Office of State Courts Administrator
P.O. Box 104480
2112 Industrial Drive
Jefferson City, Missouri 65110- 4480

CONTRACT NO. OSCA 19-00284-16
Renewal 005
TITLE: Specialized Treatment Provider for Treatment Court

CONTACT: Trish Adamson
PHONE NO.: (573) 526-8818
E-MAIL: osca.contracts@courts.mo.gov

ISSUE DATE: April 4, 2024

RETURN RENEWAL NO LATER THAN: May 6, 2024

Renewal submission: Renewals may be sent electronically to osca.contracts@courts.mo.gov. If you would like to submit the renewal in paper form, please print or type the RFP number on the lower left hand corner of the envelope.

RETURN PROPOSAL TO:

(U.S. Mail)
Office of State Courts Administrator
Attn: Contracts
P.O. Box 104480
Jefferson City, MO 65110 - 4480

or

(Courier Service)
Office of State Courts Administrator
Attn: Contracts
2112 Industrial Drive
Jefferson City. MO 65109

CONTRACT PERIOD: JULY 1, 2024 THROUGH JUNE 30, 2025

DELIVER SUPPLIES/SERVICES FOB DESTINATION TO THE FOLLOWING ADDRESS:

VARIOUS LOCATIONS THROUGHOUT THE STATE OF MISSOURI

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, and in accordance with all requirements and specifications contained herein, including the Terms and Conditions attached hereto. The offeror further agrees that the language of this RFP shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order or when this RFP is countersigned by an authorized official of the Office of State Courts Administrator, a binding contract shall exist between the offeror and the Office of State Courts Administrator.

SIGNATURE REQUIRED

AUTHORIZED SIGNATURE: Peter Lyskowski	DATE: 5/29/24
PRINTED NAME: Peter Lyskowski	TITLE: Executive Vice President
COMPANY NAME: Compass Health, Inc.	
MAILING ADDRESS: 3515 Amazonas Drive	
CITY, STATE, ZIP: Jefferson City, MO 65109	
E-MAIL ADDRESS: plyskowski@compasshn.org	
TELEPHONE NUMBER: 660-207-7237	FACSIMILE NUMBER:

NOTICE OF AWARD (OSCA USE ONLY)

ACCEPTED BY OFFICE OF STATE COURTS ADMINISTRATOR AS FOLLOWS: As Submitted.		
CONTRACT NO. OSCA 19-00284-16	CONTRACT PERIOD July 1, 2024, through June 30, 2025	
CONTRACTS SECTION /s/Trish Adamson	DATE 05/29/2024	DEPUTY STATE COURTS ADMINISTRATOR R. Morrisey

PRICING PAGES

Contract Amendment 004

OSCA 19-00284 Renewal 005

The Office of State Courts Administrator (OSCA) hereby amends the above referenced contract. All other terms, conditions and provisions of the current contract period shall remain the same.

The amendment adds the following: Replaces all of section 2.0 Performance Requirements and updates Pricing Pages, Level of Services by Treatment Provider and Exhibit A (Additional Treatment Provider Information).

2.0 Performance Requirements

2.0.1 The contractor shall provide services for the treatment courts in accordance with the provision and requirements stated herein on an as needed, if needed basis. OSCA and the treatment courts make no specific guarantee of a minimum or maximum number of units of service that may be utilized under this contract.

2.0.2 The contractor shall:

1) Be an agency certified by the Missouri Department of Mental Health (DMH), Division of Behavioral Health, as a substance use and/or mental health treatment provider to deliver the appropriate level of care based on a validated assessment;
    a. Services shall vary in level of intensity based on individual needs. Referral relationships may be established to meet the individual's assessed need.
2) Remain certified for the duration of the contract;
3) Serve participants referred by the treatment court and be domiciled in Missouri;
4) Agree and understand that the treatment court is the sole referral source for this contract and must approve changes, including termination, of any participant in the program;
5) Offer services during the day, evening, and weekend hours to accommodate participants and work with treatment court(s) on the development of provisions for crisis intervention services;
6) Participate in any research project or outcome study initiated by or required of OSCA or the treatment court(s);
7) Not connect a personal computer or electronic computing device to an OSCA computer or network without prior written approval from OSCA; and
8) Provide or assist the treatment court in arranging transportation to and from the program site if participants do not have a means of transportation to promote participation in treatment and rehabilitation services, if the contractor does not have a program site in the county of an awarded treatment court to sustain all contracted services. If the contractor has a program site in the county of an awarded treatment court, the participant(s) shall be responsible for their transportation to the program site.

2.0.3 It is highly desirable that the contractor provide services as follows:

1) For all counties within a judicial circuit; and
2) To all participants referred within the county awarded, as specified on the pricing pages.

2.0.4 The treatment court shall have the authority to determine the composition of groups, for counseling and education purposes, for their referrals.

2.0.5 If the contractor elects or is required to vacate their current facilities, the contractor shall notify OSCA and the treatment court(s) in writing, a minimum of thirty (30) days prior to the date. If the contractor is relocating, the facility should meet the approval of the treatment court(s).

2.0.6 An evidence-based, manualized curriculum is recommended for substance use and/or mental health treatment. A list of evidence-based practices is provided under the Evidence-Based Practices Resource Center.

2.0.7 Cognitive Behavioral Therapy (CBT) is required for participants who score high risk on the Risk and Needs Triage (RANT®).

2.0.8 The continuum of treatment services must include access to medication assisted treatment (MAT) or be provided through a contractual agreement.

1). MAT must be permitted to be continued for as long as the prescriber determines the medication is clinically beneficial for the participant. A judge may retain judicial discretion to reduce the risk of use, misuse, or diversion of these medications.

2.0.9 Any programmatic changes to this contract as a result of state statute, regulation, or court order adopted after the proposal receipt, which would materially alter the services to be provided, shall be accomplished by a formal contract amendment.

2.1 Cost Avoidance

2.1.1 Each participant must be evaluated for eligibility of Medicaid benefits (and presumptive eligibility for Medicaid if the contractor is a qualified entity), private insurance coverage, or other medical benefits. The Treatment Court Resources Fund should be the primary source of payment for services. The treatment court program shall not pay for services that are subject to payment from a third party. If a third party requires the member to pay any cost-sharing (such as co-payment, coinsurance, or deductible), the treatment court program may pay the cost-sharing amounts.

2.1.2 The contractor should maintain information detailing third party savings. OSCA may request this information during the contract period utilizing the form provided on **Attachment 2**, Third Party Savings Report. The contractor shall maintain records in such a manner as to ensure that all money collected from third party resources can be identified on behalf of participants. The contractor shall make these records available for audit and review, and shall certify, upon request, that all third-party collections are properly identified and used as a source of revenue.

2.1.3 The contractor may retain up to one hundred (100) percent of its third-party collections if all of the following conditions exist:

1) Total collections received do not exceed the total amount of the contractor's financial liability for the participant;

2) There are no payments made by OSCA related to fee-for-service; and

3) Such recovery is not prohibited by Federal or State law.

