Providing Behavioral Health Services in
Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD MEETING

DATE: **Friday, January 21, 2022**

TIME: **9:00 AM – 11:00 AM**

LOCATION: **VIRTUAL ONLY:** **We will use the ZOOM virtual platform.**

Recommend participation by either computer or ZOOM app on your mobile phone. Please use this link to download ZOOM to your computer or phone: https://zoom.us/support/download.

LINK TO JOIN BY COMPUTER OR PHONE APP:

Join Zoom Meeting:
https://us06web.zoom.us/j/89103863343?pwd=OEhGbFFyRnI5a0gzOXV4V083YXc5dz09

Meeting ID: 891 0386 3343

Passcode: 713652

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

Dial by your location: 1-253-215-8782

Meeting ID: 891 0386 3343

Passcode: 713652

AGENDA

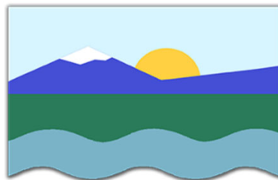
Salish Behavioral Health Administrative Services Organization – Executive Board

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of SBH-ASO Executive Board Meeting Minutes for December 10, 2021 (Attachment 5)
6. Action Items
   a. Election of SBH-ASO Executive Board Chair and Vice-Chair
   b. 2021/2022 SBH-ASO Risk Assessment (Attachment 6.b)
7. Informational Items
   a. Olympic Community of Health Update (Attachment 7.a)
   b. SBH-ASO Advisory Board Update
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BAART	A BayMark health services company, opioid treatment company
BH-ASO	Behavioral Health Administrative Services Organization
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHPW	Community Health Plan of Washington
CMS	Center for Medicaid & Medicare Services (federal)
COVID-19	Coronavirus Disease 2019
CPC	Certified Peer Counselor
CRIS	Crisis Response Improvement Strategy
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DCR	Designated Crisis Responder
DDA	Developmental Disabilities Administration
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
FIMC	Full Integration of Medicaid Services
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
ITA	Involuntary Treatment Act
MAT	Medical Assisted Treatment
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OPT	Opiate Treatment Program
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QUIC	Quality Improvement Committee
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SABG	Substance Abuse Block Grant
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
TAM	Technical Assistance Monitoring
UM	Utilization Management
VOA	Volunteers of America
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Full listing of definitions and acronyms



Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

Friday, January 21, 2022

Action Items

A. ELECTION OF SBH-ASO EXECUTIVE BOARD CHAIR AND VICE-CHAIR

The SBH-ASO Interlocal Agreement dictates that, annually, the Board shall elect a Chair and Vice-Chair by majority vote. In 2021, Commissioner Brotherton served as Chair and Commissioner Gelder served as Vice-Chair.

Staff respectfully requests that the Executive Board Elect Chair and Vice-Chair for 2022.

B. 2021/2022 SBH-ASO RISK ASSESSMENT

In accordance with 45 CFR §164.308 the SBH-ASO is required to maintain, review, and update a Risk Assessment. This document provides a process by which the SBH-ASO continually monitors its operations to identify areas of potential risk and opportunities for mitigation. In order to ensure this document is comprehensive, SBH-ASO Staff worked collaboratively to identify areas of risk in all avenues of its business operations. The draft Risk Assessment was reviewed by the SBH-ASO Quality and Compliance Committee on December 14, 2021, and opportunity for subcontractor feedback was provided.

For the 2021/2022 Risk Assessment, the top 3 identified risks include:

- Process for procurement and/or administration of new program development while managing staff bandwidth, agency bandwidth, and challenges with information flow.
- Changes to Regional Crisis System as a result of State level (i.e., judicial, legislative, regulatory) changes could inhibit community response to behavioral health crises.
- Delays in timely issuance of revenue contracts or amendments creating cascading delays in amending subcontracts to include updated terms and issuing payment.

This document is attached for review, comment, and approval by the Executive Board.

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Informational Items

A. OLYMPIC COMMUNITY OF HEALTH UPDATE

OCH Executive Director, Celeste Schoenthaler, will provide an update on the work the Olympic Community of Health is leading in the region. This update will include a review of the 2022-2026 Olympic Community of Health Strategic Plan. A high-level summary of this strategic plan has been included in the Board Packet.

B. SBH-ASO ADVISORY BOARD UPDATE

Lois Hoell, Chair, will provide an update on behalf of the Advisory Board.

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

Friday, December 10, 2021
1:00 p.m. - 3:00 p.m.
VIRTUAL ONLY: ZOOM Virtual Platform

CALL TO ORDER – Commissioner Greg Brotherton, Chair, called the meeting to order at 12:59 p.m.

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – None.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS – None.

APPROVAL of AGENDA – Commissioner Greg Brotherton

> **MOTION: Request Commissioner Gelder moved to approve the agenda as submitted. Commissioner Ozias seconded the motion. Motion carried unanimously.**

APPROVAL of MINUTES –

> **MOTION: Commissioner Gelder moved to approve the meeting minutes as submitted for the September 17, 2021 meeting. Commissioner Ozias seconded the motion. Motion carried unanimously.**

ACTION ITEMS

- **SBH-ASO ADVISORY BOARD MEMBER APPOINTMENTS**

On November 12, 2021, Salish BH-ASO Staff outreached SBH-ASO Advisory Board Members with expiring terms and inquired about interest in continuing to serve on the Board. Staff received responses from all Board Members listed below, except for Jolene Sullivan. All Board Member responses confirmed interest in continuing to serve.

The following SBH-ASO Advisory Board Members have expiring terms:

- Sandy Goodwick, 2-year term expires 12/31/21
- Janet Nickolaus, 1-year term expires 12/31/21
- Anne Dean, 2-year term expires 12/31/21
- Helen Havens, 1-year term expires 11/30/21
- Jon Stroup, 1-year term expires 12/31/21
- Jolene Sullivan, 2-year term expires 12/31/21

The recommendations regarding Board Member reappointment made during the December 3, 2021, Advisory Board Meeting will be presented to the Executive Board.

The Advisory Board unanimously recommended that the Executive Board reappoint the following members to the following terms:

- Sandy Goodwick, Clallam County, *01/01/22-12/31/23*
- Janet Nickolaus, Clallam County, *01/01/22-12/31/22*
- Anne Dean, Jefferson County, *01/01/22-12/31/23*
- Helen Havens, Kitsap County, *12/01/21-11/30/22*
- Jon Stroup, Kitsap County, *01/01/22-12/31/22*

Inquiry regarding the necessity to stagger memberships, specifically noting Kitsap County does not have staggering as others. Discussed that Kitsap County has more representation than other counties. Reviewed that at the beginning of the ASO inception staggering was needed, however, the staggering was carried forward from the SBHO bi-laws and operation. SBH-ASO will evaluate staggering and update the bi-laws.

MOTION: Commissioner Ozias moved to approve SBH-ASO Advisory Board Member Appointments as stated above. Commissioner Gelder seconded the motion. Motion carried unanimously.

➢ APPROVAL OF CALENDAR YEAR 2022 BUDGET

There are several new funding streams incorporated into the 2022 calendar year budget. A summary of new funding and corresponding new programming is summarized below.

Youth Mobile Crisis Outreach: Senate Bill 5092 appropriated funds to support the development and/or expansion of youth mobile crisis outreach teams. The bill requires that each BH-ASO region have at least 1 youth mobile crisis outreach team by June 30, 2022.

