this Agreement until all final reports and data are received and accepted. Additionally, the final payment shall be held until all pending corrective action and liquidated damages are completed.

12. NONDISCRIMINATION

During the performance of this Agreement, the parties shall comply with all federal and state non-discrimination laws and regulations.

13. RECORDS MAINTENANCE

CONTRACTOR and subcontractors shall maintain books, records, documents and other evidence, which sufficiently and properly reflect all direct and indirect costs expended in the performance of the services described herein. NSRSN shall maintain books, records, documents and other materials relevant to this Agreement which sufficiently and properly reflect all payments made, the MHD's rate setting activities related to the NSRSN, or other actions taken in regard to CONTRACTOR's performance of the services described herein.

These records shall be subject to inspection, review or audit by personnel of both parties, other personnel duly authorized by either party, the Office of the State Auditor, and federal officials so authorized by law (e.g. Department of Health and Human Service, Health Care Financing Administration, the Comptroller General or any of their duly authorized representatives).

CONTRACTOR shall retain all books, records, documents, and other material relevant to this agreement for six years after expiration, and the NSRSN, Office of the State Auditor, federal auditors, and any persons duly authorized by the parties shall have full access and the right to examine any of these materials during this period.

14 ON-SITE INSPECTION

The NSRSN, Department and/or the federal Department of Health and Human Services (DSHS), may evaluate CONTRACTOR and subcontractors through inspection or other means, regarding the quality, appropriateness and timeliness of service performed under this Agreement to determine whether CONTRACTOR and its subcontractors are providing services to enrolled recipients in accordance with the requirements set forth in this Agreement, and applicable federal regulations set by DSHS as existing or hereafter amended.

15. CONFIDENTIALITY OF CLIENT INFORMATION

Pursuant to 42 CFR 431-301 and 431.302, information concerning applicants and recipients may be disclosed for purposes directly concerning the administration of this Agreement and the state Medicaid plan.

Purposes include, but are not limited to:

a. Establishing eligibility
b. Determining the amount of medical assistance
c. Providing services for recipients
d. Conducting or assisting in investigation, prosecution, or civil or criminal proceeding related to the administration of the plan
e. Assuring compliance with federal and state laws, regulations, with terms and requirements of this Agreement
f. Improving quality

CONTRACTOR shall protect all information, records and data collected from unauthorized disclosure in accordance with 42 CFR 431.300 through 431.307, Revised Code of Washington (RCWS) 70.02, 71.05, and 71.34 and, for service recipients receiving alcohol and drug abuse services, in accordance with 42 CFR Part 2. CONTRACTOR shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services.

Access to the information must be, and is, restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of DSHS.

Coordination, planning, screening and referral require the sharing of information among the various treatment providers. Disclosure of information to providers to verify eligibility, determine the amount of assistance and to provide medically necessary mental health services are all "purposes directly connected with the administration of the plan", and are all appropriate justifications for sharing information as described in the waiver or this Agreement.

All CONTRACTOR and subcontractor staff shall receive annual training on confidentiality policies and procedures. In addition, all staff shall sign an annual Oath of Confidentiality statement in the form. Signed copies of the Oath of Confidentiality shall be kept in CONTRACTOR/subcontractor personnel files.

16. CONTRACT ADMINISTRATION

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

The Program Manager for NSRSN is:

Charles R. Benjamin, Executive Director
North Sound Regional Support Network
117 North First Street, Suite 8
Mount Vernon, WA 98273

The Program Manager for CONTRACTOR is:

Jere LaFollette, CEO
Associated Provider Network
413 Gates, Suite A
Mount Vernon, WA 98273

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

17. INDEPENDENT CAPACITY

The employees or agents of each party who are engaged in the performance of this Agreement shall continue to be employees or agents of that party and shall not be considered for any purpose to be employees or agents of the other party. **The NSRSN does not provide a work place or materials for contractor's use in meeting the obligations of this Contract.**