2.2 Program Services

2.2.1 Comprehensive Assessment

1) The contractor shall conduct a comprehensive assessment of each participant which shall include the following for participants admitted to an outpatient program:
   a. An intake process which shall consist of the initial screening interview to determine the appropriateness for admission and the administrative and initial comprehensive assessment procedures related to admission into the program, and
   b. A complete assessment of each participant for an individualized treatment plan.

2) The assessment must be administered in accordance with the following DMH protocol:

   a. Must be completed by a qualified mental health professional, with finalization by a licensed mental health professional (LMHP) for completion of the diagnosis and clinical summary; and
   b. May be completed when participants transition from the various levels of care within the same agency, as clinically indicated by the treatment team.

3) Participants who score low risk/low need (Quadrant 4) on the RANT® shall not undergo a full clinical assessment and may be assigned to Early Intervention (outlined below in 2.2.9).

2.2.2 Assessment Update

1) In the event a treatment court participant has received a comprehensive assessment from a program operated by the contractor within the past six (6) months, the contractor shall administer an

assessment update upon re-admission. This service consists of an update of a participant's clinical assessment to develop treatment recommendations.

2) The assessment update must be administered in accordance with the following DMH protocol:

   a. Must be completed by a QMHP with finalization by an LMHP for completion of the diagnosis and clinical summary; and
   b. May be completed when participants transition from the various levels of care within the same agency as clinically indicated by the treatment team.

3) Participants who score low risk/low need (Quadrant 4) on the RANT®, shall not undergo an assessment update and may be assigned to Early Intervention (outlined below in 2.2.9).

2.2.3 **Case Management/Community Support**

1) Case management is defined as services which links the participant and/or family members/natural supports to community resources and monitors the services throughout the treatment court program.

   a. Transportation services are not to be billed as case management.

2) Community support services shall be delivered to those enrolled in a Comprehensive Substance Treatment and Rehabilitation (CSTAR) program. Community support is a comprehensive service designed to reduce the individual's disability resulting from a mental illness, emotional disorder, and/or substance use disorder and restore functional skills of daily living, principally by developing natural supports and solution-oriented interventions intended to achieve recovery/resiliency as identified in the goals and/or objectives in the individual treatment plan.

2.2.4 **Communicable Disease Counseling**

Communicable disease counseling assists individuals in understanding how to reduce the behaviors that interfere with their ability to lead healthy, safe lives and to restore them to their best possible functional level. Communicable disease counseling topics can include, but are not limited to, HIV, hepatitis, sexually transmitted infections (STI), tuberculosis (TB) status and/or disclosure of substance use to family members/natural supports, addressing stigma in accessing services, maximizing healthcare service interactions, reducing substance use and avoiding overdose and addressing anxiety, anger and depressive episodes. Prior to an individual being tested for HIV, counseling must be provided by qualified staff.

1) The contractor shall:

   a. Have a working relationship with the local health department, physician, QMHC, or other qualified healthcare provider in the community to provide any necessary testing services for human immunodeficiency virus (HIV), tuberculosis (TB), sexually transmitted infections (STIs), and hepatitis;

   b. Arrange for HIV, TB, STI and hepatitis testing to be available to the participant at any time during the course of the treatment;

   c. Make referrals and cooperate with appropriate entities to ensure coordinated treatment, as appropriate, is provided for any participant with a positive test;

   d. Arrange individual post-test counseling for participants who test positive for HIV or TB. Contractor staff providing post-test counseling must be knowledgeable about additional services and care coordination available through the DHSS; and

   e. Provide group education for participants and/or their family members/natural supports to discuss risk reduction and risk factors related to HIV/TB/STIs/hepatitis.

2) Group size shall not exceed 20 participants at any time.

3) Communicable disease counseling shall be provided by an LMHP, QMHP, qualified behavioral assistant (QBA) who is knowledgeable about communicable diseases, including HIV, TB, hepatitis, and STIs through training and/or previous employment experience.

2.2.5 **Crisis Intervention**

Crisis intervention is designed to interrupt and/or ameliorate a substance use and/or mental health crisis experience. The goal of crisis intervention is symptom reduction, stabilization and restoration to a previous level of functioning.

1) Key service functions include, but are not limited to:

   a. Preliminary assessment of risk, mental status and medical stability;
   b. Stabilization of immediate crisis;
   c. Determination of the need for further evaluation and/or substance use services; and
   d. Linkage to needed additional treatment services.

2) Services must be provided by an LMHP, QMHP, QBA, or credentialed support provider.

2.2.6 **Day Treatment**

Day treatment services shall consist of a comprehensive package of services consistent with the individual's treatment plan which are designed to achieve and promote recovery and improve functioning. Core components are group rehabilitative support and therapeutic structured activities.

1) Key service functions include, but are not limited to:

   a. Providing group rehabilitative support, based on individualized needs and treatment plans, designed to promote an understanding of the relevance of the nature, course and treatment of substance use and/or mental health disorders, to assist individuals in understanding individual recovery needs and how they can restore functionality;
   b. Assisting in the development and implementation of lifestyle changes needed to cope with the side effects of addiction or psychotropic medications and/or to promote recovery from the disabilities, negative symptoms and/or functional deficits associated with the substance use and/or mental health disorder; and
   c. Assisting with the restoration of skills and use of resources to address symptoms that interfere with activities of daily living and community integration.

2) Day treatment is provided by a team consisting of LMHPs, QMHPs, QBAs, and credentialed support providers.

2.2.7 **Ambulatory Withdrawal Management**

Organized outpatient services are delivered by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. Services are provided in regularly scheduled sessions under a defined set of policies and procedures or medical protocols.

1) Services shall include, but are not limited to:

   a. Assessment;
   b. Medication or non-medication methods of withdrawal management;
   c. Non-pharmacological clinical support;
   d. Involvement of family members/natural supports in the withdrawal management process;
   e. Physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal; and

f. Referral for counseling and involvement in community recovery support groups and arrangements for counseling, medical, psychiatric and continuing care.

2.2.8 **Medically Monitored Withdrawal Management:**

Medically monitored withdrawal management is the process of withdrawing an individual from a specific psychoactive substance (alcohol, illegal substances and/or prescription medications) in a safe and effective manner to restore the individual to the functionality of someone not under the influence of substances or alcohol. This service consists of the provision of care to individuals whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24 hour supervised medical care and monitoring; however, the full resources of a hospital setting are not necessary. The service is provided in a residential setting, certified by DMH, but does not include the provision of room and board.

1) Key service functions include, but are not limited to:

a. Medically supervised monitoring of vital signs, health status, and withdrawal symptoms;
b. Medication services and medication services support; and
c. Referral to ongoing treatment.

2) Services must be provided a team of LMHPs, QMHPs, QBAs, and credentialed support providers as follows:

a. A physician or APRN who is on call 24 hours per day, seven (7) days per week to provide medical evaluation and ongoing withdrawal management;
b. Licensed nursing staff must be present 24 hours per day;
c. An RN with relevant education, experience, and competency must be available on site or by phone for 24-hour supervision;
d. A minimum of two treatment assistants with specific training related to withdrawal management who provide continuous supervision and safety of individuals receiving care;
e. A physician or APRN must provide medication services;
f. A physician, APRN, RN, or LPN may provide medically supervised monitoring of vital signs and referral for ongoing treatment; and
g. All practitioners on the team may provide medically supervised monitoring of health status and withdrawal symptoms.