The Salish region does not currently have any mobile crisis outreach teams that only serve youth. Rather, each crisis team is responsible for serving all individuals in their assigned catchment area. This team will be separate and distinct from current mobile crisis outreach teams. This new youth team will provide crisis outreach services and, when indicated, coordinate with existing crisis teams for involuntary treatment investigations.

Staff conducted an analysis of the number of youth served by mobile crisis and number of services rendered for the period of January 2020 – June 2021 for both Clallam and Kitsap Counties.

The data reflected below suggests that only Kitsap County has the population and utilization to justify the cost of a youth mobile crisis team.

	Kitsap County	Clallam County
Jan-June 2020: Average # Youth Served Per Month	15	7
Jan-June 2020: Average # of Services	45	10

July-December 2020: Average # Youth Served Per Month	18	6
July-December 2020: Average # of Services	53	12
Jan-June 2021: Average # Youth Served Per Month	26	8
Jan-June 2021: Average # of Services	64	19

Staff estimates the cost of operating a 2-person youth mobile crisis outreach team in Kitsap County, 7 days a week between 7am-11pm to be $475,000. This equates to approximately 56% of the new annual funding allocated to expand youth mobile crisis outreach team capacity and aligns with Kitsap County's proportion of population in relation to Jefferson and Clallam Counties.

The remaining 44% of funding, approximately $372,000 would then be added to Clallam and Jefferson County Crisis Providers compensation to add Child Mental Health Specialists to their mobile crisis outreach teams. Staff plans to release an RFP in January 2022, specific to Kitsap County, for the Youth Mobile Crisis Outreach Team funding.

Noted Jefferson County was not included in the above Youth Mobile Crisis Outreach chart as there was not enough sample.

Reviewing the Youth Mobile Crisis there was a discussion of impacts from COVID-19, specifically community awareness of resources for individuals struggling with anxiety, isolation, etc. Board Members inquired if there has been a significant change pre-COVID-19 to present on the number of youths seeking mobile crisis outreach. SBH-ASO did not compare the utilization of youth crisis services pre-COVID to current. SBH-ASO staff noted that there is a belief that the COVID-19 impacts will continue to effect youth. Dr. Lippman referenced several resources put forth by the US Surgeon General to address some of these questions. Dr. Lippman provided the link to the Surgeon General's report: https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

Inquiry regarding the benefit of setting up a new team in Kitsap as opposed to the other two counties or setting up multiple teams. Legislation dictates that each region has at least one team and that this would be the greatest use of resources to have one single team. Reviewed the state requirement for response time for Mobile Crisis Outreach teams which is two (2) hours and unsure how functional that would be across all regions.

Certified Peer Counselor Crisis Team Expansion: Funding has been provided to add a Certified Peer Counselor (CPC) to existing Crisis teams. The CPC will be required to participate in crisis specific peer training that is being developed by DBHR. Crisis Peers may not provide the initial crisis response independently. This position may provide co-response with another crisis staff and/or peer services following a crisis event. Each of the four crisis teams across the region will add the role to their existing team.

Reviewed the Certified Peer Counselor (CPC) Crisis Team Expansion would be added to existing Mobile Crisis Outreach Teams and may be dispatched as a second due to safety and provide any follow up. Discussed that this program does not specify for adults or youth, however, CPC trainings are available for Adults, as well as Youth and Family, for parents of youth who have been through the public system.

Peer Pathfinder Transition from Incarceration Pilot: This program adds Peer services to the existing Jail Transitions Program. Peer services will be available to individuals who are exiting incarceration and up to 120 days post release. The Peer would be connected to the individual pre-release or at release to provide continuity of care through the return to community. The Peer Pathfinder will work with the individuals to bridge any barriers to returning to community. They can provide support tailored to the individuals' needs including access to community-based services, support with life skills, social support, and reintegration. They will assist the individuals with connecting to formal services as well as informal support based on individual needs and desires. The goal is to assist with transitions back to community and decrease recidivism.

Co-Responder Program: Another new program that supports the behavioral crisis system is the Co-Responder Program. A small allocation of funds, $100,000 per year, has been allocated to SBH-ASO to partner with law enforcement or other first responder agency (Fire/EMS) to pair a mental health professional and allow for co-response to emergency calls. SBH-ASO was prepared to release an RFP for these funds on 11/19/21 prior to receiving communication from the HCA on 11/18/21 that narrowed the entities that were eligible to submit a proposal.

Due to the number of new programs SBH-ASO is tasked with implementing over the next 6 months, Staff must proceed with implementing other new programs before returning to this program and developing a new plan.

Clarified that the Co-Responder Program, as stated by the Health Care Authority, will be contracted directly with law enforcement or first responders and that the intent of the legislation was for the funds to directly go those entities. The length of funding for the Co-Responder Program is unknown currently. At this time SBH-ASO will likely release the RFP in March 2022.

Non-Medicaid Budget

A summary of anticipated calendar year 2022 non-Medicaid revenue is attached for the Board's review. A summary of anticipated calendar year 2022 non-Medicaid

expenditures is attached for the Board's review. Staff will review these documents in detail.

Community Behavioral Health Enhancement Funds are the previous name for the ASO Enhancement Funds line item in the SBH-ASO Non-Medicaid Revenue – Calendar Year 2022. These funds are mean to improve behavioral health rates, recruitment, and retention.

Medicaid Budget

A summary of anticipated calendar year 2022 Medicaid Revenue and Expenditures is attached for the Board's review. Staff will review these documents in detail.

MOTION: Commissioner Mark Ozias moved to approve Approval of Calendar Year 2022 Budget as presented. Commissioner Robert Gelder seconded the motion. Motion carried unanimously.

INFORMATIONAL ITEMS

- **RECOVERY NAVIGATOR PROGRAM UPDATE**

SB5476, which is the legislative response to State v. Blake decision, requires BH-ASOs to establish a Regional Recovery Navigator Program. The Recovery Navigator Program must provide community-based outreach, intake, assessment, and connection to services to youth and adults with substance use or co-occurring needs.

In the Summer of 2021, Health Care Authority (HCA) directed BH-ASOs to have regional programs implemented by November 1, 2021. During the Joint Executive/Advisory Board Meeting on September 17, 2021, staff summarized the planning and provider engagement that had occurred to date and sought approval to contract with 5 agencies to implement the program by November 1, 2021.

SBH-ASO submitted its Recovery Navigator Program Plan to HCA on October 1, 2021. On November 1, 2021, SBH-ASO was notified by HCA that its plan was fully approved without any contingencies. Since that time, agencies have been working diligently to get staffing in place. There are five teams across the region: Peninsula Behavioral Health and Reflections in Clallam County; Discovery Behavioral Healthcare in Jefferson County; and Agape and West Sound Treatment Center in Kitsap County. Each team includes a Project Manager, Outreach Coordinator/Care Manager, and Recovery Coaches. The teams will coordinate with law enforcement, existing navigator programs, and community members to provide support to individuals who have challenges accessing care in traditional settings.

SBH-ASO has named the Recovery Navigator Program the REAL Program (Recovery, Empowerment, Advocacy, and Linkage). Staff will provide additional details regarding the progress of full program implementation.

