2024-2025 INTERGOVERNMENTAL AGREEMENT
FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

EXHIBIT B-2
SPECIALIZED SERVICE REQUIREMENTS

1. Not all Services described in Exhibit B-2 may be covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," of this Agreement. Only Services in which costs are covered in whole or in part with financial assistance pursuant to Exhibit C, "Financial Assistance Award," as amended from time to time, are subject to this Agreement.

a. Service Name: **PEER DELIVERED SERVICES (PDS)**

Service ID Code: **MHS 16**

Specialized Service: **VETERANS**

Specialized ID Code: **16A**

(1) **Service Description** (exceeding Section 1, MHS 16)

County shall:

(a) Hire, train, and supervise Peer Support Specialists (PSS) or Peer Wellness Specialists (PWS) with significant prior or current military experience;

(b) Require that PSS or PWS acquire and maintain certification with the Oregon Health Authority, Traditional Health Worker registry, including those who identify as military veterans with current behavioral health needs;

(c) Provide PDS in a culturally competent manner as defined in OAR 410-180-0300 through 410-180-0380 to Individuals who identify as military veterans with behavioral health needs. Activities may include, but are not limited to:

i. 1:1 peer support;

ii. Systems navigation;

iii. Facilitation of support and education groups;

iv. Outreach; and

v. Community education.

(d) Provide program participants with funds or material supports needed to eliminate barriers to accessing health care services which will improve the veteran's behavioral health, support treatment plans, or support the veteran's recovery, or community engagement; and

(e) Engage and serve a minimum of 25 veterans annually.

(2) **Performance Requirements** (exceeding Section 2, MHS 16)

None

(3) **Reporting Requirements** (exceeding Section 3, MHS 16)

None

(4) **Special Reporting Requirements** (exceeding Section 4, MHS 16)

Prepare and electronically submit to hsd.contracts@odhsoha.oregon.gov quarterly reports no later than 45 calendar days following the end of each subject quarter during the period for which financial assistance is awarded through this Agreement. Reports must be prepared using forms and procedures prescribed by OHA. Forms are located at https://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(a) The following information shall be provided for each report:

i. Number of veterans served annually on a regular basis as shown by being enrolled in peer services, and making use of peer supports on a weekly basis;

ii. Number of veterans offered the pre and post survey supplied by OHA;

iii. Number of veterans completing the pre and post survey;

iv. Survey responses for all completed surveys; and

v. Narrative description of program progress, successes, and barriers.

(b) The following is an optional item to report:

Recommendations for programs in the future which may seek to build on and scale this pilot model.

(5) **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**
(exceeding Section 5, MHS 16)

None

b. Service Name: **MOBILE CRISIS INTERVENTION SERVICES**

Service ID Code: **MHS 25A**

Specialized Service: **STABILIZATION SERVICES FOR CHILDREN AND THEIR FAMILIES**

Specialized ID Code: **MHS 25A**

(1) Service Description (exceeding Section 1, MHS 25)

County, through its Community Mental Health Programs (CMHP), shall require that stabilization services are available for eligible children (Birth through 20 years of age) and their families for up to 56 calendar days, following the initial crisis response, in accordance with OAR 309-072-0100 to 309-072-0160. This model of care is based on a national crisis response model for children, and known as Mobile Response and Stabilization Services (MRSS). Stabilization services are outlined in MHS 25A and are required. MHS 25A will replace the former MHS 08 Crisis and Transition Services (CATS).

When a provider responds to a child and family in crisis, they will work in partnership with the child and their families, to de-escalate the current crisis and connect the family to needed resources. In some cases, the provider may determine, in partnership with the child and family, that they may benefit from immediate access to stabilization services and supports to assist the family while waiting for longer term ongoing services to be available.

Stabilization services are meant to be a short-term intervention that provides bridge services that may include brief individual or family therapy, skills training, family and youth peer support services and medication management while also helping the family access the appropriate community-based service and supports.

Each family enrolled is offered rapid access to a Qualified Mental Health Professional (QMHP) and Family Support Specialist who work directly with the child and their family to create a service plan with short term goals and objectives to meet the unique needs of the family, stabilize behavioral health needs; and improve functioning in life domains while establishing and transitioning care to longer term services and supports.