18. INDEMNIFICATION

CONTRACTOR, its Member Agencies, affiliates and subcontractors shall assume the risk of, be liable for, and pay all damages, costs and expenses as incurred of NSRSN, its officers, officials, directors and employees arising out of the performance of this Agreement, except to the extent caused by the gross negligence and/or willful misconduct of NSRSN. CONTRACTOR, its Member Agencies, affiliates and subcontractors, shall hold harmless, defend and indemnify NSRSN against all claims, losses, suits, costs, attorneys' fees, damages, or judgments or decrees by reason of damage to any property or business and/or any death, injury or disability to any person arising, directly or indirectly, by contract or any act, error or omission of

CONTRACTOR (including CONTRACTOR's employees, agents, subcontractors, participants and volunteers). CONTRACTOR, its Member Agencies, affiliates and subcontractors, shall also indemnify NSRSN against injury to or claim brought by CONTRACTOR's or its subcontractor's employees and s**hall waive its protection under the Washington Industrial Insurance Act.**

19. INSURANCE

NSRSN certifies it is self-insured for all exposure to tort liability, general liability, property damage liability, and vehicle liability as provided by Chapter 43.19, Revised Code of Washington.

CONTRACTOR shall maintain a managed care liability policy in a form acceptable to NSRSN, and providing coverage of risks related to managed care operations, including but not limited to selection, maintenance and supervision, in the amount of $1,000,000. CONTRACTOR and each of its subcontractors certify that they shall each maintain commercial liability insurance of $1,000,000 per occurrence and $2,000,000 aggregate and shall provide evidence of such insurance to NSRSN within fifteen (15) days of execution of this agreement. All such policies shall name NSRSN as a covered entity under said policy(s).

20. CONTRACT PERFORMANCE/ENFORCEMENT

NSRSN shall be vested with the rights of a third party beneficiary, including the "cut through" right to enforce performance should CONTRACTOR be unwilling or unable to enforce action on the part of its provider network. In the event that CONTRACTOR dissolves or otherwise discontinues operations, NSRSN may, at its sole option, assume the right to enforce the terms and conditions of this Agreement directly with CONTRACTOR’s service provider network. CONTRACTOR shall include this clause in its contracts with its Member Agencies, affiliates, and subcontractors. In the event of the dissolution of CONTRACTOR, NSRSN’s rights in indemnification shall survive against CONTRACTOR’s members.

21. AGREEMENT ALTERATIONS AND AMENDMENTS

This Agreement may be amended by mutual agreement of the parties. Such amendments shall not be binding unless they are in writing and signed by Personnel authorized to bind each of the parties.

22. RESOLUTION OF DISPUTES

The parties wish to provide for prompt, efficient, final and binding resolution of disputes or controversies that may arise under this Agreement and therefore establish this dispute resolution procedure. All claims, disputes and other matters in question

between the parties arising out of, or relating to, this Agreement shall be resolved exclusively by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

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

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

a. The parties shall each select one person as arbitrator. Those two arbitrators shall agree on the selection of a third arbitrator. The dispute shall be promptly resolved on the basis approved by any two of the three arbitrators.
b. If there is a delay of more than ten (10) days in the naming of any arbitrator, either party can ask the presiding judge of Skagit County to name any remaining arbitrator(s).
c. The prevailing party shall be entitled to recover from the other party all costs and expenses, including reasonable attorney fees. The arbitrators shall determine which party, if any, is the prevailing party.
d. The parties agree that in the absence of fraud by one of the parties, the arbitrators' decision shall be binding, final and not appeal able to any court of law.
e. Unless the parties agree in writing otherwise, the unresolved claims in each notice of dispute shall be considered at an arbitration session which shall occur in Skagit County no later than thirty (30) days after the close of the meeting described in paragraph b. above.
f. The Provisions of this section shall, with respect to any controversy or claim, survive the termination or expiration of this Agreement.
g. Nothing contained in this Agreement shall be deemed to give the arbitrators the power to change any of the terms and conditions of this Agreement in any way.

23. SURVIVAL UPON TERMINATION

The provisions of sections entitled “Indemnification”; “Right to Withhold, Reduce, Offset or Recoup Payments”; “Rights in Data and Software”; ”Order of Precedence”, “**Resolution of Disputes”** and Contract Performance/Enforcement” shall survive any termination of this Agreement.

