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Behavioral Health
Crisis Services
Provider Guide

Spokane County Regional Behavioral Health
(Administrative Services Organization)

Spokane County Community Services,
Housing, and Community Development Department
1116 W. Broadway Avenue, Spokane, WA 99260

Behavioral Health Crisis Services Provider Guide

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Chapter I

1. Behavioral Health Crisis Response Services

Spokane County Community Services, Housing, and Community Development (CSHCD), Spokane County Regional Behavioral Health (Administrative Services Organization) (SCRBH) ensures there are Behavioral Health Crisis Response Services available twenty-four (24) hours, seven (7) days per week, three hundred sixty-five (365) days per year to all Individuals within the Spokane Regional Service Area (RSA), which includes Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens Counties. Crisis services, including Involuntary Treatment Act (ITA) services, shall be provided regardless of an Individual's health insurance or ability to pay.

Crisis services provide immediate and short-term intervention aimed at assisting Individuals to stabilize during an actual or perceived urgent or emergent situation that occurs when an Individual's stability or functioning is disrupted and there is an immediate need to resolve the situation, to prevent a serious deterioration in the Individual's mental or physical health, or to prevent the need for referral to a significantly higher level of care.

Crisis services are intended to stabilize an Individual by providing immediate treatment and intervention in a location best suited to meet the needs of the Individual and provide treatment services in the least restrictive environment available. Crisis behavioral health services, including ITA services, may be provided without an intake evaluation or screening process.

Behavioral health crisis services are provided to Individuals experiencing mental health or substance use related symptoms, which are impacting an Individual's safety, well-being and functioning. Crisis services include:

 Behavioral Health Crisis Hotline services staffed by skilled professionals to assess, resolve crisis by phone, make appropriate referrals, and/or dispatch mobile teams or the Designated Crisis Responder (DCR). The Spokane RSA Behavioral Health Crisis Hotline Number is 1(877) 266-1818;

 Walk-In crisis services are available during business hours through contracted behavioral health crisis providers within the Spokane RSA, which include:

- Adams County: Adams County Integrated Health Care
    - 425 E. Main Street, Suite 600, Othello, WA 99334;
- Ferry, Lincoln, and Stevens Counties: North East Washington Alliance Counseling Services
    - Ferry County: 65 N. Keller, Republic, WA 99166
    - Lincoln County: 1211 Merriam Street, Davenport, WA 99122
    - Stevens County: 165 E. Hawthorne Avenue, Colville, WA 99114 or 301 E. Clay, Suite 201, Chewelah, WA 99109

- Pend Oreille County: Pend Oreille County Counseling Services
    - 105 S. Garden Avenue, Newport, WA 99156;
- Spokane County: Frontier Behavioral Health
    - 107 S. Division Street, Spokane, WA 99202

 Mobile crisis response services with the ability to respond to a behavioral health crisis in the community (e.g., homes, schools, or hospital emergency rooms);

 Involuntary Treatment Act (ITA) services includes all clinical services and administrative functions for the evaluation for involuntary detention or involuntary treatment of Individuals in accordance with RCW 71.05 and RCW 71.34. Crisis services become ITA services when a DCR determines an Individual must be evaluated for involuntary behavioral health treatment. ITA services continue until the end of an involuntary commitment;

 A range of short-term crisis stabilization services (e.g., Lesser Restrictive Alternative (LRA) in the community with natural supports to assist in implementing a safety plan, Crisis Stabilization facilities, Sobering, Withdrawal Management); and

 Urgent and Emergent care services with the capacity for immediate clinical intervention, triage, and stabilization (e.g., Crisis Stabilization facilities, Evaluation and Treatment (E&T) centers, Secure Withdrawal Management and Stabilization Services facilities, inpatient psychiatric admissions, Single Bed Certification (SBC) placement).

Contact information for the local crisis response provider for each county may be found on the CSHCD SCRBH website https://www.spokanecounty.org/4891/Regional-Behavioral-Health-ASO

Chapter II

2. CSHCD SCRBH (ASO) Crisis Response Policies and Procedures:

CSHCD SCRBH requires contracted crisis response providers to comply with the CSHCDS SCRBH Crisis Response Services Provider Guide, crisis response system policies, procedures, and protocols to ensure consistent, quality services within the Spokane RSA. Each contracted agency may have their own protocols, policies and procedures crisis response employees are required to comply with in the delivery of services. Please reference individual provider policies through the behavioral health agency (BHA).

CSHCD SCRBH Policies and Procedures may be accessed at: https://www.spokanecounty.org/3139/Policies-Procedures. The policy and procedures listed on the next page are applicable to the delivery of crisis services. Additional Management Information Systems and Claims and Encounter Submission policies are identified in **Chapter V, Section 8 Management Information Systems** of this guide.

Policy Number	Policy Name
AD - 4	Practice Guidelines
AD - 5	Compliance with Other Federal and State Laws
AD - 6	Age Culturally and Linguistically Competent Services
AD – 8	Program Integrity
AD - 9	Protocols for Tribes and Non-Tribal IHCPs
AD - 14	Staff Qualifications and Mental Health Professional Exception Request
AD - 20	Coordination of Benefits and Third-Party Liability
AD - 22	Credentialing and Re-credentialing
AD - 23	Customer Care Services
CSI – 10	Administrative Policy on the Involuntary Treatment Act
CSI - 11	CSHCD SCRBH DCR No Bed Policy
QM - 1	Incident Reporting and Media Contact
QM - 3	Grievance and Appeal System
QM - 4	Ombuds Service
QM – 8	Program Monitoring
QM - 10	Compliance Plan
QM - 14	Fraud and Abuse Compliance Provider Payment Suspensions
QM - 15	Quality Assessment and Performance Improvement Plan
QM - 16	Utilization Management Plan
QM - 17	Utilization Management Triage and Referral for Behavioral Healthcare
QM - 18	Utilization Management Communication Services
RD - 6	Single-Bed Certification
RS – 2	Crisis Plans
RS – 3	Crisis Response Services
RS – 4	Advance Directives
RS - 6	Behavioral Health Disaster Response
RS - 7	Individual Rights
RS - 8	Timely Access to Care
RS - 9	Behavioral Health Service Delivery via Interactive Video Technology
RS - 10	Behavioral Health Service Delivery via Interactive Video Technology During COVID-19
RS – 17	Timely Access to Authorization
RS - 18	Screening Assessment for Co Occurring Disorders (GAIN-SS)
RS - 19	Resource Management
RS - 20	Access to Personal Property
RS - 21	Available Resources
RS - 24	Care Coordination
RS - 27	Behavioral Health Crisis Hotline Telephone Access Standards

Policies and protocols will be reviewed and revised at a minimum of every twelve (12) months, or more often when there is a change in standards or law requiring a modification.

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3. Tribal Designated Crisis Responders

Tribal authorities within the Spokane RSA retain the right to establish a Tribal DCR operated under the authority of the Tribe, or Tribes if the Tribal Authority(s) located within the Spokane RSA elect to share Tribal DCR(s), to implement ITA and crisis response services in accordance with RCW 71.05, 71.24 and 71.34. Upon notification or request from the Tribal Authority, the CSHCD SCRBH shall provide assistance and designate at least one (1) person from the requesting Tribe as a Tribal DCR according to rules set forth by the HCA and in accordance with RCW 71.05.020, 71.24.025 and 71.34.020.

Tribal DCR's are fully designated DCRs with the same authority under the statute, and as such shall be referred to as a DCR, or Tribal DCR when specificity demands, throughout this guidance document and applicable policy and procedures. As stipulated by the Washington State Health Care Authority (HCA), Tribal DCRs operate independent of the authority of the CSHCD SCRBH or Tribal Authority. Per these stipulations, the requirements specifically outlined for DCR crisis provider agencies within this document, and specified in their contracts, shall not apply. However, requirements under the statute and agreements with the HCA remain.

CSHCD SCRBH contracted DCR crisis provider agencies shall engage collaboratively with Tribal DCRs operating within their county region and provide, upon request, reasonable opportunity to shadow and receive on-the-job training and technical assistance to support. In addition, CSHCD SCRBH contracted DCR crisis provider agencies shall make every effort to coordinate, engage, and include Tribal DCR(s) in all applicable county or regional collaborative groups or trainings, and ensure prompt communication and notification of needs, crisis system issues, or local/regional impacts to crisis service delivery.

The CSHCD SCRBH shall work with the Tribal Authority(s) and the HCA to implement an operational agreement and coordination plan to ensure continuity of crisis services within the requesting Tribal Authority area of responsibility, enhance collaboration and regional cooperation, and develop a mutually agreed upon methodology for the funding of responsible services. The CSHCD SCRBH will work with the HCA, Tribal Authority(s), and regional crisis providers to develop and incorporate regional Tribal Coordination Plans to ensure collaboration, regional engagement, responsive communication, and guidelines for cross-county coordination. The CSHCD SCRBH shall actively engage and make every effort to include Tribal DCRs in the regional work on crisis services collaborative groups, trainings, and policy impacts within the Spokane RSA.

4. Designated Crisis Responder Protocols

CSHCD SCRBH contracted DCRs must incorporate and adhere to the statewide DCR Protocols into the practice of their DCRs.

Source	Protocol Name
Washington State	2020 Designated Crisis Responder Protocols and any successor • Adults (Chapter 71.05 RCW) • Minors (Chapter 71.34 RCW) • Criminal Insanity Statute (Chapter 10.77 RCW)
Health Care Authority	Washington State Health Care Authority DCR Website

5. Crisis Response Protocols

The Behavioral Health Crisis Response Protocols must address relevant mental health and substance use situations utilizing clinically based triage and referral protocols that are in keeping with current acceptable practices for the delivery of behavioral healthcare.

These protocols are approved and maintained by the CSHCD SCRBH with input from practitioners, clinicians, and participating programs and partners. The following protocols shall guide trained crisis responders with active Washington State Department of Health (DOH) credentials or licensure.

A. Emergent, Urgent, and Routine Prioritization

Emergent care means services provided for a person that, if not provided, would likely result in the need for crisis intervention, or hospital evaluation due to concerns of potential danger to self, others, or grave disability per RCW 71.05 and 71.34. Emergent mental health care must be provided within two (2) hours of a request for crisis mental health treatment from any source.

Urgent care means a service to be provided to persons approaching a mental health crisis. If services are not received within twenty-four (24) hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary. Urgent care must be provided within twenty-four (24) hours of a request for mental health crisis services from any source.

Prioritization of Cases:

The crisis service providers are required to triage all incoming requests for crisis response services.

Cases are prioritized based on Emergent, Urgent, and Routine care, as well as current location. For example, an Urgent case in the community might be prioritized over an Emergent case in an Emergency Department due to the safety the ED provides for that Individual.

Emergent, Urgent, Routine care is not dependent on the Individual's current location. For example, an Individual in an Emergency Department will still likely be prioritized as Emergent, even though he/she are in a safe environment.

Criteria for an Emergent Response:
Referral information indicates the presence of an imminent danger to self, others, property, or an inability to provide for basic self-care needs due to a mental disorder or substance use disorder (SUD).

Referral information indicates an Individual appears to be an imminent danger to self, others or an inability to provide for basic self-care due to a probable mental health or SUD, and the Individual cannot be contacted to verify the information.

Another community emergency response system requests assistance regarding an imminent situation.

Examples may include:

- Unscheduled Walk-ins
- Involuntary Treatment Act (ITA) requests
- Against Medical Advice (AMA) requests for Individuals who are receiving involuntary services at the time of referral

Criteria for an urgent response Individual is deemed at risk of harm to self, others or is gravely disabled but risk is not imminent:
An individual who is demonstrating significant disruptive, non-imminent behavior, most likely due to a mental disorder and or SUD, which may impact the Individual's ability to care for himself or herself and/or maintain a safe level of functioning in a community setting.

An individual who is significantly at risk of losing a vital stabilizing resource such as housing, financial support, etc., and such loss has a high probability of directly impacting the person's ability to maintain a safe level of functioning in the community unless assistance within twenty-four (24) hours is provided.

An Individual who remains agitated, verbally intimidating, and unable to cooperate with a plan of action or crisis plan, or is only marginally able to comprehend reality, despite attempts to provide supportive listening or telephone crisis intervention.

Another community emergency response system requests assistance regarding a non-imminent situation.