County shall provide stabilization services in accordance with Service Element MHS 25 and OAR 309-072-0160.

(a) Family Support Specialist (FSS) Role and Responsibilities

i. The County will ensure a FSS is available in accordance with OAR 309-072-0160(2)(k).

ii. OHA will partner with community stakeholders to create a Family Guide for Stabilization Services. Providers shall require that each family enrolled in services receives a copy of the Family Guide for Stabilization Services starting in March 2024.

(b) Subcontractors

i. The County is ultimately responsible for making sure that all required service elements and OARs are being met whether directly provided or provided under sub-contractual arrangement.

ii. County may subcontract with another agency to provide stabilization services.

iii. Subcontractors are required to have a Certificate of Approval (COA) to provide stabilization services.

iv. Subcontractors are required to meet all applicable rules under OAR 309-072-0160.

v. County is required to submit either a copy of the contractual agreement with the subcontractor or an MOU to HSD.Contracts@odhsoha.oregon.gov within 45 calendar days of execution of this contract and must include at a minimum:

A. Roles and responsibilities of both the County and subcontractor; and,

B. Plan for ongoing communication and coordination of services between County and subcontractors.

(c) Whenever possible, providers should prioritize key leadership and direct service staff attendance in the monthly Learning Collaborative facilitated by the Oregon Health Authority.

(2) **Performance Requirements** (exceeding Section 2, MHS 25)

(a) **Optional Performance Requirements**

i. County may be eligible for an additional $10,000 in funding from OHA if County can clearly demonstrate in writing, completion of one of the activities listed below.

ii. County shall submit written documentation to: hsd.contracts@odhsoha.oregon.gov prior to Jan. 31, 2024, to be considered for payment.

iii. Eligible activities include the following:

A. 50% of the 2 person mobile crisis intervention teams dispatched to the community will include a face-to-face response, by either a QMHP or Family Support Specialist.

B. 50% of staff working with children and families attend the Youth Save Training.

C. County is able to demonstrate, a 10% reduction in emergency department boarding during calendar year 2023, for children in their community.

D. 50% of staff receive an OHA approved advanced training in working with neurodiverse and Intellectual and Developmental Disabilities (IDD) children and their families.

E. CMHP will provide no less than 5 presentations to their local community stakeholders on Mobile Crisis Intervention Services and stabilization services for children and their families, within their service area.

(3) **Reporting Requirements** (exceeding Section 3, MHS 25)

None.

(4) **Special Reporting Requirements** (exceeding Section 4, MHS 25)

(a) Forms are located at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

(b) County or subcontractor shall complete and submit the Authority approved pre and post assessment tool and at the start and end of stabilization services and submit the assessment to the Authority approved contractor.

(c) County agrees to work directly with OHA approved contractor to submit the required pre and post assessment tools and other data points related to stabilization services.

(d) The OHA approved contractor is responsible for analyzing the provided data and developing quarterly reports which includes outcome data for stabilization services.

(e) County is responsible for reviewing and approving the quarterly reports generated by the OHA approved contractor which include stabilization services outcome data.

(f) OHA approved contractor shall submit the quarterly report to OHA via hsd.contracts@odhsoha.oregon.gov on behalf of the County, no later than 45 calendar days after the end of each quarter.

(5) **Financial Assistance Calculation, Disbursement, and Confirmation of Performance and Reporting Requirements Procedures**
(exceeding Section 5, MHS 25)

None.

c. Service Name: **NON-RESIDENTIAL MENTAL HEALTH SERVICES FOR YOUTH & YOUNG ADULTS IN TRANSISTION**

Service ID Code: **MHS 26**

Specialized Service**:** **EARLY ASSESSMENT AND SUPPORT ALLIANCE (EASA)**

Specialized ID Code: **26A**

(1) **Service Description** (exceeding Section 1, MHS 26)

Early Assessment and Support Alliance (EASA) is a transitional, coordinated specialty care program, serving young Individuals experiencing symptoms consistent with a diagnosable psychotic disorder or at clinical high risk for such, for approximately 2 years.