Inquiry regarding how Law Enforcement will know to access The R.E.A.L. Program and if any training will be done. SBH-ASO staff shared that part of the model of this program is the development of a Policy Coordinating Group (PCG), as well as Operational Workgroup (OWG), which will include Law Enforcement, first responders, court, etc. to help develop processes to implement The R.E.A.L. Program.

The R.E.A.L. Program is expected to provide these outreach services across the entire county, not just more densely populated regions. This is the case for all 3 counties.

The SBH-ASO Executive Board provided congratulations for SBH-ASO for the remarkable work on the R.E.A.L. Program and approval by the Health Care Authority (HCA).

Reviewed the credentialing requirements by the HCA for the Recovery Navigator Programs has been an evolution. The credentialing and data components have been the main focus on discussion. An example is that if a contractor is only providing support for this program and not other types of behavioral health services, the credentialing and data reporting requirements will be limited.

SBH-ASO acknowledged our R.E.A.L. Program providers and the work that they have done to identify individuals to fill these positions and we are extremely impressed with their understanding and exemplification of the culture of this program.

- **HB1310 UPDATE**

During the July 30th Executive Board Meeting, Staff provided a high-level summary of HB1310 and the impact on the crisis system. SBH-ASO has taken several steps to support the local community and mitigate the risk of the breakdown of collaborative working relationships between behavioral health crisis agencies and law enforcement agencies.

On August 19th, SBH-ASO facilitated a regional meeting with law enforcement agencies surrounding the impact of HB1310 in the Salish community. SBH-ASO extended an invitation to every law enforcement jurisdiction across the region, Fire/EMS agencies and Behavioral Health Crisis Agencies. Attendance and participation far exceeded expectations. Participants expressed interest in continuing to hold this meeting on a quarterly cadence and SBH-ASO agreed to organize and facilitate.

Representatives Goodman, Johnson and Orwall have been facilitating conversations about clarifying legislative language regarding law enforcement responses to behavioral health calls and situations. It is anticipated that there may be a legislative “fix” in the upcoming session.

- **HB1477 (9-8-8 BILL): CRIS COMMITTEE UPDATE**

During the March 2021 Executive Board Meeting, staff provided a high-level summary of HB1477, commonly referred to as the “9-8-8 Bill”. HB1477 was, in part, a legislative

response to federal legislation. In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 which changes the National Suicide Prevention Lifeline (NSPL) hotline number and Veteran's Crisis Line number from 1-800-273-8255, to the 3-digit number, 9-8-8. This change will go fully into effect on July 16, 2022. The ease of remembering the 9-8-8 number made this a welcome change across the U.S. This legislation passed by Congress permits states to add a tax to telecom bills to pay for expected increase in call volume associated with the change to 9-8-8. 9-8-8 calls can only be routed to call centers accredited by the National Suicide Prevention Lifeline.

In addition to creating a single 3-digit number that anyone in Washington can utilize when wishing to reach a suicide prevention line, HB1477 directs significant changes to and expansion of the behavioral health crisis response system. HB1477 established the Crisis Response Improvement Strategy (CRIS) Committee and CRIS Steering Committee. Two of the thirty-six CRIS Committee seats are held by BH-ASO Representatives.

The CRIS Steering Committee is comprised of a senior member of Department of Health, a senior member of Health Care Authority, representative from the Governor's office, an individual with lived experience, a member from the House of Representatives, and a member of the Senate. Link provided in Zoom Chat regarding the CRIS committee and CRIS Steering Committee membership listing: cris-committee-member-list-20210923.pdf (wa.gov).

- **SBH-ASO ADVISORY BOARD UPDATE**

Lois Hoell, Chair, will provide an update on behalf of the Advisory Board.

Lois Hoell is not present to provide an SBH-ASO Advisory Board Update.

- **2022 SBH-ASO EXECUTIVE BOARD MEETINGS**

SBH-ASO Executive Board Meetings in calendar year 2022 are planned for the 3rd Friday of the month from 9am-11am in the months of January, March, May, July, September, and November. Once this plan is confirmed by the Board, staff will send out calendar invitations to secure the dates.

Noted that due to budget reviews, it may be recommended to move the November 2022 meeting to December 2022. Commissioner Ozias has a conflict for the May 20th meeting and will not be able to attend. SBH-ASO staff will follow up to offer alternative meeting dates for May and December 2022.

PUBLIC COMMENT

- Commissioner Mark Ozias reported on his participation with the Raklhous Workgroup and there is a formal rollout within the first quarter of 2022.
- Joe Roszak, Zoom Chat asked: Are the SBH-ASOs intending to advocate for an increase in the overall non-Medicaid funding to meet current workforce shortage demands and inflation?

- Stephanie Lewis, SBH-ASO Administrator, noted that there is a large amount of new funding provided to the SBH-ASO at a very rapid pace. Stephanie also noted that there have been continuous conversations among ASO Leadership regarding the need to fully fund the recommendations of the Behavioral Health Workforce Report.

- Dr. Glenn Lippman, SBH-ASO Medical Director, shared that yesterday, the SBH-ASO completed they're regularly monitoring with all five (5) Managed Care Organizations (MCOs) and wanted to compliment the SBH-ASO staff for their effectiveness and efficiency as they received 100% score.
- Lisa Rey Thomas, UW Addictions, Drug & Alcohol Institute, and the American Indian Health Commission f WA State, expressed appreciation, both professionally and then as a resident of this region for all the great work that the SBH-ASO, as well as the SBH-ASO Executive Board for their thoughtful questions and decisions.

GOOD OF THE ORDER

- Commissioner Robert Gelder wished all health and happy holidays.

ADJOURNMENT – Consensus for adjournment at 2:54 p.m.

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS
Commissioner Mark Ozias	Stephanie Lewis, SBH-ASO Administrator	Joe Roszak, KMHS
Commissioner Greg Brotherton	Jolene Kron, SBH-ASO Deputy Admin/Clinical Director	Sharon Brunner Rowe, Assistant Mental Health Ombuds, DRC Kitsap County
Commissioner Robert Gelder	Doug Washburn, Kitsap Human Services	Colleen Bradley, PAVE, Family Voices of Washington
Celeste Schoenthaler, OCH Executive Director	Martiann Lewis, SBH-ASO Staff	Lisa Rey Thomas, UW Addictions, Drug & Alcohol Institute, and the American Indian Health Commission f WA State
Excused:	Nicole Oberg, SBH-ASO Staff	G'Nell Ashley, Reflections Counseling Services
Theresa Lehman, Tribal Representative	Dr. Glenn Lippman, SBH-ASO Medical Director	Jenny Oppelt, Clallam Health and Human Services
Lois Hoell, SBHASO Advisory Board		Helen Havens, SBH-ASO Advisory Board Member

NOTE: These meeting notes are not verbatim.

SBH-ASO Risk Assessment

2021-2022

Definitions of Level of Risk (Low to High)		
Low Risk	Medium Risk	High Risk
Managing effectively and no current risk or issues in this area. Potential and probability for problems to occur at this level are considered rare or unlikely. Awareness is important, and if changes occur in relationship to the item/issue, then it should be reviewed and discussed for changes in risk level. Insignificant to marginal consequences. Less than 10% chance of occurring.	Managing sufficiently and no current risk or issues in this area. Potential for problems to occur in a variety of ways: occasional, interval, infrequent, consistent and/or seldom. Such risks are moderate and may not require extensive changes and/or resources. Marginal to moderate consequences. Less than 50% chance of occurring.	Concerns for potential item/issue to result in a problem and/or issue; may require immediate action, procedural modifications, access to extensive resources, or changes to policies and procedures with timelines and/or deliberations. Moderate to critical consequences. High likelihood for occurring and/or between 60-90% chance of occurring.