24. FUNDING CHANGES

In the event funding from state, federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to normal

completion, and after attempting in good faith to amend this Agreement in a mutually satisfactory manner that would permit its continuation through the remainder of its term, either the NSRSN or CONTRACTOR may terminate the Agreement under the "Termination" clause, subject to renegotiations under those new funding limitations and conditions.

25. ORDER OF PRECEDENCE

This Agreement is entered into pursuant to and under the authority granted by the laws of the State of Washington and any applicable federal laws. The provisions of this Agreement shall be construed to conform to those laws. In the event of an inconsistency in the terms of this Agreement, or between its terms and any applicable statute or rule, the inconsistency shall be resolved by giving precedence in the following order: (1) applicable Federal Laws; (2) applicable State Laws including regulations and administrative codes currently in effect; (3) the 1915 (b) Integrated Community Mental Health Waiver currently in effect; (4) General terms and conditions of this Agreement; (5) the statement of work, including tables incorporated by reference, exhibits and attachments, other materials incorporated by reference.

26. NO WAIVER OF RIGHTS

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

27. HEADINGS AND CAPTIONS

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

28. SEVERABILITY

If any provision of this Agreement or any provision of any document incorporated by reference shall be held invalid, such invalidity shall not affect the other provisions of this Agreement which can be given effect without the invalid provision, if such remainder conforms to the requirement of applicable law and the fundamental purpose of this agreement, and to this end the provisions of this Agreement are declared to be severable.

29. INTEGRATION

This Agreement contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this

Agreement shall be deemed to exist or to bind any of the parties hereto.

30. ASSURANCES

The parties agree that all activity pursuant to this Agreement will be in accordance with all applicable current or future federal and state laws, rules and regulations.

31. COOPERATION

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

32. WARRANTIES

The parties' obligations are warranted and represented by each to be individually binding, for the benefit of the other party. CONTRACTOR warrants and represents that it is able to perform its obligations set forth in this Agreement and that such obligations are binding upon CONTRACTOR, its Member Agencies, Affiliate Members and other subcontractors for the benefit of NSRSN. CONTRACTOR further warrants and represents that no Member Agency will change its non-profit status during the term of this Agreement (including any renewal). Concurrent with the execution of this Agreement, each party shall furnish to the other a copy of the explicit written authorization of its governing body to enter into this Agreement, or a copy of the motion, resolution or ordinance passed.

33. AUTHORITY

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

THIS AGREEMENT, consisting of 61 pages, plus Exhibits A-L, Attachments I-XX, is executed by the persons signing below who warrant that they have the authority to execute this Agreement.

ASSOCIATED PROVIDER NETWORK

_____

Signature

_____

Title Date

NORTH SOUND REGIONAL SUPPORT NETWORK

_____

Signature

_____

Title Date

Approved as to form by Brad Furlong
Attorney for NSRSN

CATHOLIC COMMUNITY SERVICES NORTHWEST

_____

Signature

_____

Title Date

COMMUNITY MENTAL HEALTH SERVICES

_____

Signature

_____

Title Date

COMPASS HEALTH

_____

Signature

_____

Title Date

WHATCOM COUNSELING & PSYCHIATRIC CLINIC

_____

Signature

_____

Title Date

LAKE WHATCOM RESIDENTIAL AND TREATMENT CENTER

_____

Signature

_____

Title Date

BRIDGEWAYS

_____

Signature

_____

Title Date

EXHIBIT A

NORTH SOUND REGIONAL SUPPORT NETWORK
INTEGRATED CRISIS RESPONSE SERVICES

I. PURPOSE

This Statement of Work is Exhibit A of the Outcome-Based Integrated Community Mental Health Program Services Agreement between North Sound Regional Support Network (referred to herein as "NSRSN") and Associated Provider Network (referred to herein as "Contractor" and "APN"). The purpose of this Statement of Work is to provide an enforceable framework for identifying specific performance obligations under the Outcome Based Integrated Community Mental Health Program Services Agreement with APN.