Examples may include:

- Involuntary Treatment Act (ITA) requests
- Against Medical Advice (AMA) requests for Individuals who are requesting to leave, but not receiving involuntary treatment services

Criteria for a Routine Response:
An Individual, family member, or natural support is seeking information about behavioral health treatment services and/or community resources.
Examples may include:

- Individual is seeking outpatient services, and only requires linkage to such services
- Information and referral

B. Involuntary Treatment Act (ITA) Services

All current DCRs in the CSHCD SCRBH Spokane RSA must successfully complete the DCR training conducted by the HCA or approved internal DCR training protocol within ninety (90) days of hire. DCRs must be designated by the CSHCD SCRBH prior to providing ITA services under RCW 71.05 and RCW 71.34. CSHCD SCRBH contracted behavioral health agencies (BHAs) with DCRs must have policies and procedures for behavioral health ITA services that implement the following requirements:

1. All ITA investigations must be conducted in compliance with RCWs 71.05, 71.34, and 10.77 and the Washington State DCR Protocols.

2. A DCR may take a person into emergency custody when the person presents an imminent likelihood of serious harm or is in imminent danger because he/she is gravely disabled as a result of a mental disorder or SUD [RCW 71.05.150(2)].

   The DCR assesses the available information to determine whether or not, as a result of the mental disorder or SUD; there is a danger to the Individual, to others, the property of others, or the Individual is gravely disabled, and if so, if it is imminent. The DCR makes this assessment:
   - Using his/her professional judgment;
   - Based on an evaluation of the Individual, review of reasonably available history and interviews of any witnesses; and
   - Consistent with statutory and other legally determined criteria.

   Symptoms and behavior of the respondent which standing alone would not justify detention may support a finding of grave disability or likelihood of serious harm when:
   - Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts; and

- These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and
- Without treatment, the continued deterioration of the respondent is probable [RCW 71.05.212(3)].

However, Individuals cannot be detained on the basis of a severe deterioration in routine functioning alone, unless the detention is also shown to be essential for the Individual's health or safety. See In re: Labelle (1986).

A DCR who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 must also evaluate the Individual under RCW 71.05.150 for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention, and to determine if the Individual is in need of assisted outpatient treatment [RCW 71.05.156].

The DCR may proceed with emergency detention if using a non-emergency detention process would cause a delay that would reasonably increase the likelihood of harm occurring before the non-emergency process could be completed.

3. Whenever a DCR is conducting an ITA evaluation, consideration shall include all reasonably available information from credible witnesses and records regarding:

- Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW.
- Historical behavior, including history of one or more violent acts ("Violent act" means behavior that resulted in homicide, attempted suicide, nonfatal injuries, or substantial damage to property) [RCW 71.05.020(19)].
- Prior determinations of incompetency or insanity under chapter 10.77 RCW.
- Prior commitments under this RCW 71.05 and/or 71.34.

Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm when:

- Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts.
- These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent.
- Without treatment, the continued deterioration of the respondent is probable.

4. For all evaluations, DCRs must attempt to ascertain if the person has executed a mental health advance directive under chapter 71.32 RCW. The interview performed by the DCR may be conducted by video provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the interview.

5. An involuntary commitment interview for an adolescent may be conducted by video by the DCR provided that a licensed health care professional or professional person, who can adequately and accurately assist the adolescent, is present at the time of the interview.

6. All investigations under the ITA must include an evaluation for the efficacy and safety of an LRA to detention. Whenever LRAs are determined viable, the DCR must ensure that warm hand-offs to the appropriate Less Restrictive Alternatives (LRA) occur; based on the Individual's level of need.

7. DCRs or crisis intervention workers cannot be required to respond to a private home or other private location to stabilize or treat an Individual in crisis, or to evaluate an Individual for potential detention under the state's ITA, unless a second trained individual, determined by the clinical team supervisor, on-call supervisor, or individual professional acting alone based on a risk assessment for potential violence, accompanies them.

8. The second individual may be a first responder, a mental health professional, a mental health paraprofessional who has received training under RCW 71.05.715, or other first responder, such as fire or ambulance personnel.

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

10. Each contracted crisis services agency must provide crisis and safety training, which includes instructions on accessing crisis response back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations.

11. Every DCR dispatched on a crisis visit, must have prompt access to information about any history of dangerousness or potential dangerousness on the Individual they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response. Information on any current or past history of dangerous behaviors may also include referral source, family members, or support persons reports, which may be the only

known source of information for Individuals who do not have a documented record of treatment.

12. Every DCR who engages in home visits for the provision of crisis services must be provided with a wireless telephone or comparable device by the BHA for the purpose of emergency communication.

C. Rule Out of a Lesser Restrictive Alternative (LRA)

An LRA is any viable plan developed by DCRs to successfully resolve an Individual's crisis without a psychiatric inpatient or secure withdrawal management and stabilization services admission. It is the DCRs responsibility to rule out any viable alternatives less restrictive before implementing involuntary treatment.

Prior to making a decision to detain or revoke, DCRs have a responsibility to investigate and evaluate the possibility of treatment less restrictive than involuntary hospitalization including, but not limited to:

- Placement with natural supports such as a responsible adult family member and/or friend;
- Stabilization resources provided by other mental health providers, SUD/withdrawal management providers, developmental disabilities, correctional facilities or other agencies and services on an outpatient basis;
- Crisis stabilization alternatives may include Foothills E&T, Calispel E&T, Alliance E&T, Daybreak Youth Services E&T, Crisis Stabilization Facility, Spokane Regional Stabilization Center;
- Mobile crisis response;
- Wrap-Around Intensive Services (WISe) for Youth;
- Program of Assertive Community Treatment (PACT) Services; Psychiatric services;
- Release to the community with referral to behavioral health services, or other specialized assistance for continued follow up to ensure continued crisis resolution;
- Consultations with psychiatrists, physicians and/or professionals in the community;
- Voluntary psychiatric hospitalization;
- Review of crisis plans available 24/7; and
- Immediate intake for services on business days within twenty-four (24) hours.

The DCR is not required to automatically accept any LRAs offered by an Individual or other collateral Individuals.

The DCR is required to assess the credibility, reliability, and viability of potential less restrictive alternatives to provide safety and care for an Individual at a level appropriate to the clinical and situational presentation of risk at the time of evaluation.

The DCR is required to remain on-site with the Individual until a viable plan for the Individual's safety is established and implemented.

The DCR is required to document all LRAs investigated and ruled out in the involuntary detention petition.

D. Assisted Outpatient Treatment (AOT)

"Assisted Outpatient Behavioral Health Treatment (AOBHT)" means a petition for LRA Treatment for up to eighteen (18) months on the basis that a person is in need of AOT filed by: the director of a hospital where the person is hospitalized; the director of a behavioral health service provider providing behavioral health care or residential services to the person; the person's treating mental health professional or SUD professional or one who has evaluated the person; a DCR; a release planner from a corrections facility; or an emergency room physician.

The petitioner must personally interview the person, unless the person refuses an interview, to determine whether the person will voluntarily receive appropriate treatment. The petitioner must allege specific facts based on personal observation, evaluation, or investigation, and must consider the reliability or credibility of any person providing information material to the petition.

If the DCR or other authorized petitioner finds that the person is in need of assisted outpatient treatment, they may file a petition requesting the court to enter an order for up to eighteen (18) months of LRA Treatment when the court process is in place for the relevant county. The petition must be served on the county prosecuting attorney and include the following:

A) A statement of the circumstances under which the person's condition was made known and the basis for the opinion that the person is in need of AOT;

B) A declaration from a physician, physician assistant, advanced registered nurse practitioner, or the person's treating mental health professional or SUD professional, who has examined the person no more than 10 days prior to the filing of the petition and who is willing to testify in support of the petition, or who alternatively has attempted to examine the person within the same period but has not been able to obtain the person's cooperation, and who is willing to testify to the reasons they believe that the person meets AOT criteria;

C) The declarations of any additional witnesses supporting the petition;

D) The name of an agency, provider, or facility that agrees to provide LRA treatment; and if the person is detained at the time of the petition, the anticipated release date of the person and any other details needed to facilitate successful reentry and transition into the community.

The prosecutor must review the petition, and if appropriate, consult with the petitioner to conform the petition with the requirements of law. The prosecutor may decline to proceed with petition that does not meet legal requirements.

E. Medical Clearance for ITA Evaluations

"Medical clearance" means a physician or another health care provider has determined that a person is medically stable and ready for referral to the DCR. RCW 71.05 does not require an Individual complete medical clearance in an emergency room prior to initiation of evaluation; however, the DCR must consider if unresolved medical issues will interfere with the Individual's ability to participate in the ITA evaluation.

Admitting inpatient and E&T facilities, such as Providence Sacred Heart Medical Center's Psychiatric Unit, Secure Withdrawal Management and Stabilization Services facility, Eastern State Hospital, Calispel E&T Facility, Foothills E&T Facility, and Alliance E&T do require medical clearance prior to admission.

The following guidelines should be used when determining if an Individual is medically stable for ITA evaluation:

- Is the Respondent sufficiently medically stable to tolerate the evaluation process, interact with the DCR and be reasonably alert to the evaluation process?
- Have all necessary medical procedures been completed to ensure the immediate safety of the Individual, without interruption of the evaluation process?
- Are there medical issues that need to be ruled out or clarified to identify the presence of a possible medical disorder, rather than a mental disorder as the cause of the behavior presenting risk to the Individual of concern?

The DCR hold is not authorization for medical treatment:

- If a physician requests an evaluation in order to get authorization for involuntary medical treatment, the physician should be directed to follow their facilities internal procedures regarding involuntary imminent medical procedures, including contacting their house supervisor or house administrator regarding informed consent laws RCW 7.70.065 and RCW 11.88.010 if necessary.
- Verbal or written authorization by a DCR to hold a Respondent for evaluation for involuntary treatment services, or completion of a Petition for Initial Detention, does NOT authorize an Emergency Room physician or other physician to initiate medical procedures which the Individual is refusing.
    - RCW 71.05.210 states: *"(1) Each person involuntarily detained and accepted or admitted at an E&T facility, secure withdrawal management and stabilization facility, or approved SUD treatment program; (b) Shall receive such treatment and care as his or her condition requires including treatment on an outpatient basis for the period that he or she is detained, except that, beginning twenty-four (24) hours prior to a trial or hearing pursuant to RCW 71.05.215, 71.05.240, 71.05.310, 71.05.320, 71.05.590, or 71.05.217, the Individual may refuse psychiatric medications, but may not refuse: (i) Any other medication previously prescribed by a person licensed under Title 18 RCW; or (ii) emergency lifesaving treatment, and the Individual shall be informed at an appropriate time of his or her right of such refusal."*
    - An evaluation for a Petition for Initial Detention may be initiated, if evidence suggests that as a result of a mental disorder or SUD, the Individual meets criteria for grave disability.

F. ITA Requests for Individuals Who Are Terminally Ill

DCRs may receive requests to evaluate Respondents for detention when the Respondent is terminally ill. Terminal illness may result in a crisis for the Respondent, including the development of symptoms of a mental disorder because of a medical condition, and result in a crisis for the persons and their care providers.

When a DCR receives a request to evaluate a terminally ill Respondent they shall:

- Respond to the request.
- Attempt all other less restrictive alternatives to involuntary in-patient psychiatric care for terminally ill Respondents. Psychiatric units discourage the admission of terminally ill Respondents who may spend the last days of their lives in a psychiatric hospital.
- Involve knowledgeable collateral resources such as Hospice, Psychiatric consultation, and Elder Services staff, supervisor assistance, etc.
- Assess and activate current resources, including an assessment of current pain management and pain medication, with the assistance of the on-call psychiatrist, as this is a common cause for increased crisis in terminally ill Respondents.
- Provide all possible education, support, and assistance to the family of the terminally ill Respondent and treatment systems who are likely to be in crisis along with the terminally ill Respondent.

G. ITA Requests for Individuals Who are not Medically Stable for Discharge

If an Individual meets criterion for Initial Detention or Revocation but requires medical treatment that cannot be provided on a psychiatric inpatient unit or secure detox (i.e., is not medically ready for discharge from the medical floor), the DCR may detain or revoke the Individual, and request a SBC. The DCR cannot detain or revoke for SUD if the Individual needs to remain on a medical floor. The DCR will follow the internal policies and protocols for a medical continuance, withdrawal of the initial detention or revocation petition, or consult with physician for the use of physician Informed Consent.