Item/Issue	Level of Risk	Steps to Mitigate Risk	Priority	Comments
COVID-19 Pandemic				
Continuation of Teleworking, initially in response to COVID-19 safety guidance, as there are increased risks related to privacy and security.	Medium	All staff were provided guidance information on working from home. This includes completing a Kitsap County employee VPN access request form. Staff obtained secure VPN access to remote into secure network. Maintained regular meetings via online platform to assist in regular check-ins and to ensure collaborative work continues. Staff education about which online platform to utilize based upon type of information shared. Development of written protocol for management of PHI while working remotely.		
Integrated Healthcare				
Frequency of change to HCA Behavioral Health Supplemental Data Guide (BHDG) creates risk of incorrect and untimely data submissions.	Medium	Consistently communicate concerns with Existing process to HCA. Ensure consistent and timely communication with subcontractors		

DRAFT

Item/Issue	Level of Risk	Steps to Mitigate Risk	Priority	Comments
		regarding continuous state change to the BHDG. Communication to occur at the bi-monthly SBH-ASO Integrated Providers Meeting and via monthly data updates summary email issued by SBH-ASO IS Manager which is distributed network wide.		
HCA document submission to Managed Program mailboxes receipt isn't consistent causing delays in HCA retrieval of contract deliverables	Low	SBH-ASO Staff can Cc HCA subject matter expert on emails when deliverables are being submitted SBH-ASO Staff can send email with read receipt function Include as a standing agenda item during the HCA/ASO quarterly check-in meeting with examples if available		
Preventing Fraud, Waste, and Abuse (FWA)				
Maintaining up-to-date understanding of the importance of preventing fraud, waste, and abuse.	Low	Trainings to be provided: Prior-to or within 90 days of contractor or SBH-ASO hires, and at least annually thereafter. Ensure contractor's staff clearly understand to report suspected fraud/abuse to the SBH-ASO and State, per policy SBH-ASO annual Monitoring Reviews, which include Fiscal, Clinical, and Program Integrity components Quarterly SBH-ASO Quality and Compliance Committee (QACC) to share new information, problem solve, and discuss HHS/OIG news posted		All contractors have designated Compliance Officers
Incomplete or inaccurate credentialing of a Provider	Low	SBH-ASO Credentialing Committee meetings utilize a hands-on approach to ensuring that information is collected correctly; and that sensitive data (such as SSN) are redacted.		
Business Practices				
Subcontractors and out-of-network providers not utilizing SBH-ASO authorization processes or verifying eligibility correctly.	Low	All authorizations are completed by the SBH-ASO. With the exception of ITA services, if authorization cannot be verified the SBH-ASO will not pay.		Ranking/identification of payor of a service is the responsibility of each BHA

DRAFT

Item/Issue	Level of Risk	Steps to Mitigate Risk	Priority	Comments
		Redundant systems in place to verify eligibility at authorization, re-authorization, and billing stages.		BHAs have multiple payors
Policy and Procedure accuracy – the pace of change and frequent contract changes have resulted in a challenge to timely updates of SBH-ASO policies and procedures.	Medium	The policies and procedures are reviewed and updated as frequently as contract and/or regulatory changes necessitate.		
Delays in timely issuance of revenue contracts or amendments creating cascading delays in amending subcontracts to include updated terms and issuing payment	High	SBH-ASO proactively communicates anticipated contract changes to its network via bi-monthly Integrated Providers Meeting. SBH-ASO initiates contract amendments, as soon as sufficient revenue contract details are available, to reduce likelihood of disruption in subcontracts.	**#3 RISK**	
Changes to Regional Crisis System as a result of State level (i.e., judicial, legislative, regulatory) changes could inhibit community response to behavioral health crises	High	SBH-ASO proactively outreaches community partners and stakeholders and facilitates coordinated response efforts Ongoing participation in state and federal information sessions and program planning work sessions	**#2 RISK**	
Process for procurement and/or administration of new program development while managing staff bandwidth, agency bandwidth, and challenges with information flow	High	SBH-ASO Leadership Team routinely evaluates work priorities and adjusts staff work assignments accordingly. SBH-ASO Leadership Team evaluates projects that may need to be declined due to limited organizational bandwidth. SBH-ASO Leadership engages employees during routine supervision to monitor for and respond to staff burnout. SBH-ASO develops routine tracking and monitoring into program development processes to ensure subcontractor understanding of new program requirements.	**#1 RISK**	
Statewide workforce challenges:	High	SBH-ASO sponsored trainings to support new workforce training and development		

DRAFT

Item/Issue	Level of Risk	Steps to Mitigate Risk	Priority	Comments
Shortage of administrative, entry-level clinical, and advanced professionals is a barrier to providing behavioral health services		Participation in State level workforce development activities		
Transition of SBH-ASO database support from vendor contract to internal Kitsap County IS Department	Medium	SBH-ASO proactively working on transition plan from contracted vendor to Kitsap IS. Transition planning to ensure there is shared understanding (SBH-ASO and Kitsap IS) of prioritization of database change requests to mitigate delays in updates		
Kitsap County infrastructure changes that impact SBH-ASO operations (i.e., implementation of new financial system software, County staffing shortages, upgrades/patches to financial system software)	Low	SBH-ASO proactively works with other Kitsap County departments to ensure timely communication, trainings, and coverage needs are met during infrastructure changes.		
Detecting Fraud, Waste, and Abuse (FWA)				
Detecting Fraud, Waste, and Abuse in the provision of services and business practices	Low	SBH-ASO annual Monitoring Reviews, which include Fiscal, Clinical, and Program Integrity components SBH-ASO Grievance Monitoring Ensure methods for reporting suspected fraud, waste, and abuse are readily available to the public, clients, and subcontractors Routine SBH-ASO Integrated Providers Meetings and Quality Assurance and Compliance Committee Meetings		
Protected Health Information (PHI) & EHR Security Breaches:				
Workspace security and privacy	Medium	Staff are instructed to ensure auditory privacy during phone conversations that contain PHI Policy requires keeping PHI locked in workspaces, unless in active use by an SBH-ASO staff Staff are instructed to take steps to reduce computer visibility by non SBH-ASO staff		

DRAFT

Item/Issue	Level of Risk	Steps to Mitigate Risk	Priority	Comments
Electronic exchange of PHI between SBH-ASO staff and external recipients	Medium	SBH-ASO policy that all electronic communications which contain PHI must be encrypted. Regular review with staff of the need to ensure encryption is selected prior to transmitting PHI electronically.		
Integrity of Data	Low	Maintain current SBH-ASO Disaster Recovery Plans in alignment with Kitsap County Disaster Recovery Plans Ensure subcontractors maintain current Agency Disaster Recovery Plans		
Safety of the SBH-ASO Site:				
Maintenance of physical and security safeguards within the workplace	Low	Periodic evaluations of facility security as available from Kitsap County management		