The Integrated Community Mental Health Program Services Agreement and this Statement of Work have as their purpose the performance of an integrated, coordinated and seamless crisis response system for the NSRSN and its member counties; Island, San Juan, Skagit, Snohomish and Whatcom (the "NSRSN Service Area"). Services, which shall be directly provided by Contractor under the Integrated Crisis Response Services Agreement:

- Voluntary Mental Health Crisis Response Services as required by RCW 71.24 and WAC 388-865
- Mental Health Crisis Respite Service Options
- Involuntary Treatment Act Services as required by RCW 71.05, 71.34 and WAC 388-865, for Island, San Juan, Skagit and Whatcom Counties
- Coordinated and seamless service link with Snohomish County ITA
- Coordinated and seamless service link with mental health crisis line, triage and dispatch of outreach services provided for NSRSN Service Area through Volunteers of America (the NSRSN "Care Crisis Response" system)
- Coordinated, integrated cross-system crisis response services throughout the NSRSN Service Area
- County-specific Crisis Services

The Contractor shall develop and implement the cross-system Integrated Crisis Response System and shall assure it operates uniformly throughout the NSRSN Service Area, providing Mental Health crisis response services for individuals regardless of the presenting problem and as required in the NSRSN Clinical Eligibility and Care Standards Manual.

II. CRISIS RESPONSE SYSTEM PRINCIPLES AND VALUES

All performance of this Statement of Work shall comply with all of the provisions of the Motion adopted by the NSRSN Board of Directors on September 25, 1997 (attached hereto, as Attachment III), AND shall be consistent with the Mental Health Division's mission and values (Attachment I), AND shall be consistent with NSRSN Core Values and Principles (Attachment II).

Services provided or coordinated under this Statement of Work shall be offered in the least restrictive community setting possible to effectively and safely resolve the crisis, and such services shall be matched to individual need and the severity of the crisis to assure efficient use of public funds.

PRINCIPLES

The intent of the NSRSN, which is hereby adopted by Contractor, is that the entire Integrated Crisis Response System will operate in accordance with the following principles:

1. Crisis response services shall include both voluntary and involuntary service options.

2. Crisis response services shall be delivered across social service systems in a fully integrated, seamless and consistent manner.

3. A person in crisis will be treated as a whole person, rather than focusing on categorical problems.

4. A crisis will be self-defined, rather than needing to meet categorical criteria.

5. A person in crisis will have easy and timely access to appropriate attention and care.

6. The Crisis Response Program will be able to refer to a complete continuum of care in order to respond to a variety of needs.

7. A person in crisis will be referred to the least restrictive resource available to effectively manage the crisis.

8. The Crisis Response Program will be community based.

9. Crisis Response services will be available to both adults and children.

10. Crisis services and information will be available 24 hours a day, 365 days a year throughout the NSRSN/PHP.

11. Crisis Services will be fully integrated and coordinated at both the local and regional level.

12. All crisis services will be culturally competent and responsive.

13. Standards of care will be adhered to throughout the NSRSN/PHP.

14. Individuals experiencing a psychiatric crisis will be stabilized in the least restrictive setting, in the person's home or any in vivo setting.

15. Crisis services will be provided in a seamless manner recognizing the uniqueness of each individual case.

16. The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.

17. The integrated crisis system will be responsive and supportive of family members and persons experiencing a crisis.

B. REQUIREMENTS

In the performance of its obligations under this Statement of Work, Contractor shall comply with all of the following requirements:

1. NSRSN constituent counties shall be included and part of the planning and monitoring of crisis service provision.

2. NSRSN Clinical Eligibility and Care Standards Manual shall be implemented throughout the NSRSN Service Area.

3. The NSRSN regional crisis system will build upon existing systems of crisis provision that are consistent with NSRSN Clinical Eligibility and Care Standards Manual.

4. NSRSN must be able to track crisis services through the timely and systematic entry of utilization data to the NSRSN database.

III. COORDINATION OF SERVICES AND CLINICAL OVERSIGHT

The Contractor shall be responsible for the coordination, quality assurance and improvement, and clinical oversight of all services provided under this contract. Such services are subject to the development and maintenance of protocols and policies and procedures, which are consistent with the NSRSN Clinical Eligibility and Care Standards Manual which define how services will be provided and coordinated. Such standards, protocols, policies and procedures shall be consistent with the Crisis Response System Values and Principles as outlined in Section II of this Exhibit, and are subject to NSRSN and/or County review and acceptance originally and upon revision. Furthermore, they shall not conflict with any such requirements established currently or in the future by the NSRSN.