H. No Beds Available for Persons Meeting Detention Criteria

Crisis services providers shall ensure that their DCRs make a report to the HCA when he or she determines a person meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710 and there are not any beds available at a designated involuntary treatment inpatient facility, the person has not been provisionally accepted for admission by a facility, and the person cannot be served on a SBC or LRA.

The DCR is responsible for submitting an Unavailable Detention Facility Report (No Bed Report) within twenty-four (24) hours if, based on an evaluation of a person they find meets the criteria for detention for involuntary treatment but are unable to detain the person due to the lack of an involuntary treatment bed. For individuals with active Medicaid coverage and an assigned managed care organization (MCO), the DCR must make best efforts to notify the appropriate MCO either by sending them the

Unavailable Detention Facility Report (No Bed Report), or notification by phone.

When a DCR submits an Unavailable Detention Facility Report (No Bed Report) to the HCA, the crisis services provider agency will attempt, regardless of location, to re-evaluate the Individual on a daily basis to determine if they continue to meet criteria for detention and to seek an involuntary treatment bed if they do. Each day that the person continues to meet criteria for detention, but the DCR office is unable to find an involuntary treatment bed, an Unavailable Detention Facility Report shall be submitted. The notification report must contain at a minimum:

1. The date and time that the investigation was completed;
2. The identity of the responsible ASO;
3. A list of facilities which refused to admit the person;
4. Identifying information for the person, including age or date of birth;
5. Other reporting elements deemed necessary or supportive by the HCA; and
6. A new ITA and No Bed Report must be completed each day (twenty-four (24) hours) until an appropriate inpatient bed is located or the Individual no longer meets detention criteria under RCW 71.05 or 71.34.

Crisis providers and the Individuals assigned MCO or CSHCD SCRBH must attempt to engage the person in appropriate services for which the person is eligible and report back within seven (7) days to the HCA.

Crisis providers and CSHCD SCRBH are required to implement an adequate plan to provide evaluation and treatment services, which may include the development of LRAs to involuntary treatment, or prevention programs reasonable calculated to reduce demand for evaluation and treatment.

The HCA will initiate corrective action when appropriate to ensure an adequate plan is implemented. Corrective actions may include remedies under RCW 71.24.330 and 43.20A.894, including requiring expenditure of reserve funds.

I. Single Bed Certifications

The SBC process is allowable under RCW 71.05.745 and WAC 182-300-0100 to provide additional treatment capacity for a person suffering from a mental disorder for whom an appropriate treatment bed is not available.

The facility that is the proposed site of the SBC must be a facility that is willing and able to provide the person with timely and appropriate treatment either directly or by arrangement with other public or private agencies. An SBC must be specific to the individual receiving treatment.

A DCR who submits an application for an SBC for treatment at a facility that is willing and able to provide timely and appropriate mental health treatment in good faith belief that the SBC is appropriate may presume that the SBC will be approved for the purpose of completing the detention process and responding to other emergency calls.

J. ITA Requests for Incarcerated Individuals

When a jail, prison, or correctional facility requests an ITA, a DCR may not rule out any referral for investigation solely because the Individual is incarcerated. Incarcerated Individuals who have a mental disorder and meet detention criteria may be involuntarily detained for evaluation and treatment with or without a jail hold.

ITA evaluations will be conducted for a defendant or offender who is the subject of a discharge review within seventy-two (72) -hours prior to release from confinement, which does not include weekends or holidays.

If an investigation is requested for an incarcerated person who has undergone a competency evaluation under RCW 10.77, an evaluation shall be conducted of such person under RCW 71.05 and RCW 10.77.065(1)(b). To the extent possible, the DCR, upon request of the correctional facility, will conduct the investigation shortly before the person's scheduled release date or when the correctional facility has the authority to release the person if the detention criteria are met.

The DCR shall obtain information from the jail, prison, or correctional facility, which shall be maintained in the Individual's clinical record, regarding the following:

- The Individual's criminal history, arrest reports, and current criminal charges status;
- Release date, if eligible for release;
- The facility's policy regarding release;
- Any order to Dismiss and Detain or Dismiss and Refer;
    - For Dismiss and Detain orders: the threshold of evidence for evaluation is a preponderance of evidence
    - For Dismiss and Refer orders: the threshold of evidence for evaluation is clear, cogent, and convincing
- Any competency evaluations;
- Court orders for commitment or involuntary treatment while in custody; and
- Any mental health evaluations by jail, prison, or correctional facility staff.

DCRs shall coordinate with law enforcement, court, jail, prison, Tribal jail, or correctional facility personnel on medical clearance, transportation, and admission into an appropriate treatment facility under RCW 71.05 or RCW. 71.34.

K. ITA Requests Involving Individuals with Veterans Status

During the twelve (12)-hour period in which a person may be held in a facility for evaluation by a DCR, the inpatient facility must inquire into the person's veteran status or eligibility for veteran's benefits. If the person identifies as a veteran or is eligible for veteran's status, the facility must ask the person whether he or she would be amenable to treatment by the Veteran's Health Administration (VHA). This information must be shared with the DCR.

If the person has been identified as being potentially eligible for veterans administration services, is amenable for those services, and is appropriate in light of reasonably available information about the person's circumstances, the DCR must first refer the person to the VHA for mental health or SUD treatment at a facility capable of meeting the needs of the person including, but not limited to, the involuntary treatment options available at the Seattle division of the VA Puget Sound health care system.

If the person is accepted for treatment by the VHA and is willing to accept treatment by the VHA as an alternative to other available treatment options, the DCR, the VHA, and the facility where the patient is located will work to make arrangements to have the person transported to a VHA facility.

Chapter III

6. Triage and Referral Protocols

A. Levels of Urgency:

Requests for routine mental health or SUD treatment services from physicians, prescribers, schools, therapists or SUD Professional /SUD Professional Trainees, guardians, or others: Crisis response providers will assist Individuals in establishing an appointment or access to walk-in services with a BHA and/or physician office. Individuals who do not have Medicaid, private medical insurance, or are not at or below the two hundred twenty percent (220%) Federal Poverty Level (FPL) for CSHCD SCRBH funded behavioral health services within available resources will be referred to a community resource and self-help support groups.

New onset mental health or SUD issues: Crisis response providers will assess the Individual for risk, safety and protective factors to determine if the Individual needs stabilization, urgent or emergent care services. Facilitation into the appropriate care setting will occur for Individuals who need short-term stabilization or an acute inpatient admission when a viable safety plan cannot be established in the community. Individuals considered at low risk and safe in the community will be linked to outpatient behavioral health services or an appointment will be provided when the Individual elects to access outpatient services from the crisis response agency. Individuals who do not have Medicaid, private medical insurance, or are not at or below the two hundred twenty percent (220%) FPL for CSHCD SCRBH funded behavioral health services within available resources will be referred to a community resource and self-help support groups.

Individuals with a chronic mental health and SUD: Crisis response providers will assess the Individual for risk, safety and protective factors to determine if the Individual needs stabilization, urgent or emergent care services. Facilitation into the appropriate care setting will occur for Individuals who need short-term stabilization or an acute inpatient admission when a viable safety plan cannot be established in the community. Individuals considered at low risk and safe in the community will be linked to outpatient behavioral health services or an appointment will be provided

when the Individual elects to access outpatient services from the crisis response agency. Individuals who do not have Medicaid, private medical insurance, or at or below the two hundred twenty percent (220%) FPL for CSHCD SCRBH funded behavioral health services within available resources will be referred to a community resource and self-help support groups.

Acute illness or SUD that impacts ability to function but does not present imminent danger: Crisis response providers will assess the Individual for risk, safety and protective factors to determine if the Individual needs stabilization, urgent or emergent care services. Facilitation into the appropriate care setting will occur for Individuals who need short-term stabilization.

Danger to self, others, property or inability to care for self, due to a SUD or mental illness: Crisis response providers will assess the Individual for risk, safety and protective factors to determine if the Individual needs stabilization, urgent or emergent care services. Facilitation into the appropriate care setting will occur for Individuals who need short-term stabilization or an acute inpatient admission when a viable safety plan cannot be established in the community. DCRs will rule out an LRA, when possible. An ITA evaluation will be conducted when a viable safety plan cannot be developed, or the Individual is not good faith for voluntary or does not have the capacity to consent for treatment.

Medically risky situation due to mental illness or substance use (e.g. neglect of serious wounds, uncontrolled diabetes): Crisis response providers will assess the Individual for risk, safety and protective factors to determine if the Individual needs stabilization, urgent or emergent care services. Facilitation into the appropriate care setting will occur for Individuals who need short-term stabilization or an acute inpatient admission when a viable safety plan cannot be established in the community. Designated crisis responders will rule out an LRA, when possible. An ITA evaluation will be conducted when a viable safety plan cannot be developed, or the Individual is not good faith for voluntary or does not have the capacity to consent for treatment. Refer to protocols for ITA Requests for Individuals Who Are Terminally Ill and ITA Requests for Individuals Who are not Medically Stable for Discharge.

B. Appropriate Care Settings

Behavioral health crisis and clinical treatment services provided to Individuals in appropriate care settings must be medically necessary services.

Medically necessary service/medical necessity: A requested service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. “Course of treatment” may include no active intervention at all.

Where required or appropriate, the crisis service or behavioral health treatment providers shall obtain the prior Apple Health Plan MCO or private insurance

authorization in accordance with health plan provider manuals unless the situation is one involving the delivery of Emergency Services. Upon and following Individuals' assignment, the provider shall coordinate the provision of covered services to Individuals and ensure continuity of care in accordance with the HCA, MCO, CSHCD SCRBH, or private health plan requirements.

Emergency care (e.g. hospital emergency department care, withdrawal management/detoxification programs, E&Ts, etc.): Facilitation into the appropriate care setting will occur for Individuals who need short-term stabilization or an acute inpatient admission when a viable safety plan and LRAs cannot be established in the community. Emergency care may be necessary to ensure medical conditions are treated and stabilized prior to consideration of emergency behavioral health care settings. Individuals may access emergency care settings on a voluntary or involuntary bases dependent upon the setting. Voluntary admissions can be facilitated into E&Ts, inpatient psychiatric facilities, withdrawal management facilities, and sobering. Eastern State Hospital and Secure Withdrawal Management and Stabilization Services facilities require an involuntary detention for admission.

If crisis services provider refers an Individual to a hospital emergency room for covered services, the provider shall provide notification to CSHCD SCRBH by the next business day.

Intensive treatment (e.g. Intensive Day Support, urgent visits, residential treatment): Facilitation into the appropriate care setting will occur for Individuals who need short-term stabilization as part of a viable safety plan may include SUD ASAM level 3.5, 3.3, or 3.1 levels of care, Spokane Treatment and Recovery Services Cub House or Karen's House programs, Providence Sacred Heart Medical Care Center's Behavioral and Education Skills Training (BEST) program, Lutheran's Family Outreach Crisis Intervention Services (FOCIS) program, Institute for Family Development's Homebuilder's program, Wrap-around with Intensive Services (WISe) for Children and Youth, Excelsior Integrated Care Center LifePoint Program, Assisted Living Facility, respite at Hope House or House of Charity, or an Adult Residential Treatment Facility (ARTF).

Routine care (e.g. office visits for prescribing, therapy): Individuals will receive assistance in establishing an appointment or access to walk-in services with a behavioral health agency and or physician. Individuals who do not have Medicaid, private medical insurance, or at or below the two hundred twenty percent (220%) FPL for CSHCD SCRBH funded behavioral health services within available resources will be referred to a community resource and self-help support groups.

Intake, assessment and evaluation services for mental health and SUD, if they are offered in the community: Individuals considered at low risk and safe in the community will be linked to outpatient behavioral health services or an appointment will be provided when the Individual elects to access outpatient services from the crisis response agency. These may include intake or assessment at a mental health, SUD, or co-occurring treatment provider.

Community resources (e.g. AA, NA, self-help support groups): Individuals considered at low risk and safe in the community will be linked to resources to include self-help

groups. Individuals who do not have Medicaid, private medical insurance, or are not at or below the two hundred twenty percent (220%) FPL for CSHCD SCRBH funded behavioral health services within available resources will be referred to a community resource and/or self-help support groups. Additionally, Individuals accessing any formal behavioral health services will be encouraged to access these supports to complement and support their recovery process.