DRAFT

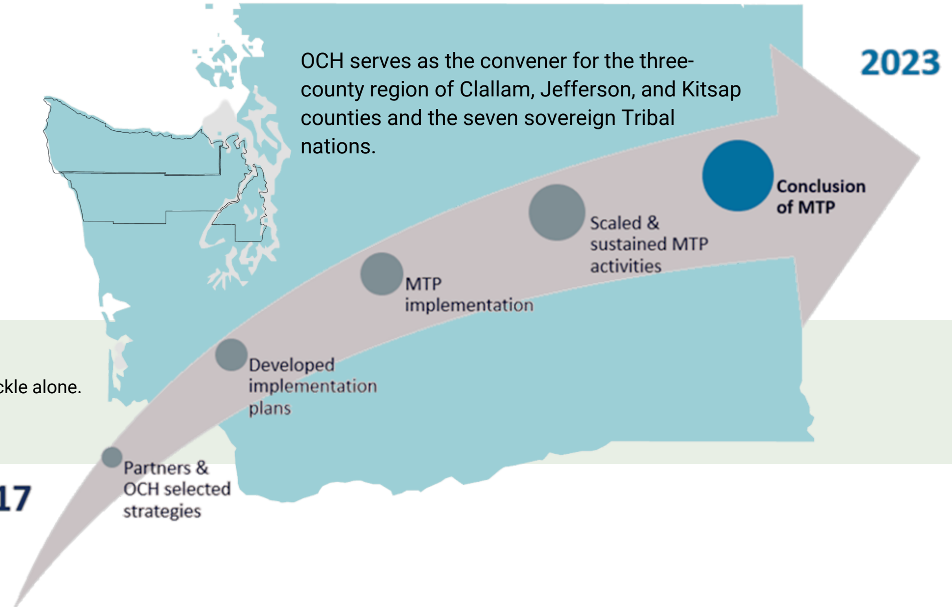
Attachment 7.a

2022-2026 STRATEGIC PLAN

HIGHLIGHT SUMMARY

Background

OCH was established as a 501(c)(3) non-profit organization in 2017 when the Washington State Health Care Authority (HCA) launched the Medicaid Transformation Project (MTP). Certified as one of nine Accountable Communities of Health (ACH), **OCH brings together partners to tackle health issues no single sector or Tribe can tackle alone.**



Mission To solve health problems through collaborative action

Purpose To tackle health issues that no single sector or tribe can tackle alone.

Vision A healthier, more equitable three-county region

In March 2020, the OCH Board of Directors established a Visioning Taskforce to lead the strategic planning efforts for OCH beyond MTP.

Future state timeline

2021	2022	2023	2024	2025	2026
MTP implementation		MTP closeout			
MTP reporting/funding					
		Future state			

2022-2026 strategic plan

Empowerment
Well-being
Connection
Place

STRONGER TOGETHER: Foster a region of healthy people, thriving communities

GOAL

Improve individual and population health and advance **equity** by addressing the **determinants of health**

STRATEGIES

- Funding coordination
- Advocacy & engagement
- Data sharing & transparency
- Communication
- Place-based approaches

MOVING UPSTREAM — FOCUS AREAS

- Long-term, affordable, quality **housing**
- Access to the full **spectrum of care**
- Individual **needs are met** timely, easily, and compassionately
- Reduced **substance** misuse & abuse

GEOGRAPHIC REACH

The Olympic Region: Clallam, Jefferson, and Kitsap Counties, and seven Tribal Nations

TARGET POPULATION

Community members who experience barriers to attaining the healthy lifestyle they desire and the health serving workforce

OCH ROLES

Catalyst for change — Community connector — Seed planter

Olympic COMMUNITY of HEALTH

Value proposition

"Stronger Together: Foster a region of healthy people, thriving communities"

Goal

"Improve individual and population health and advance equity by addressing the determinants of health"

Core values

Connection
Provide opportunities for people to collaborate.

Empowerment
Provide opportunities for growth and learning.

Place
Listen and respond to community needs. Tackle the connections between place and health.

Well-being
Promote best practices that fit the needs of the community.

Roles of OCH

Catalyst for change
Advocacy, education, and organizing to change policies and paradigms around health in the region

Seed planter
Allocate dollars and resources through a targeted portfolio of complementary efforts.

Community connector
OCH success and sustainability is tied to the well-being of the populations we serve

Focus Areas

The four focus areas featured in this section represent the priorities that OCH will address. As needs and priorities change in the Olympic region, focus areas will be reviewed and adapted. The focus areas are interconnected and highly dependent on a multi-disciplinary and collaborative approach.

Reduced substance misuse and abuse

OCH aims to ultimately reduce unhealthy use of all substances, with an emphasis placed on primary prevention and coordinating region-wide standards of care. OCH can serve in a lead role, expanding on initial collaborative successes addressing the opioid epidemic to include additional substances such as alcohol and stimulants.

Access to the full spectrum of care

Partners of OCH hold a common vision for a region of healthy people, thriving communities – which includes access to the full spectrum of care - physical, behavioral, dental, specialty, and social services. Access to care encompasses coverage, services, the ability to access care timely and efficiently, and a capable, qualified, culturally competent workforce. An equitable system also reduces barriers including language, transportation, and internet access.

Long-term, affordable, quality housing

Access to long-term, affordable, and quality housing is one of the most important determinants of health. Housing is a complex issue that no single sector or Tribe can tackle alone. Regional partners can strengthen their approach by collaborating on solutions catered to the unique housing needs of each community, county, and Tribe, while leaning on each other's expertise, perspective, and skills.

Individual needs are met timely, easily, and compassionately

OCH can support and maximize local efforts to address the determinants of health by coordinating partner activities, identifying gaps, and expanding innovative and equitable solutions.

Strategies

Strategies represent how OCH will tackle the focus areas.

Convening, learning, & maximizing

Funding coordination

Advocacy & engagement

Data sharing & transparency

Communication

Place-based approaches

Target population

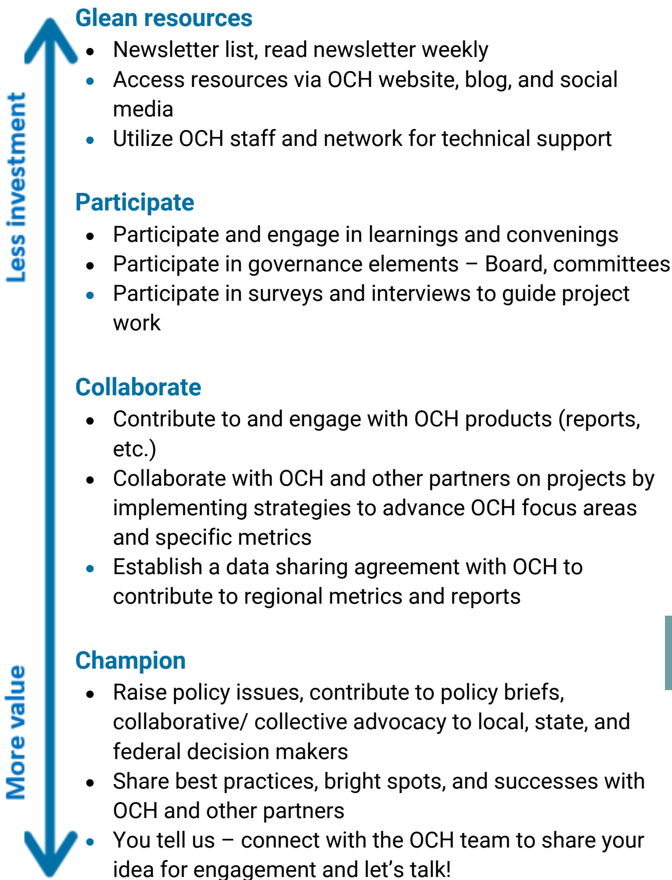
Beyond MTP, OCH will expand the target population to better address individual and population health.