A. County-Specific Oversight Committee

The Contractor and community-based Crisis Services subcontractor(s) are required to participate in the Local Oversight Committee within each of the 5-county members of the NSRSN. The Local Oversight Committee will operate in accordance with written rules of governance and operational procedures developed by the team according to NSRSN requirements. Regional participation on Local Oversight Committee will occur at the request of either the NSRSN or local committee, but at a minimum of twice a year.

Functions of the Local Oversight Committee shall include review of critical incidents and exceptional circumstances, review of Integrated Crisis Response System complaints, as well as identifying gaps in local crisis response services. The Local Oversight Committee also may initiate contract non-compliance financial sanctions as described in Liquidating Damages section of this Agreement. County-specific documented protocols, which coordinate services with other community resources, county services, and alternative systems of care, will also be developed by this Committee.

In approving additional documented protocols unique to their local community, the Local Oversight Committee must certify in writing to the NSRSN that local protocols are consistent with regional standards or address any areas of variance. The County Coordinator or designee shall chair the Local Oversight Committee and must approve the local protocol prior to its submission to the NSRSN. The purpose of the regional review is to assure compatibility with NSRSN Clinical Eligibility and Care Standards Manual and to assess whether the local protocol has regional implications.

The Local Oversight Committee shall also conduct a variety of crisis response advisory activities. The purpose of these activities is to advise the NSRSN, each county and Integrated Crisis Response System management on issues of Integrated Crisis Response System development and implementation, provide a venue for community input into Integrated Crisis Response System services, provide cross systems networking opportunity for the Integrated Crisis Response System, and identify service gaps to be addressed. Representation in these activities should include, but not be limited to the following:

- Mental health services clients, family members, and advocates
- Hospital emergency department staff
- Chemical dependency/detox services providers
- Developmental disabilities service providers
- Law enforcement
- County mental health, substance abuse and developmental disabilities staff and corresponding local advisory board members
- Ethnic minority communities

The purpose of these activities is to provide meaningful opportunities for community stakeholders to have a significant impact on regional and community-based Integrated Crisis Response System design and services. Activities may include, but are not limited to:

- Focus groups
- Public meetings
- Formation of task oriented committees
- Client satisfaction surveys

B. Regional Program Management Team

The Contractor shall participate on a Regional Program Management Team administered by the NSMHA. This Team shall consist of Integrated Crisis Response System management staff from county specific mental health crisis response, ITA and community mental health systems, and Volunteers of America. Additional representatives from other service systems and agencies may be added to this team on an as needed basis.

The purpose of this team will be to provide a clinical review and oversight function for services provided under the Integrated Crisis Response System. The Program Management Team will conduct case reviews, review Integrated Crisis Response System complaints, identify and correct service problems related to internal coordination of services, and identify gaps in Integrated Crisis Response System services. The Program Management Team will be responsible for addressing issues identified by the NSRSN Quality Management Overview Committee and coordinate with the Contractor's internal quality assurance activities. The Program Management Team will be responsible for insuring the appropriateness and consistent application of standards of care and protocols, policies and procedures which assure the delivery of high quality services that are provided in a predictable, timely, consistent, and clinically appropriate manner throughout the NSRSN.

Representatives from this Team will serve as members of the Local Oversight Committee as required by this Exhibit and Agreement.

The Regional Project Management Team shall meet a minimum of once a month. Minutes of the Project Management Team will be kept by the NSMHA and distributed to the Contractor and Local Oversight Committee Chairpersons.

This team will be responsible for the review of the patterns of client referrals to ongoing care. This review will assure that:

- There is a uniform basis for such referrals.

- Referrals are clinically appropriate, based on client needs, and respect client choice of provider.

C. Clinical Disputes

The Contractor shall establish and codify in the Integrated Crisis Response System's policies and procedures a mechanism for the timely review and resolution of circumstances in which there is a difference of opinion among treating providers from any service system, as to the most appropriate course of action for providing clinical services to a particular client or program response. This mechanism shall ensure that the client is not denied timely services on the basis of this dispute. APN shall adhere to NSRSN approved protocols delineating a means for brief consultation among providers on relevant issues of concern, establishing whose professional judgment shall prevail during the crisis episode, and delineating a prompt review process.