Services are described in the EASA Practice Guideline (Melton, R.P., Penkin, A., Hayden-Lewis, K., Blea, P., Sisko, R., & Sale, T. (2013), incorporated by reference herein.

Services shall prioritize communities that have been historically impacted by racism, discrimination and health inequities. Services shall be trauma informed and culturally and linguistically responsive and work to reduce the impacts of adverse childhood and traumatic experiences.

(a) **Definitions:**

i. **Multi-Family Groups** means a structured family group which can consist of either multiple families from the community, or multiple members of a single family network.. Multi-family groups are a preferred method of treatment for most Individuals and their families/support system (McFarlane, 2002). Where Multi-Family Groups are not available, single-family groups can be offered following the same format. Fidelity to Multi-Family Groups standards in each of the key stages is critical: joining sessions, family workshops, and carefully structured initial and ongoing problem solving sessions.

ii. **Participatory Decision Making** means Individuals and family/primary support system involved in service planning, delivery, monitoring, and evaluation seem to facilitate the development of ongoing services that are accessible and culturally appropriate for them and may result in more responsive treatment providers, better quality of care, and more empowered Individuals and primary family/primary support system (McGorry et al., 2010).

iii. **Psycho-education** means developing a shared and increased understanding of the illness and recovery process for both the Individual and the family/support system. Specific attention is given to cultural values and norms of an audience and broad accessibility to this information is essential (EASA Fidelity Guidelines, 2013).

iv. **Psychosis-Risk Syndrome** means Schizophrenia-related conditions frequently have a gradual onset. Neurocognitive, sensory, perceptual, and affective changes, usually accompanied by a decline in functioning, characterize the at-risk mental state. Identifying,

monitoring, and providing needs-based care during a potential psychosis-risk mental state is optimal. The evidence regarding the effectiveness of specific interventions (therapy, medications, etc.) remains preliminary. It is measured by the Structured Interview for Psychosis-Risk syndrome (SIPS), performed by a skilled diagnostician certified in the tool (McGlashan, Walsh, & Woods, 2010), incorporated by reference herein.

v. **Community Education** means a core element of early intervention services is a proactive and ongoing campaign to increase early identification and the speed and number of early referrals and reduce attitudinal barriers about schizophrenia-related conditions. This reduces the duration of untreated psychosis. Specific attention is given to cultural values and norms of an audience and broad accessibility to this information is essential (EASA Fidelity Guidelines, 2013).

(2) **Performance Requirements** (exceeding Section 2, MHS 26)

County shall provide Services to eligible Individuals as listed below:

(a) Eligible Population: EASA Services are to be provided to Individuals ages 12 through 27 years of age whom:

i. Have not had a diagnosable psychotic disorder other than psychosis-risk syndrome, identified by the Structured Interview for Psychosis Risk Syndrome (SIPS) or other EASA Center for Excellence (C4E) approved formal assessment, for a period longer than 12 months; and

ii. Have psychotic symptoms not known to be caused by the temporary effects of substance intoxication, major depression, or attributable to a known medical condition.

(b) Access to EASA across all referral sources: emergency departments, hospitals, community partners, schools, and families, regardless of ability to pay. Upon referral, contact shall be made within two (2) business days of the referral by EASA staff with the Individual (and family) in a location that best suits the Individual. Individuals are enrolled in EASA once they are determined to have met the eligibility criteria and agree they are comfortable with the program;

(c) Services intended to be a transitional coordinated specialty care service, designed to last an average of 2 years. An Individual's Services can be flexible with the timing of the transition, based on the needs of the Individual, their family, and the Individual's progress and goals;

(d) Services rendered based on the needs of the Individual and their family as frequently as needed to optimize the EASA program's support and impact. EASA teams should provide access to crisis services for the EASA Individual, family, and primary supports.

(e) Provide Services as described in the EASA Practice Guidelines (Melton, R.P., Penkin, A., Hayden-Lewis, K., Blea, P., Sisko, R., & Sale, T. (2013).