2.2.9 **Early Intervention**

Early Intervention is designed for adult treatment court and veterans treatment court participants who score low risk/low need on the RANT® (Quadrant 4). A clinical assessment is not needed for participants who score low risk/low need, however an intake session (consisting of approximately ½ hour) will be needed to schedule classes and gather information. Services are designed to address problems or risk factors related to substance use and to help individuals recognize the harmful consequences of high-risk substance use. Length of service varies according to the individual's ability to comprehend the information provided and use that information to make behavior changes and avoid problems related to substance use. The appearance of new problems may require treatment at another level of care.

1) Individualized outpatient services are provided by staff as indicated in this RFP.

2) Group size shall not exceed 20 participants at any time.

2.2.10 **Family Conference**

Family conference is defined as a service that coordinates care with, and enlists the support of, the natural support system through meeting with family members/natural supports and referral sources about the participant's treatment plan, transfer, and/or discharge plan.

1) Family conference services must be provided by an LMHP, QMHP, or QBA.

2.2.11 **Family Therapy**

Family therapy consists of counseling or family-based therapeutic interventions such as role playing, psychoeducational discussions for the primary individual and/or one or more family members/natural supports. It is designed to address and resolve patterns of dysfunctional communication and interactions that have become engrained over time, particularly as it relates to the impact of substance use. It is delivered by specialized staff in accordance with the primary individual's treatment plan. One or more family members/natural supports must be present. Services can be offered to members of a single family, or members of multiple families dealing with similar issues. Services to the individual's family members/natural supports is for the direct benefit of the individual, in accordance with their needs and treatment goals identified in the treatment plan and for the purpose of assisting in the individual's recovery.

1) Family therapy must be provided by a licensed or provisionally licensed clinical social worker, professional counselor, marital and family therapist, or psychologist practicing within their current competence.

2.2.12 **Group Counseling**

Group counseling is the goal-oriented therapeutic interaction among a counselor and two or more participants based on needs and goals identified in individual treatment plans. Services are designed to promote recovery through personal disclosure and interpersonal interaction among group members. Group counseling groups shall not exceed 12 participants.

1) Group counseling must be provided by a licensed or provisionally licensed clinical social worker, professional counselor, marital and family therapist, psychologist, QAP, or associate substance use counselor practicing within their current competence.

2.2.13 **Collateral Dependent Counseling (Individual and Group)**

Collateral dependent counseling is the planned, goal-oriented therapeutic interaction with an individual or group of individuals, to address dysfunctional behaviors and life patterns associated with being a family member/natural support of an individual who has a substance use and/or mental health disorder and is currently participating in treatment.

1) Key service functions of collateral dependent counseling include, but are not limited to:

   a. Exploration of substance use and/or mental health disorders and its impact on family members' functioning;
   b. Development of coping skills and personal responsibility for changing dysfunctional patterns in relationships;
   c. Examination of attitudes, feelings, and long-term consequences of living with a person with a substance use and/or mental health disorder;
   d. Identification and consideration of alternatives and structured problem-solving;
   e. Productive and functional decision-making; and
   f. Development of motivation and action by group members through peer support, structured confrontation, and constructive feedback.

2) Collateral dependent counseling must be provided by a licensed or provisionally licensed clinical social worker, professional counselor, marital and family therapist, psychologist, QAP, or associate substance use counselor practicing within their current competence.

2.2.14 **Group Rehabilitative Support**

Group rehabilitative support consists of facilitated group discussions, based on individual needs and treatment plan goals, designed to promote an understanding of the relevance of the nature, course and treatment of substance use and/or mental health disorders, to assist individuals in understanding their recovery needs and how they can restore functionality.

1) Key service functions of group rehabilitative support may include, but are not limited to:

   a. Classroom style didactic lecture to present information about a topic and its relationship to substance use and/or mental health;
   b. Presentation of audio-visual materials that are educational in nature with required follow-up discussion and are relevant to individuals' needs and treatment plan goals. Instructional aids shall be incorporated to enhance understanding and promote discussion and interaction among individuals. Aids may include, but are not limited to, videos or other electronic media, worksheets and informational handouts and shall not comprise more than 20% of group rehabilitative support sessions;
   c. Promotion of discussion and questions about the topic presented to the individuals in attendance; and
   d. Generalization of the information and demonstration of its relevance to recovery and enhanced functioning.

2) Programs must have a schedule and curriculum for delivery of group rehabilitative support that address topics and material relevant to the individuals served. Individuals should only attend groups with topics that are relevant to their needs based on the assessment and interventions recommended in their treatment plan.

3) Group rehabilitative support must be provided by an LMHP, QMHP, QBA, or credentialed support provider.

2.2.15 **Group Rehabilitative Support (Trauma)**

Group rehabilitative support (trauma) is the presentation of recovery and trauma-related information and its application to individuals, along with group discussion in accordance with individualized treatment plan objectives. The contractor shall use evidence-based models of trauma with specific training related to trauma and addiction. Trauma rehabilitative support groups provided must be gender specific. Group size shall not exceed an average of 30 participants during a calendar month, per facilitator, per group. Group averages are calculated per site.

1) Trauma group rehabilitative support must be provided by an LMHP, QMHP, QBA, or credentialed support provider with specialized training in trauma and substance use.

2.2.16 **Individual Counseling**

Individual counseling is a structured and goal-oriented therapeutic counseling interaction to resolve issues related to the use of alcohol and/or other drugs and/or mental health disorders that interfere with the individual's functioning. This includes evidence-based interventions such as motivational interviewing, cognitive behavioral therapy and trauma-specific services.

1) Key service functions of individual counseling may include, but are not limited to:

   a. Exploration of an identified problem and its impact on individual functioning;
   b. Examination of attitudes, feelings and behaviors that promote recovery and improved functioning;
   c. Identification and consideration of alternatives and structured problem-solving;
   d. Discussion of skills to aid in making positive decisions;
   e. Application of information presented in the program to the individual's life situations to promote recovery and improved functioning; and
   f. Discussion of harm reduction strategies to reduce substance use, lower health risk complications, such as hepatitis C, and reduce overdose deaths.

2) Individual counseling must be provided by a licensed or provisionally licensed clinical social worker, professional counselor, marital and family therapist, psychologist, QAP, or associate substance use counselor practicing within their current competence.

2.2.17 **Individual Counseling (Co-Occurring Disorder)**

Co-occurring disorder counseling services is a structured and goal-oriented therapeutic interaction between an individual and their counselor designed to identify and resolve issues related to substance use and co-occurring mental illness.

1) Individual counseling must be provided by a licensed or provisionally licensed clinical social worker, professional counselor, marital and family therapist, psychologist, QAP, or associate substance use counselor practicing within their current competence.