D. Flexible Funding

Contractor shall use flex funds consistent with the NSRSN Clinical Eligibility and Care Standards Manual.

Contractor shall assure that policies and procedures are established which delineate the process for approving funding requests, maximum dollar amount allowable for each request, and identify acute care, housing arrangements, goods and services deemed unacceptable for purchase through flexible funding.

Documentation for the use of flexible funding shall be entered into client chart. Appropriate flexible use of funds shall be determined through NSRSN Concurrent reviews, grievance reviews and QRT reviews.

IV. INVOLUNTARY TREATMENT ACT SERVICES FOR ISLAND, SAN JUAN, SKAGIT AND WHATCOM COUNTIES

APN shall perform its duties under this Agreement in full compliance with the Involuntary Treatment Act, CDMHP Protocols, Exhibit A-1 and the NSRSN Clinical Eligibility and Care Standards Manual and participate directly in Probable Cause Hearings by making evaluations of individual in preparation, paperwork and testimony of 14-day Probable Cause Hearing, and 90 and 180-day court proceedings.

A. REFERRALS TO ITA SYSTEM

Care Crisis Response Services (VOA) shall screen calls and shall refer directly to County Designated Mental Health Professionals. A County Designated Mental Health Professional (CDMHP) shall determine:

- Whether an emergency or danger exists that requires immediate attention by other interveners, for example: emergency medical services, law enforcement agencies, or fire department;

- The order of priority if there are multiple emergent referrals;

- Whether mental health specialists, such as ethnic minority, geriatric, developmental disability, children, etc., are needed in order to adequately assess and triage cases.

- The following information shall be documented by APN during the referral process, as appropriate and clinically necessary:

  Demographic Data
  - Client Name
  - Date of birth
  - Most recent address and phone number
  - Name and phone number of relatives, friends, etc.
  - Social Security Number

  Presenting Problem
  - Reason for client involvement with referral source
  - Description of clients current behavior
  - Risk related behavior and statements of possible risk
  - Specific concerns regarding client's welfare
  - Diagnostic impression supporting danger to self/others, or grave disability
  - Name and phone number of person bring client to CDMHP attention (police, family, friend, etc.).

  Psychosocial History
  - Previous inpatient/outpatient treatment. Institution/agency
  - Current psychiatric treatment; therapist, case manager, agency
  - Psychotropic medication; past/present use

  Voluntary Status
  - Client willingness to be admitted into a mental health unit on a voluntary basis
  - Availability of voluntary psychiatric bed
  - If hospitals with mental health units been contacted regarding bed availability
  - If there are no voluntary beds available, or if the client is denied voluntary admission, written documentation must be made regarding the reason for denied admissions.

Medical Status

- Is immediate medical treatment requiring inpatient medical care necessary
- If alcohol is part of the presenting problem, a blood alcohol level should be taken
- A tox-screen may be necessary in situations involving prescription medication or other drugs

No Decline Policy

- APN shall not refuse to provide ITA evaluation to individuals referred by NSRSN/Snohomish Quality Assurance/Clinical Staff.

- APN shall not decline a referral for face-to-face ITA evaluation services from Volunteers of America (VOA) Crisis Response System, and shall determine if back up or other provisions are needed to assure safety.

When conducting investigations, the CDMHP shall use language interpreter services when appropriate.

B. CARE CRISIS RESPONSE SYSTEM (VOA) REFERRALS

There shall be a no decline policy for all requests for CDMHP interviews and investigations by Care Crisis Response System (VOA Triage). Referrals for CDMHP Investigations shall include, but not be limited to:

- An investigation of an inmate when the CDMHP, upon VOA's determination that the inmate meets the criteria of RCW 71.05. Referrals will also be accepted from jail staff, jail health professionals, County Prosecutor's Office or judge.

- "Mental Health Fitness for Jail" evaluations. This referral may also come as a request from local community police officers.

- A request from the attending physician or the physician's representative, an evaluation of a patient who is receiving treatment in a local hospital.

- Requests for evaluations at mental health units within two (2) hours of the request. Pending a CDMHP evaluation, persons who are inpatients of hospital medical units may be involuntarily detained at the referring facility. However, a psychiatrist or mental health professional must have determined that the patient may be an imminent risk.