(f) Provide technologically-based support to EASA participants that include, but are not limited to, text messaging, email, and telemedicine in order to communicate and facilitate Services.

(g) The EASA team works with people in five phases: Assessment and stabilization, adaptation, consolidation, transition, and post-graduation.

i. Phase 1 (up to 6 months): Assessment and stabilization: Outreach, engagement, assessment, initiation of medical treatment (including psychosis and alcohol/drug dependency), identification of strengths, resources, needs, and goals, start of multi-family groups, stabilization of current situation.

ii. Phase 2 (approximately 6 months): Adaptation: More extensive education to the individual and family/primary support system, address adaptation issues, refine/test the relapse plan, move forward on living and/or vocational goals, identify accommodations as needed at work or school, identify and develop stable long-term economic and social support, provide opportunities for peer involvement, physical fitness, etc.

iii. Phase 3 (approximately 6 months): Consolidation: Continue multi-family group, vocation support and individual treatment, work toward personal goals, develop a relapse prevention and long-term plan.

iv. Phase 4 (approximately 6 months): Transition: Maintain contact with EASA Team, continue multi-family group, participate in individual and group opportunities, establish ongoing treatment relationship and recovery plan.

v. Phase 5: Post-graduation: Continue multi-family group (in some situations), continue with ongoing providers, invitation to participate in events and mentoring, EASA planning/development activities, and periodic check-ins and problem solving as needed.

(h) Within and in addition to the phases described above, the following elements are part of the successful delivery of the EASA model and implementation of the EASA program:

i. Rapid access to psychiatric and counseling services;

ii. Education about causes, treatment, and management of psychosis and explanations about potential causes for the onset of symptoms;

iii. Coaching on rights regarding access to employment, school, housing, and additional resources;

iv. Single family psycho-education and multi-family groups;

v. Support for vocational education and independent living goals consistent with Individual Placement and Support (IPS) framework that is the Supported Employment fidelity program that is integrated into EASA services and currently overseen by the Orgon Supported Employment Center for Excellence (OSECE);

vi. Access to licensed medical psychiatric care, health related nursing care, mental health treatment, case management, supported education and employment, peer support for young adult and family, and occupational therapy or skill development;

vii. Provision of substance use disorder treatment within the team.

viii. Peer support (peers having lived experience with psychosis preferred regardless of age), participatory decision-making, and meaningful young adult engagement in program, community, and leadership activities as an EASA program component, and;

ix. Community-education.

(i) Setting(s) for Service Delivery: Determined by the needs and goals of the Individual and their circumstances.

(j) Recommended Staff and Staff Training: EASA team members include licensed medical providers (LMP's), nurses, staff trained in case management and care coordination, staff qualified to provide occupational therapy and associated skill training, mental health therapists, mental health screeners, peer support specialists, supported education and employment specialists.

(k) EASA services and supports must be provided by staff that enable the team/provider to meet or pursue fidelity standards located at http://www.easacommunity.org. If County lacks qualified providers to deliver EASA services and supports, a plan to adjust the model will be developed with the EASA Center for Excellence staff and OHA.

(l) Additional Licensing or Certification Requirements:

i. The assessment for EASA Services and supports must be provided by Providers that meet fidelity standards, located at http://www.easacommunity.org/PDF/Practice%20Guidelines%202013.pdf. If County lacks qualified Providers to deliver EASA Services and supports, County shall implement a plan, in consultation with OHA, to develop a qualified Provider network for Individuals to access EASA Services.

ii. EASA-specific training requirements and opportunities are listed on the EASA Center for Excellence website: http://www.easacommunity.org.

(m) Staff working in the programs must have training in suicide prevention and intervention strategies and Trauma Informed Care and be provided with ongoing maintenance of the skills and practice associated with these approaches.

(3) **Reporting Requirements** (exceeding Section 3, MHS 26)

None

(4) **Special Reporting Requirements** (exceeding Section 4, MHS 26)

Forms are located at https://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

Counties providing EASA Services shall submit data quarterly, directly into the Oregon Health & Science University (OHSU) EASA RedCap Data System. Instructions for data entry into RedCap are located at https://www.easacommunity.org/resources-for-professionals.php and individual provider entry is located at https://octri.ohsu.edu/redcap/. Quarterly data shall be submitted no later than 45 calendar days following the end of each subject quarter for which financial assistance is awarded through this Agreement.