2.2.18 **Trauma Individual Counseling**

Trauma individual counseling is provided to the individual in accordance with their treatment plan to resolve issues related to psychological trauma in the context of a substance use and/or mental health disorder. Personal safety and empowerment of the individual must be addressed.

1) Trauma individual counseling must be provided by a licensed/provisionally licensed clinical social worker, professional counselor, marital and family therapist, psychologist, QAP, or associate substance use counselor practicing within their current competence.

2.2.19 **Medication Services**

Treatment court participants shall have access to medications to treat substance use and/or mental health disorders. This service consists of goal-oriented interaction to assess the appropriateness of medications to assist in a participant's treatment, to prescribe appropriate medications, periodic evaluation/reevaluation of the efficacy of any prescribed medications, and ongoing management of a medication regiment within the context of the individual's treatment plan. Medication Services are also included in MAT funding (section 2.3).

1) Key service functions include, but are not limited to the following:

   a. Assessment of the participant's presenting condition;
   b. Mental status exam;
   c. Review of symptoms and screening for medication side effects;
   d. Review of participant functioning;
   e. Assessment of the participant's ability to self-administer medication;
   f. Participant education regarding the effects of medication and its relationship to the participant's behavioral health disorder(s); and
   g. Prescription of medications when indicated.

2) Services shall be provided by a physician or resident physician (including psychiatrist), physician assistant, assistant physician, or advanced practice registered nurse. who is in a collaborative practice arrangement with a licensed physician.

2.2.20 **Medication Services Support**

Services consists of medical and other consultation for the purpose of monitoring and managing an individual's health needs while taking medications.

1) Key service functions include, but are not limited to:

   a. Evaluating individuals' physical condition and need for withdrawal management;
   b. Recording initial medical histories and vital signs;
   c. Monitoring health status during withdrawal management;
   d. Monitoring general health needs and meeting with individuals about medical concerns Educating individuals about disease prevention, risk reduction and reproductive health;
   e. Triaging medical conditions that occur during treatment and managing medical emergencies such as accidental injuries and drug reactions;
   f. Conferring with healthcare providers and coordinating medical services from other providers, as needed;
   g. Arranging or monitoring special dietary needs for medical conditions;

h. Reviewing medication requirements and the benefits of taking prescribed medications as prescribed with individuals served;
i. Consulting with medication prescribers or pharmacy staff to confirm medications prescribed;
j. Consulting with individuals on use of over-the-counter medications and monitoring their use;
k. Administering therapeutic injections of medication (subcutaneous or intramuscular);
l. Monitoring lab levels and providing feedback to individuals served, as well as consulting with healthcare providers and treatment team members;
m. Coordinating individuals' medication needs with pharmacies, family members/natural supports and prescription/drug assistance programs;
n. Monitoring medication side-effects, including the use of standardized evaluations; and
o. Monitoring medication orders from healthcare providers for treatment modifications and educating individuals, as necessary.

2) Services shall be provided by an APRN, RN, LPN, paramedic, or certified medical assistant (CMA).

2.2.21 **Medication**

FDA-approved medications prescribed for substance use disorder to participants as a component of substance use treatment may be provided. Medication is also included in MAT funding (section 2.3).

2.2.22 **Peer and Family Support**

Peer and family support services are coordinated within the context of a comprehensive, individualized treatment plan that includes specific individualized goals. Peer and family support services are person-centered and promote individual ownership of the treatment plan. These services may be provided to the individual's family members/natural supports when such services are for the direct benefit of the individual being served, in accordance with the needs and goals identified in their treatment plan and for assisting in the individual's recovery.

1) Key service functions include, but are not limited to:
   a. Person-centered planning to promote the development of self-advocacy;
   b. Empowering the individual to take a proactive role in the developing, updating and implementing their individualized treatment plan;
   c. Crisis support;
   d. Assisting the individual and family members in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the treatment plan so the individual remains in the least restrictive settings; achieves recovery and resiliency goals, self-advocates for quality physical and behavioral health and medical services in the community;
   e. Assisting individuals/families in identifying strengths and personal/family resources to aid recovery/promote resilience and recognize their capacity for recovery/resilience. Serving as an advocate, mentor or facilitator for the resolution of issues and skills necessary to enhance and improve the health of a child/youth with substance use or co-occurring disorders; and
   f. Providing information and support to parents/caregivers of children with emotional disorders so they have a better understanding of the individual's needs, the importance of their voice in the development and implementation of the individualized treatment plan, the roles of the various service providers and the importance of the "team" approach and assisting in the exploration of options to be considered as part of treatment.

2) Services shall be provided by a credentialed support provider. Supervision is provided by an LMHP, QAP, or community support supervisor.

2.2.23 **Residential Support**

Residential support service shall consist of twenty-four (24) hour supervised room, board and structured activities.

2.2.24 **Treatment Court Day**

Treatment court day is staff participating in treatment court staffing and/or hearings, as required by the treatment court.

2.2.25 **Drug/Alcohol Testing**

1) The contractor shall provide collection services for drug testing services as deemed necessary by the treatment court. This may include MAT services as well.
2) All individuals collecting samples for drug testing must follow the Collector Standards (Exhibit G).
3) The following documents must be submitted to OSCA for each individual who collects urine samples before providing this service:
   a. A copy of their criminal history background check (Exhibit H);
   b. A copy of the results from the Missouri Family Care Safety Registry (Exhibit H); and
   c. A completed Collector Guidance Acceptance Form (last page of Exhibit G).
4) This service will not be payable to the treatment provider if urine specimen collection is unobserved.

2.3 Medication Assisted Treatment (MAT) Funding

2.3.1 Appropriations approved by the General Assembly for fiscal year 2025 established a separate appropriation for Medication Assisted Treatment (MAT). "For the purpose of funding treatment programs focused on medication assisted treatment for Missourians with substance use disorder related to alcohol and opioid addiction. The Treatment Courts Coordinating Commission shall enter into agreements with the treatment courts, DWI courts, veteran's courts, and other treatment courts of this state in order to fund medication assisted treatment programs. The Treatment Courts Coordinating Commission shall submit an annual report to both the Chairperson of the House Appropriations Committee and the Chairperson of the Senate Appropriations Committee that includes information concerning the contracts entered into and the impact of the medication assisted treatment programs on the rates of recidivism."

1) MAT services, including prescribed addiction medications, medication services and psychosocial services (substance use disorder treatment), must be invoiced by treatment providers contracted with OSCA and certified by the Missouri Department of Mental Health. Treatment providers must verify, as requested, the physician (or other medical professional) is licensed/certified to prescribe medication and/or order administration by qualified staff.