Chapter IV

7. Behavioral Health Crisis Response Services Scope of Work

A. Crisis Response Services - Adams County Integrated Health Care, North East Washington Alliance Counseling Services, Pend Oreille County Counseling Services, and Frontier Behavioral Health

Behavioral health agencies provide services to promote recovery for Youth and Adults and through its contracted provider network. Recovery means the processes through which people are able to live, work and/or attend school, learn, and participate fully in their communities. Resiliency means the personal and community qualities that enable Individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

"Crisis" means a Behavioral Health Crisis, defined as a turning point, or a time, a stage, or an event, whose outcome includes a distinct possibility of an undesirable outcome. "Crisis Services" (Behavioral Health) means providing evaluation and short-term treatment and other services to Individuals with an emergent mental health condition, or are intoxicated or incapacitated due to substance use, and when there is an immediate threat to the Individual's health or safety.

Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the Individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Services are provided by or under the supervision of a Mental Health Professional (MHP).

Contracted behavioral health crisis response providers shall ensure crisis services are available twenty-four (24) hour, seven (7) days per week, three hundred sixty-five (365) days per year to provide immediate and short-term intervention aimed at assisting Individuals to stabilize during an actual or perceived urgent or emergent situation that occurs when an Individual's stability or functioning is disrupted and there is an immediate need to resolve the situation, to prevent a serious deterioration in the Individual's mental or physical health, or to prevent the need for referral to a significantly higher level of care. Behavioral health crisis services include community-based outreach crisis intervention designed to divert psychiatric hospitalization.

Crisis services are intended to stabilize an Individual by providing immediate treatment and intervention in a location best suited to meet the needs of the Individual and provide treatment services in the least restrictive environment available.

Crisis providers shall make available at least one (1) SUD Professional with experience conducting behavioral health crisis support for consultation by phone or on site during regular business hours.

Crisis providers shall make available at least one (1) Certified Peer Counselor with experience conducting behavioral health crisis support for consultation by phone or on site during regular business hours.

Behavioral health crisis services, that are medically necessary, shall be provided as described in the CSHCD SCRBH Behavioral Health Crisis Services Provider Guide, CSHCD SCRBH, MCOs, and Agency Policy and Procedures, recognized professional practice standards in conformance with federal and state legislative, and administrative regulations, and as required by the HCA and MCOs' standards and contracts.

Behavioral health crisis services, that are medically necessary, shall be provided by a professional within the normal scope of practice and licensure of a provider. Crisis services shall be provided by individuals with active DOH credentials or licenses who have training and competence in delivering crisis services, in accordance with Washington State laws, and supervised by an MHP. The use of peer support specialists trained in crisis intervention strategies and supports may be included within the array of professionals delivering crisis response services in the community.

Behavioral health services, including crisis services, shall be provided to Individuals at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

Crisis service providers shall access Individuals' crisis support plans, when available, to support positive intervention outcomes. Crisis service provider will develop crisis support and/or safety plans in the delivery of crisis services. The Crisis Plan will be developed collaboratively with the individual (including parents for those twelve (12) and under), natural supports, and involved the behavioral health professionals, if applicable. A copy of the Crisis Plan will be provided to the Individual, legal guardians or representatives, and natural supports with the signed consent of the Individual for Individuals age thirteen (13) or older.

Providers shall in all instances obtain informed consent prior to treatment. Without regard to Medicaid Benefit Plan limitations or cost, the Provider shall communicate freely and openly with an Individual about his or her health status, and treatment alternatives (including medication treatment options); about their rights to participate in treatment decisions (including refusing treatment); and providing them with

relevant information to assist them in making informed decisions about their health care.

Crisis services providers shall aggressively work to convert non-Medicaid Individuals who are Medicaid eligible to Medicaid status, including helping families to access health insurance coverage for their children under the provisions of the Children's Health Insurance Program.

Language and Communication Support

Free and professional interpreter services and language translation shall be available to all Individuals accessing crisis services, including telephone crisis calls for Individuals with a preferred language other than English, to ensure equitable access to crisis services twenty-four (24) hours a day, seven (7) days a week, regardless of language or culture. Communication assistance for Individuals who are Deaf or hard of hearing using American Sign Language (ASL), Telecommunications Device for the Deaf (TDD)/Teletypewriter (TTY) technology machines and other aids shall also be provided free of charge.

Behavioral health crisis providers shall have access to TDD/TTY technology and certified Interpreters for crisis calls with Individuals who are deaf or hearing impaired. Interpreter services shall be provided for all interactions between the Individual and the behavioral health crisis provider when the need is indicated. Behavioral health crisis providers shall be proficient in the use of TDD/TTY and alternate languages, for the hearing impaired and limited English proficient population(s).

Contracted behavioral health crisis providers shall submit a monthly activity report of the number of interpreter services accessed for Individuals receiving crisis telephone services to the CSHCD SCRBH. This information may be included on the monthly Compliance Log submitted to the CSHCD SCRBH with an identifier to distinguish crisis telephone service requests for interpreters from interpreter services request for other behavioral health services within the agency.

Behavioral Health Co-Occurring Disorder Screening and Assessment Requirements

The HCA requires behavioral health providers to utilize the Integrated Co-Occurring Disorder Screening Tool (GAIN-SS found at https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/gain-ss). The behavioral health agency shall train behavioral staff on use of the tool to address the screening and assessment process and quadrant placement.

Service Encounter Reporting

Contracted behavioral health crisis providers shall follow the HCA Service Encounter Reporting Instructions (SERI), the HCA Data Guide, the CSHCD SCRBH Service Duration Matrix, the CSHCD SCRBH Data Dictionary, and any attendant updates and will report all Individuals and services funded in part or wholly by CSHCD SCRBH to the CSHCD SCRBH Information System (IS). The CSHCD SCRBH IS System is called “Raintree.” The behavioral health crisis provider is required to follow

all the reporting requirements in SERI including ensuring their providers have the appropriate license and credentials to provide the services.

Behavioral Health Crisis Hotline services provided to Individuals assigned under the Washington Apple Health Fee-For-Service (FFS) plan for Individuals who identify as American Indian/Alaska Native (AI/AN) shall have demographic data submitted through the State's portal and their service encounters billed to the State's ProviderOne system.

Behavioral health crisis interventions and outcomes for all Individuals must be reported to the CSHCD SCRBH in the request reporting format within twenty-four (24) hours of the crisis response. The CSHCD SCRBH will distribute Medicaid enrollee crisis intervention and outcome reports to the assigned Apple Health Plan MCO to ensure the MCO is aware that their member contacted the crisis system. Contracted behavioral health crisis providers will ensure encounter and outcome data is submitted to CSHCD SCRBH prior to the twenty-four (24)-hour notification submission requirement.

Allowable Service Modalities for Crisis Response

Each contracted behavioral health crisis providers authorized allowable service modalities should be within the agency's current DOH Licensures and listed on the CSHCD SCRBH Behavioral Health Agency Service Grid, by the behavioral health agency name and programs. Contracted behavioral health crisis provider are required to use the most current version of the CSHCD SCRBH Behavioral Health Agency Service Grid to determine which services modalities, Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes. The CSHCD SCRBH Behavioral Health Agency Service Grid is updated by the CSHCD SCRBH IS team and will be sent via email to the agency as updates are available. The current version of the CSHCD SCRBH Behavioral Health Agency Service Grid will be available in the CSHCD SCRBH portal.

Care Coordination

Crisis response services includes linkage to behavioral health services, physical healthcare needs, medical services, services associated with the social determinants of health as needed, and referral to emergency resources. Emergency resources include, but are not limited to, food, emergency shelter, domestic violence advocacy and public assistance.

The CSHCD SCRBH shall provide Apple Health Plan MCOs information on crisis interventions and outcomes to their Medicaid enrollees to ensure Individuals access needed healthcare services and other resources to support continuity of care.

The CSCHD SCRBH, behavioral health agencies including crisis response providers, and Apple Health Plan MCOs or other healthcare plans, if applicable, will coordinate care for high-risk Individuals for effective crisis planning and treatment services, which support stabilization and safety.

Coordination of care strategies will seek to reduce utilization of crisis services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of wellness recovery action plans and mental health advance directives in treatment planning.

The CSHCD SCRBH shall coordinate continuity of care with the Apple Health Plan MCOs for Individuals who transition between Medicaid eligibility and ineligibility (i.e. Spenddowns, etc.) to prevent crises and a disruption in medically necessary services.

For eligible non-Medicaid Individuals, CSCHD SCRBH, behavioral health agencies including crisis response providers shall ensure best, good-faith efforts in scheduling Prescriber and other Provider appointments to occur within seven (7) calendar days of an Individual's discharge and documented as such in the Individual's electronic health record. Information on the prescriber appointment shall be communicated back to discharging facility, including for those Individuals discharging from the state hospital forensic units, to ensure a seamless transition and warm handoff.

The CSCHD SCRBH and responsible behavioral health agencies, including crisis response providers, will assist and provide coordination support to Spokane RSA eligible Individuals, including those covered by commercial insurance and not enrolled in a managed care plan, determined to need assistance in accessing and obtaining LRA treatment services.

Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination, as defined under the applicable HCA Contract(s). Possible subjects for Grievances may include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or an employee, or failure to respect an Individual's rights.

Individuals may file a Grievance with the behavioral health provider, the MCO or CSHCD SCRBH, as applicable. Crisis providers shall attempt to resolve any Grievance brought forth to the provider directly, in compliance with WAC 246-341-0600(1)(i). Crisis providers are responsible for notifications to Individuals who file a Grievance directly with the provider. The provider shall ensure Individuals are informed of Ombuds Services and contact information to access Ombuds Services. Crisis providers shall include the Individual, any identified Representatives, and/or the Ombuds throughout the Grievance process.

When a resolution cannot be reached with an Individual and the crisis provider, the provider will notify the Individual that he/she may escalate the Grievance to the MCO if he/she is a Medicaid recipient or the CSHCD SCRBH for Individuals who do not have Medicaid. The crisis provider shall notify the MCO or CSHCD SCRBH no later than the end of the next business day following this notification to the Individual.

The MCOs and CSHCD SCRBH maintain a Grievance process consistent with applicable state and federal requirements, including those that apply to General Fund State-funded services. The MCO and CSHCD SCRBH shall be responsible for providing any notices related to a Grievance for Grievances filed directly with the

MCO or CSHCD SCRBH. Crisis providers shall collaborate with and provide all reasonable assistance to the CSHCD SCRBH and the MCOs, as needed, during the investigation and resolution process of an Individual's complaint, Grievance, or inquiry related to a crisis service.

The crisis services provider and CSHCD SCRBH shall promptly refer to the MCO any non-Grievance inquiries or requests it receives from Members or MCO providers that are unrelated to the Services provided by the crisis services provider under this Agreement.

Critical Incident Reporting

The crisis services provider shall send immediate notification to CSHCD SCRBH and, when indicated, to the applicable MCO of any Critical Incident involving an Individual who is receiving or has received behavioral health crisis services in accordance with CSHCD SCRBH Policy and Procedures. Notification shall be made during the business day on which the crisis services provider becomes aware of the Critical Incident. If crisis services provider becomes aware of a Critical Incident involving an Individual who is receiving or has received behavioral health crisis services after business hours, the crisis services provider shall provide notice to CSHCD SCRBH and, when indicated, to the applicable MCO as soon as possible the next business day.

The crisis services provider shall provide to CSHCD SCRBH and, when indicated, to the applicable MCO all available information related to a Critical Incident at the time of notification, including: a description of the event, including the date and time of the incident, the incident location, incident type, information about the individuals involved in the incident and the nature of their involvement; the client's or other involved Individuals' service history with the crisis services provider; steps taken by the crisis services provider to minimize potential or actual harm; and any legally required notification made by the crisis services provider.

Upon CSHCD SCRBH or a MCO's request, and as additional information becomes available, the crisis services provider shall update the information provided regarding the Critical Incident and, if requested, shall prepare a written report regarding the Critical Incident, including any actions taken in response to the incident, the purpose for which such actions were taken, any implications to the crisis services provider's delivery system, and efforts designed to prevent or lessen the possibility of future similar incidents. Reporting shall comport with CSHCD SCRBH's Policy and Procedures.