Community members who experience barriers to attaining the healthy lifestyle they desire and the health serving workforce including (but not limited to):

- those on Medicaid and/or Medicare
- those un- or under-insured, and even some groups on commercial insurance
- Black, Indigenous, and People of Color (BI&POC)
- those experiencing homelessness
- those with behavioral health needs
- those without access to care
- undocumented community members
- non-English speakers
- individuals with disabilities
- LGBTQ+ community members
- and more

Partnership model

Moving forward, staff recommend a model where partners can choose how to engage from a variety of options. This partnership model provides flexibility, ease of entry, and the ability to maximize the strength and capacity of partners across the region.



Glean resources

- Newsletter list, read newsletter weekly
- Access resources via OCH website, blog, and social media
- Utilize OCH staff and network for technical support

Participate

- Participate and engage in learnings and convenings
- Participate in governance elements – Board, committees
- Participate in surveys and interviews to guide project work

Collaborate

- Contribute to and engage with OCH products (reports, etc.)
- Collaborate with OCH and other partners on projects by implementing strategies to advance OCH focus areas and specific metrics
- Establish a data sharing agreement with OCH to contribute to regional metrics and reports

Champion

- Raise policy issues, contribute to policy briefs, collaborative/ collective advocacy to local, state, and federal decision makers
- Share best practices, bright spots, and successes with OCH and other partners
- You tell us – connect with the OCH team to share your idea for engagement and let's talk!

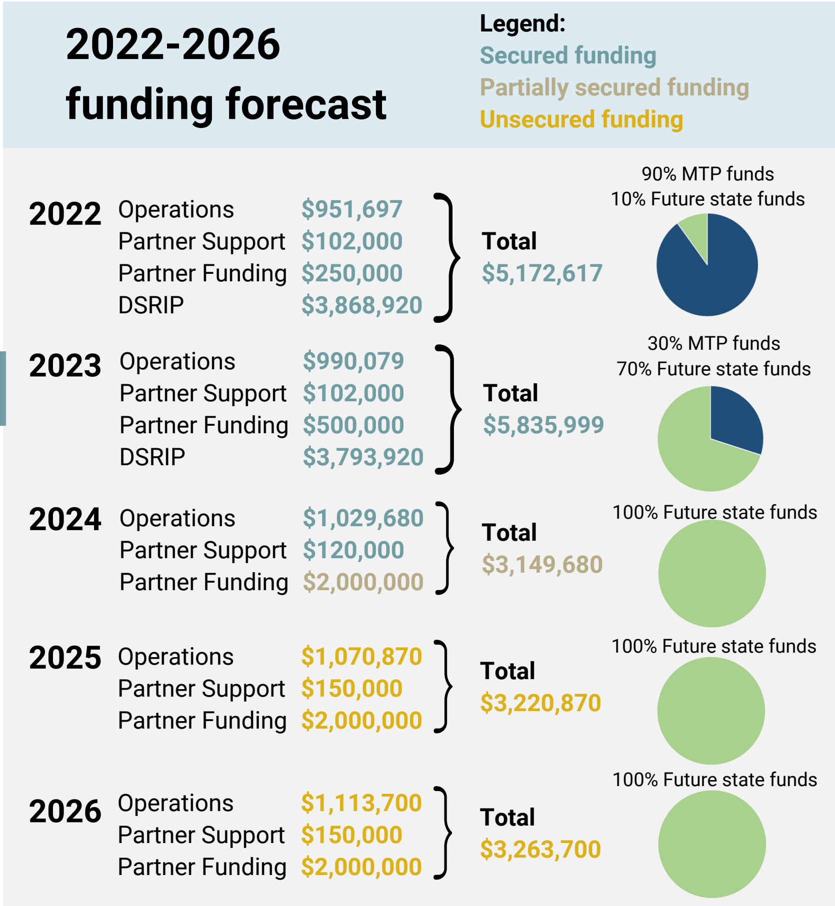
Funding model

The Board of Directors has expressed interest in determining high-level annual budgets for the initial five-year future state of 2022-2026.

OCH has set aside approximately

$2 million

to launch initial future state activities.



2022-2026 funding forecast

Legend: Secured funding; Partially secured funding; Unsecured funding

Year	Item	Amount	Total	Funds
2022	Operations	$951,697	$5,172,617	90% MTP funds, 10% Future state funds
	Partner Support	$102,000		
	Partner Funding	$250,000		
	DSRIP	$3,868,920		
2023	Operations	$990,079	$5,835,999	30% MTP funds, 70% Future state funds
	Partner Support	$102,000		
	Partner Funding	$500,000		
	DSRIP	$3,793,920		
2024	Operations	$1,029,680	$3,149,680	100% Future state funds
	Partner Support	$120,000		
	Partner Funding	$2,000,000		
2025	Operations	$1,070,870	$3,220,870	100% Future state funds
	Partner Support	$150,000		
	Partner Funding	$2,000,000		
2026	Operations	$1,113,700	$3,263,700	100% Future state funds
	Partner Support	$150,000		
	Partner Funding	$2,000,000		

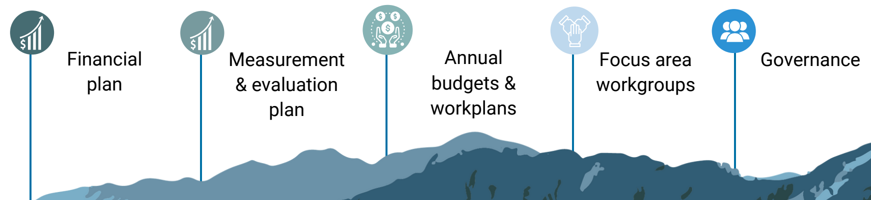
Potential funding sources

Partner feedback and external inputs point towards a blended funding model as a promising approach for OCH.

Two or more funding sources are put into a collective pool. Funds are more flexible because they are not tracked back to the original source. Usually there are not specific requirements or constraints on funds.

What's next?

This strategic plan outlines the big picture work of the future of OCH. There are several key items that will be addressed along the way.



Providing Behavioral Health Services in
Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD MEETING

DATE: **Friday, March 18, 2022**

TIME: **9:00 AM – 11:00 AM**

LOCATION: **VIRTUAL ONLY:** **We will use the ZOOM virtual platform.**

Recommend participation by either computer or ZOOM app on your mobile phone. Please use this link to download ZOOM to your computer or phone: https://zoom.us/support/download.