Data collected through RedCap will reflect outreach, referral, intake and outcome-based measures. The outcome measures will be determined based on fidelity guidelines as stated above and best practices for First Episode of Psychosis treatment.

(5) **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures** (exceeding Section 5, MHS 26)

None.

d. Service Name: **OLDER OR DISABLED ADULT MENTAL HEALTH SERVICES**

Service ID Code: **MHS 35**

Specialized Service: **GERO-SPECIALIST**

Specialized ID Code: **35A**

(1) **Service Description** (exceeding Section 1, MHS 35)

Older or Disabled Adult Mental Health Services (MHS 35) Specialized Service requirement (MHS 35A) are mental health services delivered directly or indirectly to older or disabled adults with mental illness.

(2) **Performance Requirements** (exceeding Section 2, MHS 35)

(a) The funds awarded for MHS 35A Services may only be expended on community based direct and indirect care services for older or disabled adults with mental illness who are determined eligible. Such direct services include, but are not limited to, medication management, quarterly interagency staffing, follow-up services after treatment in local or state inpatient psychiatric hospitals, and screenings and referrals. Indirect care services include, but are not limited to, consultation, assistance working with multiple systems, case coordination, planning, supporting interagency collaboration, and education and training to agencies and caregivers who provide services that may affect older and disabled adults with mental illness.

(b) If indirect care services, as described above, are delivered with MHS 35A funds provided through this Agreement, those services must be available to all relevant agencies and caregivers in the geographic area served by the CMHP and must be coordinated to include, but not limited to, Aging and People with Disabilities (APD), Department of Human Services (DHS)'s Aging and Disabilities Resource Connection, DHS's Adult Protective Services, CCOs, CMHPs, Acute care hospitals, Oregon State Hospital, caregivers, community partners, family members, and any other appropriate participants in client care.

(c) All MHS 35A Services delivered with funds provided through this Agreement for direct care services must either be supervised or delivered by a Qualified Mental Health Professional, as defined in OAR 309-039-0510 (10), and in compliance with Standards for Adult Mental Health Services, as such rules may be revised from time to time. Qualified Mental Health Professionals and any designated Qualified Mental Health Associates, as defined in OAR 309-039-0510 (9), delivering such services must have a background with the older and disabled adult population or be participating in relevant training programs to acquire such knowledge.

(d) Providers of MHS 35 Services delivered with funds provided through this Agreement that are subject to this Specialized Service requirement shall provide the following:

(e) Regular access to a psychiatrist or nurse practitioner for case and medication review for Individuals receiving direct care MHS 35 Services;

(f) Regular participation in interdisciplinary team meetings with APD staff or contractors serving Individuals receiving direct care MHS 35 Services;

(g) Discharge assistance (from in-patient psychiatric hospitals) and provide or arrange for short term follow-up services for Individuals receiving MHS 35 Services;

(h) Be available to County crisis team and DHS's Adult Protective Services for consultation on geriatric cases;

(i) Regular collaboration with APD, DHS's Aging and Disabilities Resource Connection, CMHPs, CCO's and CCO ICC Teams, Acute care hospitals, Oregon State Hospital, living facilities, families, and others as appropriate;

(j) Indirect services shall include, but not be limited to, prevention, planning, coordination, education, and assistance with urgent placement services;

(k) Oversight, support, and inter-agency coordination and collaboration for substance abuse treatment and prevention with older and disabled adults; and

(l) Have the experience, knowledge, and authority to effect change, make recommendations, and communicate to leadership.

(3) **Reporting Requirements** (exceeding Section 3, MHS 35)

None

(4) **Special Reporting Requirements** (exceeding Section 4, MHS 35)

None

(5) **Financial Assistance Calculation, Disbursement, and Agreement Settlement Procedures** (exceeding Section 5, MHS 35)

None