2.3.2 Approved Funding Categories for MAT:

1) Addiction Medications:
   a. U.S. Food and Drug Administration (FDA) approved medications for use in the treatment of opioid and/or alcohol dependence. As of February 1, 2024, these medications include:
      - Naltrexone and Extended-Release Injectable Naltrexone (Vivitrol®)
      - Buprenorphine (Subutex®), Buprenorphine/Naloxone (Suboxone®), Buprenorphine Extended-Release Injection (Sublocade™), and Burprenorphine Implants
      - Methadone
      - Acamprosate
      - Disulfiram
   b. As new medications are approved by the FDA in the treatment of substance use disorders, they will be added to the list of approved medications above.
   c. Approved medications paid through the MAT funding appropriation must be billed to the treatment court for payment by a contracted treatment provider.

d. Withdrawal management medications:
    - Baclofen (Lioresal)
    - Benztropine (Cogentin)
    - Carbamazepine (Tegretol)
    - Chlordiazepoxide (Librium)
    - Clonazepam (Klonopin)
    - Clonidine (Catapres)
    - Divalpores Sodium (Depakote)
    - Gabapentin (Neurontin)
    - Haloperidol (Haldol)
    - Hydroxyzine (Vistaril)
    - Folic Acid
    - Lorazepam (Ativan)
    - Olansapine (Zyprexa)
    - Prazosin (Minipress)
    - Prochlorperazine (Compazine)
    - Propranolol (Inderal)
    - Quetiapine fumarate (Seroquel)
    - Thiamine
    - Trimethobenzamide (Tigan)
    - Trazodone (Desyrel)
    - Topiramate

2) Medication Services:
    a. Medication Services must be invoiced by treatment providers contracted with OSCA who are certified by DMH. Services shall vary in level of intensity based on individual needs. Referral relationships may be established to meet the individual's assessed need.

    b. Treatment providers must verify the physician (or other medical professional) are licensed/certified by the Missouri Board of Registration for the Healing Arts to prescribe medication and/or order administration by staff whom are certified to perform the duties. Missouri Board of Registration for the Healing Arts (mo.gov) .

    c. Examples of medication services include: an assessment, physical exam, nursing services, drug testing conducted immediately prior to administration of MAT to ensure abstinence and regular follow-up visits conducted by a physician (or other medical staff) to ensure the medication is working, that the side effects are not too uncomfortable and that the person is taking the medication as prescribed. If the medication is not working as expected, the physician may adjust the dosage or prescribe a different medication. Medication Services may be provided via telehealth.

    d. Approved medication services paid through the MAT funding appropriation must be billed to the treatment court for payment to contracted treatment providers.

3) Psychosocial Services (substance use disorder treatment):
    a. Psychosocial services and substance use disorder treatment as determined by individual clinical assessments while a treatment court participant is prescribed FDA-approved medications for use in the treatment of opioid and/or alcohol dependence.

    b. Psychosocial services comprise services currently included in Section 2.2 of this RFP

    NOTE: Treatment Court Day and Testing Services are not payable with MAT Funding.

    c. Psychosocial services paid through the MAT funding appropriation must be billed to the treatment court for payment by an OSCA contracted treatment providers.

2.3.3 Section 478.004 RSMo, stipulates:

1) A treatment court shall not prohibit a participant from participating in and receiving medication assisted treatment under the care of a licensed physician;

2) A participant shall not be required to refrain from using medication assisted treatment as a term or condition of successful completion of the treatment court program; and

3) A participant shall not be in violation of the terms or conditions of the treatment court on the basis of his/her participation in medication assisted treatment under the care of a licensed physician.

2.4 Program Service Requirements

2.4.1 **Comprehensive Assessment**

1) The contractor shall conduct a comprehensive assessment with all participants within seven (7) calendar days of the date of referral from the treatment court, unless otherwise amended and/or directed by the treatment court. Any exceptions must be documented in the participant's record.

2) The comprehensive assessment is an evaluation of an individual's physical, mental and emotional health, including issues related to substance use and/or mental health, along with their ability to function within a community in order to determine service needs and formulate recommendations for treatment. Components include:

   a. Risk assessment to determine emergency, urgent and/or routine need for services;
   b. Presenting problem, brief history, current medications, current medical conditions and current symptoms as obtained from the individual;
   c. Formulation of a diagnosis by a LMHP; and
   d. Development of a treatment plan.

3) The comprehensive assessment must include the following:

   a. Basic information (demographics, age, language spoken);
   b. Presenting concerns from the perspective of the individual, including reason for referral/referral source, what occurred to cause them to seek services;
   c. Risk assessment for determining emergency, urgent or routine need for services (suicide, safety and risk to others);
   d. Trauma history (experienced and/or witnessed abuse, neglect, violence or sexual assault);
   e. Substance use treatment history and current use including alcohol, tobacco and/or other drugs. For children/youth prenatal exposure to alcohol, tobacco or other substances;
   f. Mental status
   g. Mental health treatment history;
   h. Medication information including current medications, medication allergies/adverse reactions, efficacy of current or previously used medications;
   i. Physical health summary (health screen, current primary care, vision and dental, date of last examinations, current medical concerns, body mass index, tobacco use status and exercise level). Immunizations for children/youth and medical concerns expressed by family members that may impact the child/youth;
   j. Assessed needs based on functioning (challenges, problems in daily living, barriers and obstacles);
   k. Risk-taking behaviors including child/youth risk behaviors;
   l. Living situation including living accommodations (where and with whom), financial situation, guardianship, need for assistive technology and parental/guardian custodial status for children/youth;
   m. Family, including cultural identity and current and past family life experiences. For family functioning/dynamics, relationships, current issues/concerns impacting children/youth;
   n. Developmental information, including an evaluation of current areas of functioning such as motor development, sensory, speech, hearing and language, emotional, behavioral and intellectual functioning and self-care abilities;

o. Spiritual beliefs/religious orientation;
p. Sexuality, including current sexual activity, safe sex practices and sexual orientation
q. Need for and availability of social, community and natural supports/resources such as friends, pets, meaningful activities, leisure/recreation interests, self-help groups, resources from other agencies and interactions with peers including children/youth and family;
r. Legal involvement history;
s. Legal status such as guardianship, representative payee, conservatorship and probation/parole;
t. Education, including intellectual functioning, literacy level, learning impairments, attendance and achievement;
u. Employment, including current work status, work history, interest in working and work skills;
v. Status as a current or former member of the U.S. Armed Forces;
w. Clinical formulation, an interpretive summary including identification of co-occurring or co-morbid disorders and psychological/social adjustment to disabilities and/or disorders;
x. Diagnosis(es);
y. Individual's expression of service preferences;
z. Assessed needs/treatment recommendations such as life goals, strengths, preferences, abilities and barriers; and
aa. Signature, date, title and credential(s) of staff completing the assessment.

4) The comprehensive assessment shall be completed by a QMHP, with finalization by an LMHP for completion of the diagnosis and clinical summary, including dated signature.

5) Assessment updates shall be completed as clinically indicated by the treatment team to facilitate transition between levels and placement in the appropriate level of care. At a minimum, reassessment in outpatient levels of care shall take place every 12 months.

6) Documentation for assessment updates shall include:

a. A narrative summary;
b. The recommended level of care; and
c. Any recommended changes to the treatment plan based on the reassessment.

7) Reassessment should not be conducted when an individual is intoxicated or experiencing withdrawal symptoms.