Law Enforcement Inquiries on Firearm Possession Eligibility

Crisis services providers must respond in a full and timely manner to law enforcement inquiries regarding an Individual's eligibility to possess or purchase a firearm under RCW 9.41.040(2)(a)(ii), 9.41.070, or 9.41.090. The CSHCD SCRBH may direct and track all law enforcement inquiries to notify the MCOs of inquiries related to their Medicaid Enrollees.

Law enforcement Referral — Threatened or attempted suicide

As soon as possible, but no later than twenty-four (24) hours from receiving a referral from a law enforcement officer or law enforcement agency, excluding Saturdays, Sundays, and holidays, a MHP contacted by the DCR professional agency must attempt to contact the referred person to determine whether additional mental health intervention is necessary including, if needed, an assessment by a DCR professional for initial detention under RCW 71.05.150 or 71.05.153. Documentation of the MHP's attempt to contact and assess the person must be maintained by the DCR professional agency.

Performance

CSHCD SCRBH will evaluate and monitor the performance of the crisis system and develop corrective action where needed. Examples of how this will occur may include, but are not limited to, the following:

1. Ongoing review and monitoring of crisis services providers in accordance with National Committee of Quality Assurance (NCQA) Standards and WAC and contract requirements;
2. Comparison of current and historical utilization;
3. Analysis of member and provider feedback; or
4. Participation in region-level discussions led by the Spokane County Regional Interlocal Leadership Structure.

Data and Reporting

Crisis services providers shall report data monthly to CSHCD SCRBH related to the delivery of Crisis Services, which includes:

1. The number of Individuals served by the crisis system;
2. The number and percentage of Individuals referred for mobile outreach regardless of referral source; and
3. The estimated percentage of Individuals served that were successfully diverted from Emergency Departments and/or ITA commitments.

B. Regional Behavioral Health Crisis Hotline

Frontier Behavioral Health (FBH) shall provide a Regional Behavioral Health Crisis Hotline Services to all Individuals throughout the Spokane RSA. The toll-free Regional Behavioral Health Crisis Hotline 1 (877) 266-1818.

Telephone crisis support services will be provided in accordance with WAC 246-341-0905 Crisis Mental Health services – Telephone Support Services. Behavioral Health Crisis Hotline services, which will be answered by a live voice to Individuals within the Spokane RSA on a twenty-four (24) hour, seven (7) day per week basis as a means of first contact to an Individual in crisis. Behavioral Health Crisis Hotline staff shall identify themselves by name, title, and organization when initiating or returning

calls. Staff will receive training of this requirement in their orientation, and evidence of the training material will be provided to the CSHCD SCRBH.

The Behavioral Health Crisis Hotline staff shall provide crisis screening, triage, and referrals. Implementation of de-escalation strategies prior to referral may occur. Crisis hotline services may result in a referral for further response to a county crisis responder or a WISe team for Children and Youth or PACT team for Individuals enrolled in WISe or PACT intensive services. Additionally, Individuals who do not need an emergent crisis intervention or who need follow up response after a crisis has been resolved may be referred to their behavioral health provider or physician, as appropriate to the situation. In the event that a call from an Individual with Apple Health Plan Medicaid is determined to be a non-crisis situation requiring some level of behavioral health service or further evaluation, the crisis hotline staff will provide a warm transfer of the call to the Individual's MCO's 24/7 triage line.

Frontier Behavioral Health shall ensure their agency has:

1. Written protocols for triage and referral decisions by DOH credentialed or licensed behavioral health practitioners, which require clinical judgment (e.g. assessing an Individual's potential for self-harm and determining the appropriate level and intensity of care);
2. A written protocol for the referral of an Individual to a voluntary or involuntary treatment facility for admission on a seven (7) day per week, twenty-four (24) hour per day basis, including arrangements for contacting the appropriate county DCR and/or the Spokane County Mobile Community Assertive Treatment (MCAT), as appropriate;
3. Assured communication and coordination with the Individual's primary behavioral health provider, if indicated and appropriate; and
4. Statement of Individual rights posted in a location visible to staff and agency volunteers.

Behavioral Health Crisis Hotline services will provide crisis triage and intervention to determine the urgency of the needs and identify the supports and services necessary to meet those needs, which may include dispatching mobile crisis response, DCRs or connecting the Individual to services.

Behavioral Health Crisis Hotline staff will check eligibility of callers to determine if the Individual is enrolled in Medicaid and assigned an MCO. For Individuals enrolled with an MCO, the Individual will receive assistance in connecting with current or prior service providers.

Individuals who reside within the Spokane RSA shall be eligible to access telephone crisis intervention and triage services when temporarily outside the RSA, except when outside the United States of America and its territories and possessions. Providers are not responsible to provide any crisis services when an individual is outside the United States of America and its territories and possessions.

The behavioral health crisis hotline must document each telephone crisis response contact made, including:

1. The date, time, duration, and service encounter code of the telephone call;

2. The relationship of the caller to the person in crisis, for example self, family member, or friend;
3. Whether the Individual in crisis has a crisis plan; and
4. The outcome of the call, including:
    - Any follow up contacts made;
    - Any referrals made, including referrals to emergency or other medical services;
    - Any other relevant information to assist the Individual; and
    - The name, signature, and credentials of the staff person who took the crisis call.

Frontier Behavioral Health will ensure crisis call system's technology and infrastructure has the capacity to:

1. Provide direct line access to all mobile crisis outreach teams for necessary support and information assistance after dispatch so no caller waits more than thirty (30) seconds for a live answer. Provide warm-line transfers to crisis providers, live or recorded call monitoring, and instant messaging technology to maximize call triage.
2. Provide a daily summary of the number of Individuals enrolled with each MCO which contacted the behavioral health crisis hotline for services.
3. Ensure the behavioral health crisis hotline encounter and outcome or disposition for each Individual served is submitted the CSHCD SCRBH for distribution to the appropriate MCO within twenty-four (24) hours of the crisis response to ensure the MCO is aware that their member contacted the crisis system.
4. Measure telephone access standards for average speed of answer and the abandonment rate of screening and triaging calls to meet NCQA performance outcomes HCA performance metrics:
    a. Telephone response time – average speed of answer within thirty (30) seconds. Ninety percent (90%) of crisis calls are answered live within thirty (30) seconds.
        - The thirty (30) second time from for the average speed of answer by a live voice will be measured in one of two (2) ways:
            - If access to a live person is available, time is measured from the second of the first ring.
            - If access to a live person does not allow access to a live person, time is measured from the start of the first ring.
    b. Telephone abandonment rate – standard is less than three percent (3%)
        - The abandonment rate is determined by the number of callers who hang up after thirty (30) seconds (including Individuals who hand up during an automated attendant script) divided by the total calls.

Data and Reporting Data

Frontier Behavioral Health shall submit a monthly report by the fifteenth (15^{th}) of the month for the previous month of the telephone abandonment rate and telephone response time percentages to the CSHCD SCRBH.

The Regional Behavioral Health Crisis Hotline shall report data to CSHCD SCRBH monthly related to the delivery of Behavioral Health Crisis Hotline services, which includes:

1. The number of individuals served by the crisis hotline.
2. The number and percentage of individuals the crisis hotline referred for mobile outreach regardless of referral source.
3. The estimated percentage of calls to the crisis hotline successfully diverted from Emergency Departments and/or ITA commitments.

Frontier Behavioral Health will be monitored through:

1. Monthly and annual performance outcome measures of behavioral healthcare telephone access standards, review of access to interpreter service activity, and review of timely submission of behavioral health crisis hotline encounter submissions to the CSHCD SCRBH.
2. An annual contracted provider review of NCQA standards delegated to the contracted behavioral health crisis hotline organization, monitor or review findings and/or corrective actions required in performance improvement.
3. An annual desk review of each contracted BHA's policies, procedures and protocols for crisis behavioral health services to ensure policies meet NCQA standards and are reviewed and/or updated by Frontier Behavioral Health at a minimum of every twenty-four (24) months.

C. Mobile Community Assertive Treatment (MCAT)

Frontier Behavioral Health's MCAT program provides rapid response crisis intervention intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the Individual and in the least restrictive environment available. Services will include information and referral, linkage to requested/necessary resources and appropriate community-based mental health and SUD treatment services for ongoing treatment and follow-up to support stabilization in the community.

The goals are to maintain at-risk Individuals in the community with support and appropriate resources; provide consistency in staff who can work with an Individual to ensure continuity of care and linkage to resources; and provide Individuals with rapid access to MCAT staff during hours of operation so their needs/requests can be met and crises resolved. MCAT staff provide community and home-based crisis intervention services. Other services may also be provided at Frontier Behavioral Health, behavioral health facilities, hospitals, and other settings as appropriate.

Primary Objectives:

1. Divert Individuals from an involuntary inpatient admission;
2. Provide intervention and stabilization services to Individuals who are currently detained/revoked or on an SBC to determine if community resources can be resourced in lieu of an involuntary admission; and

3. Assist Individuals to access resources to maximize any opportunity to enroll Individuals on Medicaid.

MCAT serves Individuals of all ages who are in crisis, as well as, Individuals who have a serious and persistent mental illness or personality disorder with severe functional impairments, who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services.

Priority for referrals will be given to Crisis Response Services, Emergency Departments, law enforcement, the fire department, Jail, Juvenile Detention, Community Court, the Homeless Outreach Team, shelters, family members, or Individuals seeking help for themselves.

During the delivery of crisis services, MCAT will provide assistance to Individuals who are not currently enrolled with a behavioral health provider and collaborate with sobering, withdrawal management (detoxification) programs, and/or other SUD providers when an Individual has issues of a SUD nature.

MCAT's intensive services will be provided for up to sixty (60) days unless there is an exception made and documented. MCAT will collaborate with Individuals and identified natural supports to develop person centered recovery planning to determine the amount and type of services needed to successfully divert Individuals from inpatient psychiatric admission and provide on-going stabilization services.

D. Trueblood Enhancement of Mobile Crisis Response Services

The Trueblood Enhancement of Mobile Crisis Response (MCR) services in the Spokane RSA is a result of Phase One regions of the Trueblood Settlement Agreement with the intent to reduce arrest and incarceration of Individuals experiencing behavioral health crisis that could be diverted though the use of community services.

As a result of a regional planning process, the two (2) agencies identified to receive contracts and funding for the Trueblood Enhancement of MCR services are Adams County Integrated Health Care Services and Frontier Behavioral Health.

The goals of the enhanced MCR services as identified in the Trueblood Settlement Agreement includes expanding existing services already provided through traditional MCR without duplicating or supplanting services already contracted with the CSHCD SCRBH; provide an increased response time to Individuals experiencing a behavioral health crisis; ensure crisis services are available twenty-four (24) hours a day/seven (7) days a week; and recognize the needs of the region and its ability to enlist coordinated cooperation from a multitude of community services, including the medical services, crisis stabilization / crisis triage facilities, mobile crisis interventionist, law enforcement, and other first responders.

MCR services will provide rapid response, assessment services, crisis intervention, supportive counseling, linkage to requested/necessary resources and appropriate community-based mental health and SUD treatment services for ongoing treatment

and follow-up. MCR services are primarily provided in the community. Engagement and ancillary services may also be provided at the facility as appropriate.
The goals are to maintain at-risk Individuals in the community with support and appropriate resources; provide consistency in staff who can work with an Individual to ensure continuity of care and linkage to resources; and provide Individuals with rapid access to MCR staff during hours of operation so an Individual's needs/requests can be met, and the crises resolved.

Priority for referrals will be given to hospitals, law enforcement, the fire department, co-responder law enforcement officer(s) and behavioral health professional(s) teams, high utilizers, the criminal justice system, shelters, family members, or Individuals seeking help for themselves.

- High utilizers are defined as Individuals who may have been Trueblood class members, have a mental illness/SUD/developmental disability and a history of incarceration, and a high use of emergency departments and inpatient psychiatric treatment.

The crisis provider shall collaborate with SUD providers when an Individual has issues of a SUD nature.

The crisis provider shall provide crisis services to Individuals in the amount and type of services needed to successfully divert Individuals from inpatient psychiatric admission, unnecessary incarcerations, and provide on-going stabilization services. The primary objectives for MCR are to:

1. Ensure the safety and stability of Individuals in crisis through crisis intervention services;
2. Divert Individuals from emergency rooms and an inpatient behavioral health admission when less restrictive options are viable and safe; and
3. Divert Individuals from arrests and incarceration when behavioral health symptoms are the significant contributor to behaviors and treatment would be more beneficial to the Individual and a law enforcement officer supports the diversion.