- Referrals from nursing homes, CCFs and other facilities shall receive prompt response. WAC 275-55-342 and WAC 275-55-263(2e) give these facilities

the right to detain a client for a period of time pending the arrival of the evaluating CDMHP. The CDMHP will see the client in the facility rather than have the client sent to an emergency room. If a decision to detain is made, it may be necessary to have the individual seen by an ER M.D. to determine if patient is medically stable.

- An investigation of an individual in the person's home or any in-vivo setting.

V. COORDINATED AND SEAMLESS SERVICE LINK WITH SNOHOMISH COUNTY ITA

The Contractor is responsible for establishing and maintaining coordinated and seamless services with Snohomish County ITA in order to promote continuity of care for clients in need of ITA evaluations and to assure consistency of implementation of ITA services throughout the NSRSN Service Area. Such coordination shall include, but not be limited to:

- community response and service planning activities;
- provisions for joint outreach;
- improved communication across shifts;
- procedures for consultation on status of decompensating clients.

VI. COORDINATED AND SEAMLESS SERVICE LINK WITH MENTAL HEALTH CRISIS LINE, TRIAGE AND DISPATCH OF OUTREACH SERVICES PROVIDED FOR NSRSN SERVICE AREA THROUGH VOLUNTEER'S OF AMERICA

The Contractor shall ensure its members and affiliates provide a coordinated and seamless service link with the Care Crisis System (VOA). At a minimum, the Contractor shall adhere to the Integrated Crisis Response Services Cooperation Agreement between VOA and APN and NSRSN, Contract # RSN-97-MC-11, or its successor.

VII. STAFFING REQUIREMENTS

The Contractor shall ensure that Integrated Crisis Response System staffing levels are sufficient to provide 24 hour response capability and supervision within each member county area at all times. The Contractor shall ensure that in all instances, staff is appropriately qualified by training and/or experience to fulfill the duties and responsibilities to which they are appointed and meet any WAC or RCW requirements pertinent to their position. Specific staffing requirements include:

- APN Integrated Crisis Response contact person for each County. APN shall notify NSRSN in writing of the designated contact person(s) within each County at time of execution of this contract. APN shall notify NSRSN in writing of any designated contact person changes throughout the NSRSN service area within 2 working days of said change.

- A Mental Health Professional (MHP) designated in each member county who is responsible for the day-to-day management and implementation of this contract.

The persons holding these positions must meet the WAC requirement of Mental Health Professional have substantial experience in the provision of mental health crisis intervention services, and demonstrated abilities in Integrated Crisis Response System management. These persons must have the ability to evaluate the merit of clinical decisions made and the clinical implications of crisis response program policies and development. The MHP(s) shall coordinate closely with County and NSRSN staff on issues of cross system collaboration, development of crisis services/Integrated Crisis Response System, and contractual and regulatory obligations.

- County Designated Mental Health Professional(s) (CDMHPs) for Island, San Juan, Skagit and Whatcom Counties who meet WAC 388-865 requirements and are capable of providing the Involuntary Treatment Act Services requirements of this Contract and CDMHP requirements of RCW 71.05.

- Ability to obtain consultation for culturally competent services to consumers of ethnic/cultural minority status and other special populations (e.g. children, older adults, or persons with developmental disabilities) as required.

- APN shall be required to demonstrate that staff providing services under the auspices of this contract or its subcontracts meet the qualifications stated above.

- APN shall ensure that the Voluntary Crisis Response system has the ability to utilize flexible staffing patterns to meet a variety of needs, including the provision of extra staff as needed.

- Utilization of any paraprofessional staff must be in compliance with WAC 388-865, as appropriate.

VIII. CRISIS SERVICES REIMBURSEMENT REQUIREMENTS

The consideration to be paid by the NSRSN for the work to be provided by Contractor pursuant to this Agreement shall consist of the available amount from primary funding sources as described in Exhibit G and Section I. Financial Provisions – Reimbursement Requirements of this Agreement.

IX. TERMS AND CONDITIONS OF PERFORMANCE

All terms and conditions of performance outlined in Contract No. NSRSN-APN-02 are incorporated by reference as though fully set forth herein.