8) Participants who score low risk/low need (Quadrant 4) on the RANT®, shall not undergo a full assessment, but may go through Early Intervention (outlined above in 2.2.9).

2.4.2 **Treatment Planning**

The contractor shall develop an individualized treatment plan for each participant and review the document with the treatment court within fourteen (14) calendar days of admission to the program, or sooner if required for certification, and periodically as directed by the treatment court. The contractor shall agree and understand that the treatment court has the final authority on the assignment of treatment level and approval of any changes in treatment level. The contractor shall attend meetings as required by the treatment court.

1) The individual (and parent/guardian, as applicable and appropriate) shall directly participate in the development of the treatment plan, which shall reflect their unique needs and goals. The initial treatment plan must include, at a minimum:

a. Identifying information;
b. Goals as expressed by the person served and family members/natural supports, (as appropriate) that are measurable, achievable, time-specific with start date, strength/skill based and include supports/resources needed to meet goals and potential barriers to achieving goals;
c. Specific treatment objectives that include a start date, are understandable to the individual served and sufficiently specific to assess progress, responsive to the disability or concern and reflective of age, development, culture and ethnicity; and

d. Specific interventions and services including action steps, modalities and services to be utilized, duration and frequency of interventions, who is responsible for the intervention and action steps of the individual served and family members/natural supports, as appropriate.

2) Treatment plans must include the dated signature of the QAP or QMHP completing the plan with finalization by an LMHP. The LMHP's dated signature certifies that treatment is needed and services are appropriate as described in the treatment plan and does not recertify the diagnosis.

2.4.3 Levels of Care

For the purpose of this contract, one (1) unit is defined as fifteen (15) minutes of service delivery.

1) The contractor shall notify the treatment court if there is a need for medically monitored withdrawal management services. The contractor will assist the treatment court in the referral process for such services, if requested.

2) The contractor shall only provide treatment services at the request of the treatment court. Any exceptions and/or changes to the levels of service shall be approved in writing by the treatment court and documented in the participant's treatment record prior to services being provided.

2.5 Reporting Requirements

The contractor shall document each service provided in the participant's clinical record. Progress notes shall include the following information:

1) Type of service;
2) Date;
3) Beginning and ending time;
4) Synopsis of the service; and
5) Signature, title, and credential(s) of service provider.

2.5.1 The contractor shall maintain regular communication with the treatment court, including but not limited to, a written and a verbal report from the treatment provider(s) at each staffing which includes the following:

1) Attendance of the participant at treatment appointments;
2) Active engagement by the participant) including, but not limited to good participation in all areas of the program, completing homework assignments, reporting to their PO (as applicable);
3) Compliance with treatment (Is the participant moving forward in achieving treatment plan goals and objectives?);
4) Recommendations by the treatment provider concerning:
   a. Current treatment services and any modifications to the treatment plan, if needed (participant progress in treatment);
   b. Concerns (if the participant is not progressing), suggested improvements, treatment plan updates, or sanctions, if warranted; and
   c. Identification of other agency/community resources and supports including others providing services, plans for coordinating with other agencies, services needed to be addressed through referral/services with another organization which may include:
      - Housing (emergency housing services and/or safe, supportive, and stable/sustainable housing)
      - Transportation (lack of transportation, assistance with vehicle maintenance/repairs, lack of sufficient access to public transportation)
      - Child Care (access to quality, affordable childcare)
      - Basic Needs (food, clothing, hygiene, utilities, communication access, etc.)
      - Employment (barriers/needs to obtaining/maintaining gainful employment)
      - Medical (establishing primary care, doctor's appointments, Medicaid/ Medicare application assistance)

- Mental Health (engaging with care, medication/treatment compliance, mental health crises)
- Dental (establishing dental care, emergency dental needs, preventative care)
- Training (parenting, life skills, financial literacy, time management, stress management, tenant education)

5) A summary of treatment services provided in order for the judge to ask the participant open-ended questions about their treatment and progress;
6) Drug test results (positive, negative, dilute, tampered, and no shows);
7) Medication services, MAT referrals, prescriptions; and
8) Services to include CBT, as involvement in community recovery support groups and other social activities (start date, progress, and end date).

2.5.2 The contractor shall notify the treatment court in the event any of the following occur:

1) Missed appointments;
2) Positive, dilute or tampered urinalysis results;
3) Disclosures of illegal drug or alcohol use by participants;
4) Any and all reports of participant illegal drug or alcohol use whether the report is self-disclosed or reported by any other party;
5) Staff observes drug or alcohol use and/or impairment related to such use;
6) Changes in the participant's treatment plan;
7) Need for additional services;
8) Changes in the participant's family and/or living situation, such as major illness or injury, death, pregnancy, or other; and
9) Incidents involving participants where threats, assaults, or possible crimes may have occurred.

PRICING PAGES

The offeror must provide not to exceed prices for the services identified below. Should a contract award be made based upon the offeror's proposal, the prices stated herein shall be legally binding for the entire contract period.

OFFEROR NAME: _____

Service Description	Not to Exceed Price	Unit of Service
Comprehensive Assessment	$370.14	Per assessment
Assessment update	$135.16	Per assessment
Case Management/Community Support	$25.31	Per ¼ hour
Crisis Intervention	N/A	Per ¼ hour
Day Treatment	N/A	Per day
Ambulatory Withdrawal Management	N/A	Per day
Medically Monitored Withdrawal Management	N/A	Per day
Early Intervention	$2.78	Per ¼ hour
Family Conference	$18.58	Per ¼ hour
Family Therapy	$34.46	Per ¼ hour
Group Counseling	$6.89	Per ¼ hour
Group Counseling (Collateral relationship)	$6.89	Per ¼ hour
Group Rehabilitative Support	$4.08	Per ¼ hour
Group Counseling (Trauma Related)	$6.89	Per ¼ hour
Individual Counseling	$34.46	Per ¼ hour
Individual Counseling (Collateral Relationship)	$34.46	Per ¼ hour
Individual Counseling (Co-Occurring Disorder)	$34.46	Per ¼ hour
Individual Counseling (Trauma Related)	$34.46	Per ¼ hour

Peer Support and Family Support	$22.15	Per ¼ hour
Residential Support	$44.57	Per day
Treatment Court Day	$15.12	Per ¼ hour
*****Drug/Alcohol Testing: Sample Collection Only (Lab conf. only)	N/A	Per test
*****Sample Collection with 1-panel on-site provided by contractor	$3.12	Per test
*****Sample Collection with 2-panel on-site provided by contractor	$6.24	Per test
*Sample Collection with 3-panel on-site provided by contractor	$9.36	Per test
*Sample Collection with 4-panel on-site provided by contractor	$12.48	Per test
*Sample Collection with 5-panel on-site provided by contractor	$15.60	Per test
*Sample Collection with 6-panel on-site provided by contractor	$18.72	Per test
*Sample Collection with 7-panel on-site provided by contractor	$21.84	Per test
*Sample Collection with 8-panel on-site provided by contractor	$24.96	Per test
*Sample Collection with 9-panel on-site provided by contractor	$28.08	Per test
*Drug Testing: Sample Collection and On-Site Test (Kit provided by Treatment Court)	$3.12	Per test
Drug Testing: Breathalyzer (Equipment provided by contractor)	N/A	Per test
Drug Testing: Breathalyzer (Equipment provided by Treatment Court)	N/A	Per test

The offeror must provide copies of invoices of actual cost per dose for the medications and services identified below with the double asterisk.