The crisis provider shall provide intervention and stabilization services to Individuals and develop a crisis safety plan involving natural supports and community resources can be resourced in lieu of an inpatient admission.

Performance & Reporting Expectations, if applicable

The goals of the enhanced MCR services as identified in the Trueblood Settlement Agreement includes expanding existing services already provided through traditional MCR without duplicating or supplanting services already contracted with the CSHCD SCRBH; provide an increased response time to Individuals experiencing a behavioral health crisis; ensure crisis services are available twenty-four (24) hours a day/seven (7) days a week; and recognize the needs of the region and ability to enlist coordinated cooperation from a multitude of community services, including the

medical services, crisis stabilization / crisis triage facilities, mobile crisis interventionist, law enforcement, and other first responders.

The Contractor shall provide one (1) full-time employee (FTE) crisis interventionist to provide the Trueblood enhancement of MCR Services from 8:00 am to 5:00 pm Monday through Friday throughout Adams County. Crisis Services shall include Crisis Telephone Triage, MCR, and referrals to a DCR when an Individual needs an ITA evaluation and investigation.

The Contractor shall provide behavioral health services as described in CSHCD SCRBH Policies and Procedures, the CSHCD SCRBH Behavioral Health Crisis Response Services Provider Guide, the Contractor's Policy and Procedures, and recognized professional practice standards, in conformance with federal and state legislative codes and administrative regulations, and as required by the Department of Health (DOH), the HCA, and MCO's behavioral health contracts.

Behavioral health services, except for the ITA and LRA court ordered monitoring provided to individuals assigned under the Washington Apple Health FFS plan for Individuals who identify as AI/AN, shall have demographic data submitted through the State's portal and the service encounters billed to the State's Provider One system. Service encounters shall also be submitted into the CSHCD SCRBH Raintree Data System. Third party revenues received from the state's FFS payment shall be recorded when the crisis encounter is submitted into the CSHCD SCRBH Raintree Data System.

Goal #	Task	Performance Measure
#1	Expansion and retention of MCR services by support of the following hired positions: **Adams County Integrated Health Services** 1) One (1) FTE Adams County Integrated Health Care Services Crisis Interventionist. **Frontier Behavioral Health** 1) One (1) FTE Frontier Behavioral Health (FBH) Masters Level Supervisor. 2) One (1) FBH Clinical II. 3) Two (2) FBH Clinical I. 4) One (1) FBH SUDP. 5) One (1) Peer Counselor; and 6) One (1) FBH CSR. All Administrative and Overhead expenses are included in the costs of the positions. For examples: a) Office Supplies. b) Office Space Rent and upkeep. c) Travel and Mileage Transportation.	Submit encounter reporting and supplemental transactions for the month describing the services provided that are separate from the BH-ASO contract by the 10th of each month.

#2	Community Awareness and Outreach	Provide a quarterly report on community outreach and education focusing on creating public awareness of the Enhanced MCR services. Provide copies of any outreach materials and community engagement strategies on how to request services.
#3	BH-ASO Recurring Administrative and Direct Service Cost	a. Provide in the Enhanced MCR Staff Details quarterly report and in the narrative Trueblood Settlement MCR quarterly report documentation to include b. Staffing log of personnel changes, hiring, current staffing levels. b. How the enhancements funded in this contract meet the objectives submitted in the BH-ASO approved plan to enhance/expand MCR services. c. Coordination efforts with co-responders/law enforcement; and d. Meeting the needs of urban and rural communities coordinated MCR enhancements with tribal, community hospital, behavioral health services.

The Contractor shall submit a quarterly report no later than the 7th of each month following the end of the quarter. The report must describe the Contractor's current efforts to coordinate the mobile crisis enhancement services with Tribal and law enforcement partners for a total of four (4) reports for Fiscal Year 2022 and four (4) for Fiscal Year 2023.

The Contractor shall submit a monthly report no later than the 7th of the following month that describes efforts to expand/enhance MCR services and includes how the enhancements in this contract meet the objectives submitted in the Contractors approved plan to enhance/expand MCR services; coordination efforts with co-responders/law enforcement; and meets the needs of rural communities for a total of twelve (12) reports for Fiscal Year 2022 and twelve (12) for Fiscal Year 2023.

The Contractor will provide community outreach and education focusing on creating public awareness of the Enhanced MCR services in the form of outreach materials and community engagement strategies providing instruction on how to request services. The CSHCD SCRBH will assist with messaging about MCR services.

The Contractor will adhere to the CSHCD SCRBH Crisis Provider Guide for specific program requirements, located at the website: https://www.spokanecounty.org/4687/Downstream-Crisis-Contract-Supplement-Do.

E. Certified Peer Counselor (CPC) Enhancement of Mobile Crisis Services

The Certified Peer Counselor (CPC) Enhancement of MCR services in the Spokane RSA is a result of enhanced COVID Federal Block Grant Funds with the intent to support Mobile Crisis Teams through promoting the availability of lived experience in MCR outreach and improving engagement with Individuals experiencing a behavioral health crisis to facilitate and promote positive outcomes.

The goals of the enhanced CPC MCR services include: expanding and enhancing existing services already provided through traditional MCR without duplicating or supplanting services already contracted with the CSHCD SCRBH; provide a more comprehensive response to Individuals experiencing a behavioral health crisis; ensuring crisis services are available twenty-four (24) hours a day/seven (7) days a week; recognizing the needs of the region and the ability to enlist coordinated cooperation from a multitude of community services including the medical services, crisis stabilization / crisis triage facilities, mobile crisis interventionist, law enforcement and other first responders; and promoting an Individual centered, relationship focused, trauma averse engagement through the modality of shared experience and person- centered recovery.

Enhanced CPC MCR services will support the existing crisis service array of rapid response, assessment services, crisis intervention, supportive counseling, linkage to requested/necessary resources and appropriate community-based mental health and SUD treatment services for ongoing treatment and follow-up. Enhanced CPC MCR services are primarily provided in the community. Engagement and ancillary services may also be provided at the facility as appropriate.

The goals are to provide support and appropriate resources; consistency in staff who can work with an Individual to ensure continuity of care and linkage to resources; and Individuals with recovery-oriented person driven crisis services, informing and empowering them in accessing various pathways to recovery.

The crisis provider shall provide crisis services to Individuals in the amount and type of services needed to successfully divert Individuals from inpatient psychiatric admission, unnecessary incarcerations, and provide recovery-oriented services from a lived experience. The primary objectives for enhanced CPC MCR are to:

1. Support and expand existing MCR team(s) though the addition of at least one (1) CPC staff;

2. Provide for comprehensive recovery-oriented, person-centered crisis response services through the addition of lived experience and mutual understanding; and
3. Enhance existing MCR services, increase Individual involvement and participation in their own care, and improve service delivery outcomes.

The crisis provider shall provide intervention and engagement services in accordance with state and federal law and ensure all crisis response and outreach services, involving a CPC, follow contractual and statutory obligations for peer and peer- accompanied services.

Performance and Reporting Expectations, if applicable

The Contractor shall provide crisis services to Individuals in the amount and type of services needed to successfully divert Individuals from inpatient psychiatric admission, unnecessary incarcerations, and provide recovery-oriented services from a lived experience. The primary objectives for enhanced CPC MCR are to:

1. Support and expand existing MCR team(s) through the addition of at least one (1) CPC staff;
2. Provide for comprehensive recovery-oriented, person-centered crisis response services through the addition of lived experience and mutual understanding; and
3. Enhance existing MCR services, increase Individual involvement and participation in their own care, and improve service delivery outcomes.
4. The Contractor's CPCs will be required to complete the HCA CPC continuing education curriculum for peer services in crisis environments.
5. MCR team supervisors of CPCs must complete the HCA sponsored Operationalizing Peer Support training for supervisors.
6. The Contractor will submit a quarterly Mobile Crisis Block Grant Stimulus report. The first report is due January 31, 2022 (October -December) and quarterly thereafter April 30 (January-March), July 31 (April-June), and October 31 (July-September). Submit reports to SCRBHContracts@SpokaneCounty.org. The Contractor will include in the report:
    a. A description of the aggregate number of Individuals served by CPC; and
    b. A narrative describing successes and challenges.
7. The Contractor will adhere to the CSHCD SCRBH Crisis Provider Guide for specific program requirements, located at the website: https://www.spokanecounty.org/4687/Downstream-Crisis-Contract-Supplement-Do.
8. The Contractor shall refer to its CSHCD SCRBH Crisis contract for funding allocation specific to this service.

F. Children, Youth, and Family Mobile Crisis Team Enhancement of Mobile Crisis Services

The Children, Youth, and Family Mobile Crisis (CYFMC) Enhancement of MCR services in the Spokane RSA is a result of ESSB 5092 legislation directing the HCA to develop and implement CYFMC Teams to enhance Youth focused MCR outreach and improve engagement with Youth and their families experiencing a behavioral health crisis to facilitate and promote positive outcomes.

The goals of the CYFMC enhanced MCR services as provided in ESSB 5092 include;

1. Expanding existing services already provided through traditional MCR without duplicating or supplanting services already contracted with the CSHCD SCRBH;
2. Provide for a specialized and dedicated MCR team for Children, Youth and families experiencing a behavioral health crisis;
3. Ensure crisis services are available twenty-four (24) hours a day/seven (7) days a week; and recognize the unique and specialized response necessary to assist Children and Youth in resolving crisis, and provide for the engagement and coordination of community services specializing in engagement and treatment of Children and Youth including medical services, crisis stabilization/crisis triage facilities, mobile crisis intervention services, SUD treatment facilities, outpatient behavioral health services, Wrap-around with Intensive Services (WISe), medication management services, and appropriate services as needed.

CYFMC services will provide rapid response, assessment services, crisis intervention, supportive counseling, linkage to requested/necessary resources and appropriate community-based mental health and SUD treatment services for ongoing treatment and follow-up. CYFMC services are primarily provided in the community. Engagement and ancillary services may also be provided at the facility as appropriate.

CYFMC services are to maintain at-risk Children and Youth experiencing a behavioral health crisis within their community and environment with support and appropriate resources; provide consistency in staff who can work with the Child or Youth and family to ensure continuity of care and linkage to resources; and provide the Child or Youth and family with rapid access to MCR staff during hours of operation so their needs/requests can be met, and the crisis resolved.

Priority for referrals will be given to hospitals, law enforcement, the fire department, co-responder law enforcement officer(s) and behavioral health professional(s) teams, high utilizers, the juvenile justice system, shelters, family members, or Children, and Youth seeking help for themselves.

- High utilizers are defined as Children or Youth with a mental illness/SUD/developmental disability experiencing a high use of intensive behavioral health services, emergency departments and inpatient psychiatric treatment, and/or frequent interaction with the juvenile justice system.

The crisis provider shall collaborate with SUD providers when an Individual has issues of a SUD nature.

The crisis provider shall provide crisis services to Children and Youth in the amount and type of services needed to successfully divert them from inpatient psychiatric admission, unnecessary juvenile justice interaction, and provide on-going stabilization services. The primary objectives for CYFMC are to:

1. Ensure the safety and stability of Children and Youth in crisis through the provision of developmentally appropriate crisis intervention services provided in the home or community;
2. Provide for the engagement, assistance, and support of the Child or Youth's family and legal guardian(s) in the intervention process to enhance diversion efforts, promote ongoing stabilization within the Child or Youth's environment, and reinforce natural supports to enhance wellbeing and reduce the potential for trauma;
3. Divert Children and Youth from emergency rooms and an inpatient behavioral health admission when less restrictive options are viable and safe; and
4. Divert Children and Youth from the juvenile justice system when behavioral health symptoms are the significant contributor to behaviors and treatment would be more beneficial to the Child or Youth and a law enforcement officer supports the diversion.

The crisis provider shall provide intervention and stabilization services to Children and Youth and develop a crisis safety plan involving natural supports and community resources in lieu of an inpatient admission.

Program Requirements, if applicable;

The Contractor shall enhance and expand existing MCR services through the implementation and addition of one (1) CYFBC team. The CYFMC Team shall consist of eleven (11) FTE positions and provide mobile crisis community-based services in-person, seven (7) days per week, three hundred sixty-five (365) days a year.