LINK TO JOIN BY COMPUTER OR PHONE APP:

Join Zoom Meeting:
https://us06web.zoom.us/j/89659658569?pwd=NVRaSXA2UmZXZXJDWWNJZXUwd2VCZz09

Meeting ID: 896 5965 8569

Passcode: 715701

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

Dial by your location: 1-253-215-8782

Meeting ID: 896 5965 8569

Passcode: 715701

AGENDA

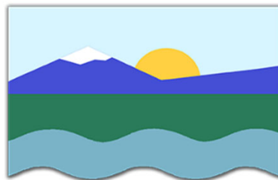
Salish Behavioral Health Administrative Services Organization – Executive Board

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of SBH-ASO Executive Board Minutes for January 21, 2022 (Attachment 5)
6. Action Items
   a. Review and Approval of SBH-ASO Policies and Procedures (Attachment 6.a.1, 6.a.2, and Supplemental Packet, 6.a.3)
7. Informational Items
   a. Update on Status of RFPs
   b. Briefing from Commissioner Ozias on Ruckelshaus Workgroup (Attachment 7.b)
   c. SBH-ASO Staffing Update
   d. Evaluating SBH-ASO Infrastructure Improvements
   e. HB1477 (9-8-8) Implementation: CRIS Committee Update
   f. Legislative Update
   g. Behavioral Health Advisory Board (BHAB) Update
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHAB	Behavioral Health Advisory Board
BH-ASO	Behavioral Health Administrative Services Organization
CAP	Corrective Action Plan
CMS	Center for Medicaid & Medicare Services (federal)
COVID-19	Coronavirus Disease 2019
CPC	Certified Peer Counselor
CRIS	Crisis Response Improvement Strategy
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DCR	Designated Crisis Responder
DDA	Developmental Disabilities Administration
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
FIMC	Full Integration of Medicaid Services
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
MAT	Medical Assisted Treatment
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OPT	Opiate Treatment Program
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QUIC	Quality Improvement Committee
RCW	Revised Code Washington
R.E.A.L.	Recovery, Empowerment, Advocacy, Linkage
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SABG	Substance Abuse Block Grant
SAPT	Substance Abuse Prevention Treatment
SBH-ASO	Salish Behavioral Health Administrative Services Organization
SUD	Substance Use Disorder
TAM	Technical Assistance Monitoring
UM	Utilization Management
VOA	Volunteers of America
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Full listing of definitions and acronyms



Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

Friday, March 18, 2022

Action Items

A. REVIEW AND APPROVAL OF SBH-ASO POLICIES AND PROCEDURES

HCA/BHASO Contractual changes, HCA TEAMonitor Review recommendations, and overall SBH-ASO growth and process improvements, necessitated Policy and Procedure updates. A spreadsheet has been included which summarizes the changes made to these Policies and Procedures.

The following policies have been included for the Board's approval:

CL200	Integrated Crisis System
CL201	Ensuring Care Coordination for Individuals
CL202	Involuntary Treatment Act Services
CL203	Levels of Care
CL205	Monitoring of Conditional Release, Less Restrictive and Assisted Outpatient Treatment Orders
CL206	State Hospital Care Coordination
CL209	SBH-ASO Recovery Navigator Program
CL210	SBH-ASO Behavioral Health Housing
CL211	Criminal Justice Treatment Account Funded Therapeutic Court Incentives
FI503	Out-of-Network Non-Medicaid Billing
QM702	Ombuds Services
UM801	Utilization Management Requirements

Informational Items

A. UPDATE ON STATUS OF RFPS

Youth Mobile Crisis Team

During the December 2021 Executive Board Meeting, staff briefed the Board on the new Youth Mobile Crisis Outreach funding that was added to SBH-ASO's revenue contract, effective 11/1/21. The briefing included a summary of SBH-ASO's plan to release an RFP in January 2022 for a Kitsap County Youth Mobile Crisis Outreach Team and to add funding to Clallam and Jefferson County crisis agencies to enhance their youth focused crisis services.

SBH-ASO released the Youth Mobile Crisis Outreach Team RFP on January 14, 2022. During the HCA/ASO Leadership Meeting on January 27th, HCA shared that they were in the early phases of developing the statewide model for youth mobile crisis outreach teams. The information HCA shared regarding several of the desired core elements of this model are notably different from the current scope of the crisis system under Integrated Managed Care. SBH-ASO opted to terminate the procurement process until additional information about the HCA's new model is available to be evaluated.

Recovery Navigator/R.E.A.L. Program

The RFP for Years 2 and 3 of R.E.A.L. Program funding was released on March 8th and will close on April 14, 2022. An Advisory Board RFP Review Sub-committee has been formed and their recommendations will be presented to the Executive Board during the May 27th Board Meeting.

Behavioral Health Co-Responder

Behavioral Health Co-Responder funding provides for a single team, a licensed mental health professional paired with law enforcement officer or first responder (Fire/EMS), to respond to behavioral health emergencies within the community. The RFP is scheduled for release by March 18th and provides for a single year of funding, July 1, 2022- June 30, 2023.

Eligible applicants include law enforcement and first responder agencies operating within Clallam, Jefferson and/or Kitsap Counties.

B. BRIEFING FROM COMMISSIONER OZIAS ON RUCKELSHAUS WORKGROUP

Commissioner Ozias will brief the Board on the progress made by the Washington Behavioral Health Communication Framework Workgroup or "Ruckelshaus Workgroup". The December 2021 Project Summary and Recommendations Report has been attached. Attachment C, which is the third to last page in the report, is a visual of the communication framework.

C. SBH-ASO STAFFING UPDATE

Per the directive in SB 5476 and the additional Recovery Navigator Administrator Funding from HCA, SBH-ASO began recruitment for an additional Care Manager/Program Supervisor in September 2021. SBH-ASO is excited to welcome Melinda Garcia to the team. Melinda started with SBH-ASO on February 28, 2022.

Another staffing change at SBH-ASO includes the resignation of Care Manager, Martiann Lewis. After 5 years of dedicated service, Martiann will be departing SBH-ASO in mid-April.

This departure prompted an evaluation of current SBH-ASO Team credentials and expertise. SBH-ASO must hire a licensed mental health professional, as the 2 remaining Care Managers are substance use disorder professionals. It is also

preferrable to add a team member with children's program experience. SBH-ASO is currently recruiting for a Children's Care Manager and Systems Coordinator.

D. EVALUATING SBH-ASO INFRASTRUCTURE IMPROVEMENTS

SBH-ASO's operating budget is comprised of administrative funding provided in HCA, MCO and Department of Commerce contracts. SBH-ASO's core contract with HCA allows SBH-ASO to retain 10% of all funds paid for administrative costs. During the period of time which SBH-ASO is administering COVID Enhanced Block Grant (2021-2023) and ARPA Block Grant funds (anticipated 2023-2025), SBH-ASO will have greater operational funding available.

Since this additional funding is time limited, staff is evaluating opportunities to invest in its infrastructure to increase efficiencies, rather than adding staff FTEs. Specific areas of focus include SBH-ASO's data system and utilization management technologies.

E. HB1477 (9-8-8) IMPLEMENTATION: CRIS COMMITTEE UPDATE

In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 which changes the national suicide prevention hotline number and Veteran's crisis line number from 1-800-273-8255, to 9-8-8. This change will go fully into effect on July 16, 2022. Legislation passed by Congress permits states to add a tax to telecom bills to pay for expected increase in call volume associated with the change to 9-8-8. 9-8-8 calls can only be routed to call centers accredited by the National Suicide Prevention Lifeline (NSPL).