**Medication Service – Physician Office Visit	No pricing needed	Per office visit
Medication: [Medication Assisted Treatment (MAT)]		
**Naltrexone - Oral	No pricing needed	Per Dose
**Extended-Release Injectable Naltrexone (Vivitrol®)	No pricing needed	Per Dose
**Buprenorphine (i.e. Subutex®),	No pricing needed	Per Dose
**Buprenorphine/Naloxone (i.e. Suboxone®)	No pricing needed	Per Dose
**Burprenorphine Implants	No pricing needed	Per Dose
**Methadone	No pricing needed	Per Dose
**Acamprosate	No pricing needed	Per Dose
**Disulfiram	No pricing needed	Per Dose
**Buprenorphine Extended-Release Injection (i.e. Sublocade™	No pricing needed	Per Dose
**Baclofen (Lioresal)	No pricing needed	Per Dose
**Benztropine (Cogentin)	No pricing needed	Per Dose
**Carbamazepine (tegretol)	No pricing needed	Per Dose
**Chlordiazepoxide (Librium)	No pricing needed	Per Dose
**Clonazepam (Klonopin)	No pricing needed	Per Dose
**Clonidine (Catapres)	No pricing needed	Per Dose
**Divalproex sodium (Depakote)	No pricing needed	Per Dose
**Gabapentin (Neurontin)	No pricing needed	Per Dose
**Haloperidol (Haldol)	No pricing needed	Per Dose
**Hydroxyzine (Vistaril)	No pricing needed	Per Dose
**Folic Acid	No pricing needed	Per Dose
**Lorazepam (Ativan)	No pricing needed	Per Dose
**Olanzapine (Zyprex)	No pricing needed	Per Dose

**Prazosin (Minipress)	No pricing needed	Per Dose
**Prochlorperazine (Compazine)	No pricing needed	Per Dose
**Propranolol (Inderal)	No pricing needed	Per Dose
**Quetiapine fumarate (Seroquel	No pricing needed	Per Dose
**Thiamine	No pricing needed	Per Dose
**Trimethobenzamide (Tigan)	No pricing needed	Per Dose
**Trazodone (Desyrel)	No pricing needed	Per Dose
Topiramate	No pricing needed	Per Dose

***Exhibits G and H must be completed for any individual who collects urine specimens for drug testing.**

Below is a list of the Judicial Circuits and Counties in the State of Missouri. Check either the applicable counties or the entire Judicial Circuit(s) that your agency shall provide services. Check the appropriate level of service and the applicable gender that shall be provided: DWI, Adult, Veterans, Family and Juvenile.

OFFEROR NAME: _____

JUDICIAL CIRCUIT	COUNTY	DWI	ADULT	FAMILY	VETERANS	JUVENILE	MALE	FEMALE
1	Clark							
1	Schuyler							
1	Scotland							
2	Adair							
2	Knox							
2	Lewis							
3	Grundy							
3	Harrison							
3	Mercer							
3	Putnam							
4	Atchison							
4	Gentry							
4	Holt							
4	Nodaway							
4	Worth							
5	Andrew							
5	Buchanan							
6	Platte							
7	Clay							
8	Carroll							
8	Ray							
9	Chariton							
9	Linn							
9	Sullivan							
10	Marion							
10	Monroe							
10	Ralls							
JUDICIAL CIRCUIT	**COUNTY**	**DWI**	**ADULT**	**FAMILY**	**VETERANS**	**JUVENILE**	**MALE**	**FEMALE**
11	St. Charles							

12	Audrain							
12	Montgomery							
12	Warren							
13	Boone	X	X	X	X		X	X
13	Callaway	X	X	X			X	X
14	Howard							
14	Randolph							
15	Lafayette	X	X	X			X	X
15	Saline		X	X	X		X	X
16	Jackson							
17	Cass	X	X	X			X	X
17	Johnson							
18	Cooper							
18	Pettis							
19	Cole	X	X	X			X	X
20	Franklin							
20	Gasconade							
20	Osage							
21	St. Louis							
22	St. Louis City							
23	Jefferson	X	X	X	X		X	X
24	Madison							
24	St. Francois							
24	Ste. Genevieve							
24	Washington							
25	Maries							
25	Phelps							
25	Pulaski							

JUDICIAL CIRCUIT	COUNTY	DWI	ADULT	FAMILY	VETERANS	JUVENILE	MALE	FEMALE
25	Texas							
26	Camden	X	X				X	X
26	Laclede							

26	Miller	X	X	X			X	X
26	Moniteau	X	X	X			X	X
26	Morgan	X	X	X			X	X
27	Bates		X	X			X	X
27	Benton		X	X	X		X	X
27	Henry		X	X	X		X	X
27	St. Clair		X	X			X	X
28	Barton							
28	Cedar		X	X			X	X
28	Dade							
28	Vernon		X	X			X	X
29	Jasper							
30	Dallas							
30	Hickory							
30	Polk							
30	Webster							
31	Greene							
32	Bollinger							
32	Cape Girardeau							
32	Perry							
33	Mississippi							
33	Scott							
34	New Madrid							
34	Pemiscot							
35	Dunklin							
35	Stoddard							
36	Butler							
36	Carter							
JUDICIAL CIRCUIT	**COUNTY**	**DWI**	**ADULT**	**FAMILY**	**VETERANS**	**JUVENILE**	**MALE**	**FEMALE**
36	Ripley							
37	Howell							
37	Oregon							
37	Shannon							

38	Christian							
39	Barry							
39	Lawrence							
39	Stone							
40	McDonald							
40	Newton							
41	Macon							
41	Shelby							
42	Crawford							
42	Dent							
42	Iron							
42	Reynolds							
42	Wayne							
43	Caldwell							
43	Clinton							
43	Daviess							
43	DeKalb							
43	Livingston							
44	Douglas							
44	Ozark							
44	Wright							
45	Lincoln							
45	Pike							
46	Taney							

EXHIBIT A
Additional Treatment Provider Information

OFFEROR NAME: _____

The offeror shall respond to each question/statement below to supply OSCA with accurate and comprehensive information regarding the services provided within offeror's agency.

TREATMENT PHILOSOPHY

1. What is the program's philosophy of treatment?
2. How is this philosophy "operationalized" on a daily basis?
3. Does the program serve a designated target population?
4. Does the program use harm reduction techniques? If so, please describe.

LEVEL OF CARE

1. What levels of care does the program provide?
2. What criteria are used to determine the appropriate levels of care?
3. Are services offered for both individuals and families?
4. What level of care metric is used?
5. What are the major differences in the levels of care provided?
6. What are the state requirements for treatment programs related to each level of care provided?
7. Are there plans to provide other levels of care in the future?