For the provision of CYFMC services, "crisis" shall be defined by the Individual, including adults, Youth, young adults and/or the parent/caregiver. CYFMC services are provided in-person in the community or home setting and shall be available within two (2) hours of contact, with best effort to maintain best practice expectations (within sixty (60) minutes). Telephonic support shall be provided until an in-person response arrives or, if the two (2) hour timeframe cannot be met.

CYFMC services seek to empower Youth and families in resolving crisis episodes through maintaining their community environment, promote and support safe

behavior in home, school, and community, and identifying, restoring and increasing family and community connections to create linkages to necessary resources.

The CYFMC services are provided in a culturally and developmentally appropriate manner, intentionally seek to ensure inclusive engagement of family/caregivers and natural supports throughout a stabilization period, and are able to serve Children, Youth, young adults and families or caregivers in their natural environments including (but not limited to) at home or in school.

The CYFMC team elements shall consist of the following:

1. The CYFMC Team must include an MHP supervisor;
2. Each team will require at a minimum, an MHP and a peer trained in Crisis Services, working jointly;
3. All peers must complete the HCA sponsored peer crisis training;
4. All individuals providing mobile crisis services, new or previously existing staff, must complete the HCA training in Trauma Informed Care, De-escalation Techniques, and Harm Reduction;
5. The Contractor shall integrate the CYFMC Team into existing MCR services, ensuring continuity of care, maintaining a responsive and coordinated service delivery model, adhering to the mobile crisis outreach requirements, and participating in all required trainings and best practices.

The Contractor will provide community outreach and education focusing on creating public awareness of the CYFMC Enhanced MCR services in the form of outreach materials and community engagement strategies providing instruction on how to request services. The CSHCD SCRBH will assist with messaging about CYFMC Enhanced MCR services.

Deliverables and Reports;

CYMC Team services shall be reported in Raintree under the appropriate MCR transaction as delineated in the HCA SERI, SCRBH (ASO) Data Dictionary and most current Behavioral Health Supplemental Data Guide.

G. Behavioral Health Disaster Response

Spokane County Community Services, Housing, and Community Development (CSHCD), Spokane County Regional Behavioral Health (Administrative Services Organization) (SCRBH) has six (6) counties and three (3) Tribal areas within its RSA, which include:

- Adams County
- Ferry County
- Lincoln County
- Pend Oreille County
- Spokane County
- Stevens County
- Colville Tribe
- Kalispel Tribe
- Spokane Tribe

CSHCD SCRBH works in conjunction with Spokane County Emergency Management (SCEM) and the Regional Emergency & Disaster (REDi) Healthcare

Coalition, to be able to respond and provide behavioral health assistance in the event of a local emergency.

The REDi Healthcare Coalition serves all of Eastern Washington totaling ten (10) counties and three (3) Tribal areas, and their mission is to prepare for, respond to, and recover from crisis using all available resources, providing patient care at the appropriate level and in the most efficient manner. The REDi Healthcare Coalition strives to build emergency preparedness and response planning across the healthcare system to create resilient communities within the region.

CSHCD SCRBH participates in the REDi Healthcare Coalition as resource for behavioral health disaster response for the six (6) counties and three (3) Tribal areas within the Spokane RSA. Additionally, Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens Counties participate in each respective county's emergency management system and plan.

Crisis response providers may be activated by the respective county's emergency management system or through the REDi Healthcare Coalition.

The Behavioral Health Disaster Response Plan for the Spokane RSA is described in CSHCD SCRBH Policy RS-6 Behavioral Health Disaster Response, which can be accessed on the CSHCD SCRBH website at: https://www.spokanecounty.org/3139/Policies-Procedures.

Chapter V

8. Management Information System Requirements

Crisis services provider agencies are to follow the CSHCD SCRBH (ASO) Crisis Services Provider Contract, including Exhibits, Attachments, and the CSHCD SCRBH Behavioral Health Crisis Service Provide Guide with references to the HCA Data Guide and HCA SERI and CSHCD SCRBH Policies and Procedures as the primary sources for guidance in submitting data through the CSHCD SCRBH for crisis services. In addition, crisis services providers are to follow the guidance of the CSHCD SCRBH Data Dictionary and associated sub-documents for instructions on data submission and management, including the Required Records document, Payer Matrix and Information Systems (IS) Agency Service Grid. For agencies submitting data electronically, the CSHCD SCRBH Supplemental Transaction Guide that documents the Electronic Data Submission (EDI) Specifications shall be followed.

9. Management Information System Policies and Procedures

Policy Number	Policy Name
CES – 1	Billing Procedure

Policy Number	Policy Name
CES – 2	Claims Document Storage and Retention
CES – 3	Claims Inventory Process and Storage
CES – 4	Claims Monitoring and Auditing
CES – 5	Billing Procedures for CSHCD SCRBH Managed Crisis Services
CES – 6	Improper Claims Payment Identification
CES – 7	Provider Dispute of an Agency Action
CES – 8	Terms and Conditions of Payment
CES – 9	Time Limits – Coordination of Benefits
CES – 10	Billing Time Limits Procedure
CES – 11	Changes in Medicaid Enrollment
MIS – 2	Merging Consumer Electronic Records
MIS – 4	Error Reconciliation and Resolution
MIS – 8	Service Encounter and Data Certification
MIS – 9	EDI Data Submission
MIS – 10	Device and Media Controls – Data Backup and Storage
MIS – 11	Restoring Data From Backup
MIS – 12	Information System Monitoring
MIS – 13	HCA Behavioral Health Data System Guide
MIS – 16	Disaster Recovery
MIS – 17	Data Security Device and Media Controls-Access Control-Encryption-Decryption
MIS – 21	Management Information System
MIS – 22	Data Reporting
MIS – 24	Oaths of Confidentiality
MIS – 25	Access Control – Automatic Logoff
MIS – 26	Access Control – Facility and Emergency Access Procedures
MIS – 28	Assigned Security Responsibility
MIS – 29	Business Associate Contracts – Agreements
MIS – 30	Device and Media Controls – Accountability
MIS – 31	Emergency Mode Operation Plan
MIS – 34	Information Access Management – Access Authorization Establishment Modification
MIS – 35	Information System Activity Review
MIS – 36	Information Systems (IS) Audit Controls
MIS – 37	Information Systems (IS) Evaluation
MIS – 38	Information Systems (IS) Integrity
MIS – 39	Information Systems (IS) Security Incident Procedures – Response and Reporting
MIS – 40	Log-in Monitoring
MIS – 41	Password Mgmt Person or Entity Authentication Access Control Unique User Identification
MIS – 42	Protection from Malicious Software
MIS – 43	Information Systems Risk Analysis
MIS – 44	Information Systems Risk Management
MIS – 45	Sanction

Policy Number	Policy Name
MIS – 46	Security Awareness and Training
MIS – 47	Security Management Process
MIS – 48	Security Reminders
MIS – 49	Testing and Revision Procedures
MIS – 50	Transmission Security – Integrity Controls and Encryption
MIS – 51	Workforce Security – Authorization and/or Supervision
MIS – 52	Workforce Security – Termination Procedures
MIS – 53	Workforce Security – Workforce Clearance
MIS – 54	Workstation Use, Workstation, and Office Security
MIS – 55	Mobile Device User Security
MIS – 56	Mobile Device Encryption
MIS – 57	Confidential Information
MIS – 58	Health Information Organization
MIS – 59	Claim and Encounter Data Accuracy, Consistency and Completeness

Policies will be reviewed and revised at a minimum of every twenty-four (24) months, or more often when there is a change in standards or law requiring a modification.

10. Management Information Systems Data Submission Activities

A. Eligibility Verification

1. CSHCD SCRBH (ASO) Crisis Services Provider Contract
2. CSHCD SCRBH Policy CES – 5 Billing Procedures for CSHCD SCRBH Managed Crisis Services
3. CSHCD SCRBH Policy CES - 11Changes in Medicaid Enrollment

B. Demographic Data Submission

1. CSHCD SCRBH (ASO) Crisis Services Provider Contract
2. CSHCD SCRBH Data Dictionary
3. CSHCD SCRBH Required Records

C. Service Encounter / Claim Submission

1. Direct Data Entry (DDE) into SCRBH Portal (Raintree)
    - HCA Service Encounter Reporting Instructions (SERI)
    - CSHCD SCRBH Data Dictionary
    - CSHCD SCRBH Payer Matrix
    - CSHCD SCRBH IS Agency Service Grid

2. Electronic Data Interchange (EDI)
    - HCA Service Encounter Reporting Instructions (SERI)
    - CSHCD SCRBH Data Dictionary

- CSHCD SCRBH Payer Matrix
- CSHCD SCRBH IS Agency Service Grid
- CSHCD SCRBH Electronic Data Submission (EDI) Specification
  - CSHCD SCRBH 837P Companion Guide
- CSHCD SCRBH Policy MIS – 9 EDI Data Submission

D. Service Encounter / Claim Attestation

1. CSHCD SCRBH Policy MIS – 8 Service Encounter and Data Certification

E. Error Resolution

1. CSHCD SCRBH Policy MIS – 4 Error Reconciliation and Resolution

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Chapter VI

11. Monitoring the Crisis System

The CSHCD SCRBH produces a quarterly Crisis Data Dashboard to monitor under- and over- utilization of crisis services and identify strategies to address trends, gaps, or areas of concerns.

The CSHCD SCRBH facilitates a reoccurring meeting with the network of crisis providers to collaborate in developing and implementing strategies to assess and improve the crisis system over time. The meeting is also an opportunity to monitor the crisis hotline, mobile crisis outreach, and DCR staffing levels to ensure they are adequate and sufficient, identify any gaps in capacity, and coordinate with contracted provide to implement strategies necessary to address the gap.

The CSHCD SCRBH facilitates a quarterly Spokane Regional Crisis Collaborative forum with a diverse array of regional stakeholders impacted by the behavioral health crisis system to gather feedback and input on the strengths, gaps, barriers, and challenges within the Spokane RSA behavioral health crisis system and strategies to overcome and improve it. The CSHCD SCRBH presents a quarterly Crisis Data Dashboard to assist the forum in identification of trends and patterns within the Spokane RSA crisis system.

The CSHCD SCRBH provides each Apple Health Plan MCOs in the Spokane RSA a Daily Crisis Log each business day of the members assigned to that MCO who have received any type of crisis services. The Daily Crisis Log identifies the type of crisis service provided, the referral source, and the outcome of the crisis service.

The CSHCD SCRBH sends each Apple Health Plan MCOs in the Spokane RSA a monthly high utilizer report to assist in identifying Individuals that may benefit from intensive care management services.

The CSHCD SCRBH provides a monthly performance report to the HCA and Apple Health Plan MCOs of the response time and abandonment rate of the Regional Behavioral Health Crisis Hotline.

The CSHCD SCRBH provides the HCA crisis system reports on a quarterly basis on the last day of the month following each quarter utilizing the HCA reporting template.

The CSHCD SCRBH conducts annual contracted provider monitoring of Crisis and ITA services, which shall monitor adherence to the DCR Protocols. Refer to the CSHCD SCRBH QM-8 Program Monitoring for policies and procedures on crisis provider monitoring.

Chapter VII

12. Updates to the Behavioral Health Crisis Services Provider Guide

This CSHCD SCRBH Behavioral Health Crisis Services Provider Guide will be reviewed and updated as policies, protocols, or service delivery requirements change, or at a minimum of every twenty-four (24) months, whichever is sooner.

Appendix A: Definitions

Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated (WAC 182-501-0125).

American Society of Addiction Medicine (ASAM) Level of Care Guidelines - a professional medical society dedicated to increasing access and improving the quality of Substance Use Disorder (SUD) treatment. ASAM Level of Care Guidelines are a set of criteria produced and distributed by ASAM for use in determining SUD treatment placement, continued stay, and transfer/discharge of individuals with substance use (SUD) and co-occurring disorders.

American Society of Addiction Medicine (ASAM) Criteria – a comprehensive set of guidelines for determining placement, continued stay and transfer or discharge of Individuals with addiction conditions.

Assisted Outpatient Treatment (AOT) – A petition filed by a DCR or other designee on the basis that an Individual is in need of LRA treatment for up to eighteen (18) months.