PROGRAM DESIGN AND TREATMENT INTERVENTIONS

1. What are the key elements of the program's design?
2. Does the design utilize evidence-based treatments? If so, please describe.
3. How does the program address cultural-specific needs of the client population?
4. Does the program use a strength-based model? Please explain.
5. Are clinical assessments conducted by licensed and certified professionals? If so, what are the licensure and certifications of the professionals conducting the assessments?
6. How frequently are clients reassessed?
7. Are clients screened and assessed for both mental and substance use disorders?
   Are standardized instruments used to screen and assess for each type of disorder? If so, what instruments are used?
8. What new interventions or services have been added in the past 2 years to enhance the program's design?
9. Which community partnerships have been established by the program, and how have these been maintained over time?
10. Does the program use manualized treatment curricula? If so, which curricula are used?
11. What experience does the program have in providing services to justice-involved populations?

PROGRAM OPERATIONS

1. Does the program offer onsite drug testing? Is there a drug-testing lab on site? How quickly are drug test results available?
2. Does the program have an established, written drug-testing protocol? If so, what does it include (e.g., process, chain-of-custody, analysis, technological and legal support, etc.)?
3. Does the program provide case management services? If so, please describe.
4. Does the program have an established community provider network in place for complementary and support services?
5. Does the program have a formal grievance process in place?
6. What types of client information are maintained by the program?
   Is this information maintained on an electronic database? Is this database encrypted?
7. What are the program's after-hours and emergency service protocols?
8. Does the program have a formal fiscal management and accounting procedure in place? If so, please describe.
9. Please provide a copy of the program's organizational chart that clearly describes key administrative and operational components.
10. Are processes in place to assist the uninsured in accessing insurance coverage, through either Medicaid or federal/state insurance exchanges?

11. Does the program offer specialized services for unique populations (e.g., gender, offender, non-offender, DWI, veterans, etc.)?
12. Does the program offer or assist with transportation services?
13. Are records kept in an analog or digital system?
14. Is the record system interoperable with the other major electronic health records systems in the area?

STAFF CHARACTERISTICS AND QUALIFICATIONS

1. What attempts have been made to provide diversity among the program's treatment team?
2. What attempts have been made to ensure cultural competency among the program's team?
3. Does the diversity of the treatment team appropriately reflect the diversity of the community?
4. Is the program team able to appropriately engage with the clients in a culturally competent manner?
5. To what extent does the treatment team include multidisciplinary staff? Do these staff have experience in working with court referrals and with drug-involved offenders?
6. Is the program's treatment team licensed and credentialed as per state requirements?
7. What type of staff training has been provided that aligns with the needs of the program's target population?
8. Does the treatment staff practice self-improvement and self-care as part of a cohesive team?
9. Does the treatment staff model the health they teach their clientele?

INSURANCE AND MEDICAID

1. Are processes in place to assist the uninsured in accessing insurance coverage, through either Medicaid or the federal/state insurance exchanges?
2. Does the provider have a system for determining whether an individual has insurance or is eligible for Medicaid?
3. Is the treatment provider eligible to receive payment from Medicaid? If so, does the provider accept Medicaid?
4. Does the program accept the major Medicaid plans or other health plans in the catchment area?
5. Does the program offer medication assisted therapies conformant to the Medicaid formularies?
6. Does the program assess individuals in a manner to ensure medical necessity in conformance with Medicaid protocols?
7. Are the treatment modalities offered in conformity with the state Medicaid plan?

QUALITY ASSURANCE MECHANISM

1. What are the federal, state, and local requirements for treatment service delivery in your catchment area? (e.g., accreditation, fire, safety, zoning, Medicaid/Medicare eligibility and billing requirements, confidentiality regulations (42 CFR), ADA specifications)
2. Does the program maintain a written set of formal policies, procedures, and/or standard operations guidelines?
3. Is the program subject to periodic onsite reviews by the state regulatory authority, accreditation agency, or other monitoring organization?
4. How does the program monitor the implementation of treatment components?
5. Does the staff have input into the program's design and changes to the design?
6. Do clients have an opportunity to voice constructive opinions regarding ways to improve the program? How is this feedback used?
7. Is clinical supervision available on site? If so, who provides this supervision?

PROGRAM EVALUATION

1. What program evaluations are required by local, state, and federal agencies? How frequently are evaluations required?
2. What program evaluations are required by funding entities? How frequently?
3. Has program evaluation been conducted to date? If so, what type of evaluation was conducted and what were the results?
4. What performance measures does the program compile and monitor? How are these measures used by program administrators?
5. Does the program operate an electronic management information system (MIS)?
   Who has access to the MIS database? What confidentiality safeguards are in place?
6. Are both qualitative and quantitative evaluation data collected? If so, please describe.
7. Would the program support an external evaluation (e.g., use of an external evaluator/ researcher)? Does the program have experience in working with an external evaluator?
8. Is the program willing to share completed evaluations (methodologies and results) with the court?

COMPETENCIES THE PROVIDER MUST HAVE OR MUST BE WILLING TO DEVELOP

1. Is the program willing to provided court-ordered treatment services to justice-involved clients?
2. Does the program provide contingency management as part of substance abuse treatment? If not, would the program support the use of these techniques?
3. Will the program provide treatment of varying duration? If so, please describe.
4. Are services time driven or based on clinical and medical need?
5. Is the program willing to communicate treatment progress with probation and parole officers and with the drug court team?
6. How does the program provide modifications to its treatment interventions and modalities?
7. How does the program address client motivation? Does the program utilize motivational enhancement theories?
8. Is the program willing to be an active member of the court team (e.g., participate in staffing and hearings)?

MEDICATION ASSISTED TREATMENT (MAT)

1. Does the program support medication-assisted treatment (MAT) approaches to recovery?
2. Does the program have a MAT prescribing physician/nurse practitioner on staff? If so, what specialized training or certification has been received?
3. Does the program have established relationships with MAT prescribing physicians in the community?
4. What communication protocols are in place with MAT prescribing physicians or other medical staff (both onsite and offsite) to ensure that there is adequate communication regarding clients' MAT compliance and progress?
5. What addiction medications are currently available to the program or the program's community MAT provider network? How long have these medications been used by the prescribing medical staff? How many existing clients within the program receive MAT?
6. Does the program have established protocols for MAT patients?
7. Does the program have a MAT taper, length of time requirement, or other policy that is not consistent with MAT evidence-based principles?
8. What types of psychosocial treatments (e.g., cognitive and behavioral therapies) are available to MAT patients?
9. What other substance abuse treatment services are available for MAT recipients?
10. Are addiction medicines stored and dispensed on site?
11. What is the program's funding source for MAT services (e.g., private insurance, federal or state insurance exchange, Medicaid, public treatment funds, self-pay, grant funding, etc.)?
12. Is there an adequate number of pharmacies in the catchment area to fill addiction medicine prescriptions?
13. Has the program negotiated addiction medication costs with pharmacies within the catchment area?
14. What staff training has been received related to MAT?