Available Resources - funds appropriated for the purpose of providing behavioral health community Mental Health (MH) and SUD programs. This includes federal funds, except those provided according to Title XIX of the Social Security Act and state funds appropriated by the Legislature.

Behavioral Health - mental health and/or SUD conditions and related services.

Behavioral Health Professional - means a licensed physician board certified or board eligible in Psychiatry or Child and Adolescent Psychiatry, Addiction Medicine or Addiction Psychiatry, licensed doctoral level psychologist, Psychiatric Advanced Registered Nurse Practitioner (ARNP) or a licensed pharmacist.

Care Coordination - an approach to healthcare in which all of an Individual's healthcare needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the Individual and the Individual's caregivers and works with the Individual to make sure that the Individual gets the most appropriate treatment, while ensuring that care is not duplicated.

Code of Federal Regulations (CFR) - the codification of the general and permanent rules and Regulations, sometimes called administrative law, published in the Federal Register by the executive departments and agencies of the federal government of the United States.

Conditional Release (CR) - means if a treating Facility determines that an Individual committed to an inpatient treatment Facility can be appropriately treated by outpatient treatment in the community prior to the end of the commitment period, the Individual may be discharged under a CR. A CR differs from a less restrictive order in that the CR is filed with the court, as opposed to being ordered by the court. The length of the CR is the amount of time that remains on the current inpatient commitment order.

Crisis – means a behavioral heal crisis, defined as a turning point, or a time, a stage, or an even, whose outcome includes a distinct possibility of undesirable outcome.

Crisis Services (Behavioral Health) – means providing evaluation and short-term treatment and other services to individuals with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the Individual's health or safety.

Crisis Hotline Services – a crisis phone number is available twenty-four (24) hours a day, seven (7) days a week and is staffed by a live person who can provide screening, de-escalation and referral, triage, and referral to DCRs when an in-person response is needed. The toll-free number is 1-877-266-1818.

Crisis Stabilization - includes short-term (less than two weeks per episode) face-to-face assistance with life skills training and understanding of medication effects on an Individual. Stabilization services may be provided to an Individual as a follow-up to crisis services provided or to any Individual determined by a mental health professional to need additional stabilization services.

Critical Incident – events that happen in the behavioral health system that must be reported to state authorities. Examples include anything that would capture media attention, deaths, violent acts, unauthorized leave of Individuals in severe crisis, serious injuries, abuse or neglect, serious medication errors, assault, substantial threats, breach or loss of protected health information, exploitation, suicide, fraud, etc. Treatment facilities report incidents to SCRBH and SCRBH reports to designated staff at the state level.

Danger to Self - a person may be dangerous to self and others when he or she have recently threatened or attempted suicide or some serious bodily injury. He or she may have demonstrated danger of substantial and imminent harm to himself and/ or others through some recent act, attempt or threat of the same. Without supervision and adequate treatment, it is probable that the mentally ill individual may succumb to death, substantial bodily injury or serious physical debilitation or disease.

Designated Crisis Responder (DCR) or Tribal Designated Crisis Responder – a mental health professional with state DCR training, which includes substance use disorders, who are appointed by the county or other authority authorized in rule to perform Involuntary Treatment Act evaluations and investigations and civil commitment duties described in Chapters 71.05 and 71.34 RCW. DCRs may involuntarily detain individuals up to one-hundred twenty (120) hours, for further evaluation and treatment.

Disaster Response – trained crisis response providers with mental health and substance use disorder credentials and disaster response training may be deployed in an emergency or disaster to provide behavioral health care to victims of a disaster. This may include brief intervention and referral, crisis intervention, community education, training and support groups, etc.

Emergent care – services that, if not provided, would likely result in the need for crisis intervention, or hospital evaluation due to concerns of potential danger to self, others, or grave disability, per RCW 71.05 and 71.34. Emergent behavioral health care must occur within two (2) hours of a request for crisis behavioral health treatment from any source.

Evaluation and Treatment - services provided for Individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric disorder. Services are provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD) facilities) licensed by the Department of Health to provide medically

necessary evaluation and treatment to the Individual who would otherwise meet hospital admission criteria.

At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses, and other MHPs, and discharge planning to ensure continuity of mental health care. Treatment may include nursing care, individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The Individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for Individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric or co-occurring SUD. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care.

This service does not include cost for Room and Board. The HCA shall authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

Evaluation and Treatment Facility (E&T) - any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the Department of Health. (RCW 71.05.020)

Evidence-Based Practices - a program or practice that has been tested where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

First Responders - police, sheriff, fire, emergency, medical and hospital emergency rooms, and 911 call centers.

Global Appraisal of Individual Needs Short Screener (GAIN-SS) – means the integrated, comprehensive screening for behavioral health conditions.

Grave disability or Gravely Disabled – a condition in which a person, as a result of a behavioral health disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety [RCW 71.05.020(24)]

Grievance - means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Individual's rights.

Grievance Process - the procedure for addressing an individual's grievances.

Health Care Authority (HCA) - the Washington State Health Care Authority, any division, section, office, unit or other entity of the HCA or any of the officers or other officials lawfully representing the HCA.

High Intensity Treatment – intensive levels of service provided to Individuals who require a multi-disciplinary treatment team in the community that is available upon demand twenty-four (24) hours per day, seven (7) days per week.

History of one or more violent acts - the period of time ten years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a mental health facility, a long-term alcoholism or drug treatment facility [effective April 1, 2018] or in confinement as a result of a criminal conviction [RCW 71.05.020(19)].

Imminent – forthcoming; likely to occur at any moment; impending

Intake Evaluation - an evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except Crisis Services, Stabilization Services, and free-standing evaluation and treatment.

Involuntary Treatment Act (ITA) - state laws that allow for individuals to be committed by court order to a hospital or facility for a limited period-of-time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to one hundred twenty (120) hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05.180, RCW 71.05.230, RCW 71.05.290, 71.34 RCW, and RCW 71.24.300).

Involuntary Treatment Act Services - includes all services and administrative functions required for the evaluation and treatment of individuals civilly committed under the involuntary treatment act in in accordance with Chapters 71.05, and 71.34 RCW, and RCW 71.24.300.

Less Restrictive Alternative (LRA) – any viable plan developed by a DCR to successfully resolve an individual's crisis without a psychiatric inpatient or secure withdrawal management and stabilization services admission.

Less Restrictive Alternative (LRA) Treatment - a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in the minimum services that all Individuals who are under a less restrictive order must be offered as per RCW 71.05.585.

Less Restrictive Alternative (LRA) Treatment Order - "Less Restrictive Alternative (LRA) Treatment Order" means if a court determines that an Individual committed to an Inpatient Facility meets criteria for further treatment but finds that treatment in a less restrictive setting is a more appropriate placement and is in the best interest of the Individual or others, an LRA order may be issued. The LRA order remands the Individual to outpatient treatment by a Behavioral Health service provider in the community who is responsible for monitoring and providing LRA treatment. The Individual must receive at least a minimum set of services and follow the conditions outlined in the LRA order. The length of an LRA order is usually ninety (90) or one hundred eighty (180) days but in certain cases can be for up to one (1) year. (RCW 71.05.320). An LRA order may be extended by a court.

Medical Clearance - A physician or other health care provider has determined that a person is medically stable and ready for referral to the DCR. [RCW 71.05.020(37)]

Medically Necessary Services - means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Individual that endangers life, cause suffering of pain, result in an illness or infirmity, threaten to cause or

aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the Individual requesting the service. “Course of treatment” may include mere observation or, where appropriate, no treatment at all.

Medication Management - the prescribing and/or administering and reviewing of medications and their side effects.

Medication Monitoring – face to face, one-on-one cueing, observing, and encouraging an individual to take medications as prescribed.

Mental Health Advance Directive - a written document in which the Individual makes a declaration of instructions, or preferences, or appoints an agent to make decisions on behalf of the Individual regarding the Individual’s mental health treatment that is consistent with Chapter 71.32 RCW.

Mental Health Professional (MHP): A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the secretary of DOH pursuant to this chapter [RCW 71.05.020(39)] "Mental health professional" or "MHP" means a designation given by DOH to an agency staff member or an attestation by the licensed behavioral health agency that the person meets the following:

a) A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

b) A person who is licensed by DOH as a mental health counselor or mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

c) A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, experience that was gained under the supervision of a mental health professional recognized by DOH or attested to by the licensed behavioral health agency;

d) A person who meets the waiver criteria of RCW 71.24.260, and the waiver was granted prior to 1986; or

e) A person who had an approved waiver to perform the duties of a mental health professional (MHP), that was requested by the behavioral health organization (BHO) and granted by the mental health division prior to July 1, 2001. [WAC 246-341-0515].

Mobile Community Assertive Treatment (MCAT) – Community and home-based crisis intervention services designed to provide intervention and stabilization services to Individuals who have been detained. The goal is to divert them from involuntary inpatient admission and assist with transition/discharge plans into the community.

Peer Support - behavioral health services provided by peer counselors to Individuals under the consultation, facilitation, or supervision of a Behavioral Health Professional, including a Mental Health Professional or Chemical Dependency Professional.

Peer Support Services - individualized, recovery- focused service provided by people with lived experience in the behavioral health system that allows Individuals the opportunity to learn

to manage their own recovery and advocacy process. Interventions of Peer Support staff serve to enhance the development of natural supports, as well as coping and self-management skills.

Program for Assertive Community Treatment (**PACT**) **-** an evidence based intensive outpatient treatment program designed to assist adults overcome the barriers to their recovery from severe and persistent behavioral health disorders.

Program for Assertive Community Treatment (PACT) services - PACT is for people with severe mental health disorders, who frequently need care in a psychiatric hospital or other crisis service. These clients often have challenges with traditional services and may have a high risk or history of arrest and incarceration. Intensive outreach services are evidence-based, recovery-oriented, and provided through a team approach. With small caseloads, PACT teams can address each person's needs and strengths to provide the right care at the right time.

Psychiatric – relating to mental illness or its treatment

Psychological Assessment - all psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist.

Recovery – a process of change through which Individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Revocation – the official cancellation of a decree, decision, or promise

Respondent – term used in the court system to designate the individual who is responding to a case filed against them.

Revised Code of Washington (RCW) - the laws of the state of Washington.

Secure Withdrawal Management and Stabilization Services Facility – services are provided to an Individual who are involuntarily detained for SUD ITA under Chapter 71.05 or 71.34 RCW for up to ASAM 3.7 withdrawal management level to assist in the process of withdrawal from psychoactive substances in a safe and effective manner, or medically stabilize and individual after acute intoxication.

Single Bed Certification – a process for requesting an exception to be granted to allow a facility that is willing and able but is not certified under WAC 182-300 to provide timely and appropriate, involuntary inpatient mental health treatment to an adult on a 120-hour initial detention or detention pending a revocation proceeding, a fourteen (14)-day commitment, or for a maximum of thirty (30) days to allow a community facility to provide treatment to an adult on a ninety (90)- or one hundred eighty (180)-day inpatient involuntary commitment order [RCW 71.05.745, WAC 182-300]

Single bed certification will not be available for Individuals detained due to SUD until July 1, 2026.

Stabilization Services - services provided to Individuals who are experiencing a mental health crisis. These services are provided in the person's home, or another home-like setting, or a setting which provides safety for the Individual and the MHP. Stabilization Services may be provided prior to an Intake Evaluation for mental health services.

Substance Use Disorder (SUD) - a problematic pattern of use of condition in which the use of alcohol and/or drugs one (1) or more substances that causes leads to a clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school or home.

Transportation - means the transport of Individuals to and from behavioral health treatment facilities.

Urgent care - means a service to be provided to persons approaching a behavioral health crisis. If services are not received within twenty-four (24) hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary. Urgent care must occur within twenty-four (24) hours of a request for behavioral health crisis services from any source.

Viable - capable of working successfully; feasible.

Washington Administrative Code (WAC) - the rules adopted by state agencies to implement legislation.

Withdrawal Management - Withdrawal management refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence**.**

Wrap-around with Intensive Services for Youth (WISe) – a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program is for Individuals up to age 21 who are experiencing mental health symptoms that are causing severe disruptions in behavior and/or interfering with their functioning in family, school, or with peers requiring: a) the involvement of the mental health system and other child-serving systems and supports; b) intensive care collaboration; and c) ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.