In Washington, HB1477 (2021) was, in part, a legislative response to federal legislation. This allows anyone in Washington to utilize 9-8-8 when wishing to reach a suicide prevention line. HB1477 (2021) directs significant changes to and expansion of the behavioral health crisis response system. HB1477 established the Crisis Response Improvement Strategy (CRIS) Committee and CRIS Steering Committee. Two of the thirty-six CRIS Committee seats are held by BH-ASO Representatives.

The CRIS Committee and its sub-committees have been progressing quite slowly. The CRIS Committee first convened in September 2021. In December 2021, there was an "All-subcommittee Kick-off" and most subcommittees have not re-convened since this kickoff. There continue to be many questions related to the roll out of changes and the impact to the current crisis system.

In February 2022, the CRIS Steering Committee approved the formation of an Ad Hoc Workgroup to address the vision of this work. Salish is one of two BH-ASO representatives participating in this Ad-hoc Visioning Workgroup which convened for the first time on March 1, 2022.

This workgroup facilitated by Health Management Associates (HMA) was developed to assist in creating a vision statement for Crisis Response and Suicide Prevention System. Concern has been expressed by many, that a clear vision needs to be in place to be able to move the work of the CRIS committee and

subcommittees forward. It is anticipated that the only change in July 2022 will be the addition of 9-8-8 as a contact number for the NSPL, and additional work towards implementation of statewide changes is pending.

F. LEGISLATIVE UPDATE

Staff will provide an update on the status of the following behavioral health related bills:

Related to Behavioral Health Workforce

- E2SSB 5884: Establishing Behavioral Health Support Specialists

Related to Law Enforcement

- SHB 1735: Modifying the Standard for Use of Force by Peace Officers

Related to Involuntary Treatment

- SHB 1773: Concerning Assisted Outpatient Treatment for Persons with Behavioral Health Disorders

G. BHAB UPDATE

Lois Hoell, Chair, will provide an update on behalf of the Advisory Board.

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

Friday, January 21, 2022
9:00 a.m. - 11:00 a.m.
VIRTUAL ONLY: ZOOM Virtual Platform

CALL TO ORDER – Commissioner Greg Brotherton, Chair, called the meeting to order at 9:00 a.m.

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – None.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS – None.

APPROVAL of AGENDA – Commissioner Brotherton

> **MOTION: Request Commissioner Ozias moved to approve the agenda as submitted. Commissioner Gelder seconded the motion. <u>Motion carried unanimously.</u>**

APPROVAL of MINUTES –

> **MOTION: Commissioner Gelder moved to approve the meeting notes as submitted for the December 10, 2021 meeting. Commissioner Ozias seconded the motion. <u>Motion carried unanimously.</u>**

ACTION ITEMS

- **<u>ELECTION OF SBH-ASO EXECUTIVE BOARD CHAIR AND VICE-CHAIR</u>**

The SBH-ASO Interlocal Agreement dictates that, annually, the Board shall elect a Chair and Vice-Chair by majority vote. In 2021, Commissioner Brotherton served as Chair and Commissioner Gelder served as Vice-Chair.

Staff respectfully requests that the Executive Board Elect Chair and Vice-Chair for 2022.

Members of the Executive Board indicated their continued unanimous support for Commissioner Brotherton to continue as Chair, noting his leadership as Chair of the SBH-ASO Executive Board was exceptional.

Commissioner Gelder offered to continue as Vice-Chair and Executive Board graciously supported this offer.

> **MOTION: Commissioner Ozias moved to approve Election of SBH-ASO Executive Board Chair as Commissioner Brotherton and Vice-Chair as Commissioner Gelder. Tribal Representative Theresa Lehman seconded the motion. <u>Motion carried unanimously.</u>**

- **<u>2021/2022 SBH-ASO RISK ASSESSMENT</u>**

In accordance with 45 CFR §164.308 the SBH-ASO is required to maintain, review, and update a Risk Assessment. This document provides a process by which the SBH-ASO continually monitors

its operations to identify areas of potential risk and opportunities for mitigation. In order to ensure this document is comprehensive, SBH-ASO Staff worked collaboratively to identify areas of risk in all avenues of its business operations. The draft Risk Assessment was reviewed by the SBH-ASO Quality and Compliance Committee on December 14, 2021, and opportunity for subcontractor feedback was provided.

For the 2021/2022 Risk Assessment, the top 3 identified risks include:

- Process for procurement and/or administration of new program development while managing staff bandwidth, agency bandwidth, and challenges with information flow.

- Changes to Regional Crisis System as a result of State level (i.e., judicial, legislative, regulatory) changes could inhibit community response to behavioral health crises.

- Delays in timely issuance of revenue contracts or amendments creating cascading delays in amending subcontracts to include updated terms and issuing payment.

This document is attached for review, comment, and approval by the Executive Board.

Reviewed Risk Assessment ranking at the top of document.

Inquiry regarding the effectiveness of using read-receipt function when submitting deliverables. Noted that as of current it has not been utilized thus effectiveness has not been established. Salish staff have utilized the method of cc'ing a subject matter expert in deliverable emails to confirm receipt which has been helpful. There are no terms in our HCA contract requiring a deliverable recipient to confirm receipt.

Discussion of the purpose of the Risk Assessment which is to analyze risks to the SBH-ASO as an organization and to identify potential mitigations.

Discussion of the specific risk related to delays in contracting and contract related communication with the HCA.

Discussion of whether other ASO's across the state are also seeing similar risks and encouraged that if there are patterns to ensure HCA is aware of these risks. Executive Board members discussed the importance of sharing with the HCA this risk assessment.

Discussion of risk related to staff wellness, retention and managing the increased workload, specifically program development. Noted that this is an area of continued difficulty across the SBH-ASO as well as regional providers. Discussion of SBH-ASO routine supervision, check ins, and staff retreats in the Summer 2021 and Winter 2021 as an opportunity to connect with each other. Encouraging SBH-ASO staff to use PTO. SBH-ASO continues to monitor and focus energy on this area.

> **MOTION: Commissioner Ozias moved to approve 2021/2022 SBH-ASO Risk Assessment. Tribal Representative Theresa Lehman seconded the motion. <u>Motion carried unanimously.</u>**

INFORMATIONAL ITEMS

- **<u>OLYMPIC COMMUNITY OF HEALTH UPDATE</u>**

OCH Executive Director, Celeste Schoenthaler, will provide an update on the work the Olympic Community of Health is leading in the region. This update will include a review of the 2022-2026 Olympic Community of Health Strategic Plan. A high-level summary of this strategic plan has been included in the Board Packet.

Noted there are two versions of the strategic plan, condensed (short) version or a full version. The condensed (short) version was provided in the packet. A link to the full version of the Olympic Community of Health Strategic Plan was provided in the Zoom chat: https://bit.ly/3lBRgkU. Reviewed attachments in the Executive Board packet. Reviewed OCH focus areas, role in the community, and core principles.

The OCH original funding was to function for 5 years, however, there is a focus to continue this work in our community. OCH will review funding opportunities between now and 2022 to 2026 when Medicaid transformation concludes.

The OCH has hired new data analysts to work on our new measurement plan to have county wide data.

Encouragement for OCH to reach out to the regional tribes to identify how they have been able to provide support around the OCH needs and funding opportunities.

- **SBH-ASO ADVISORY BOARD UPDATE**

Lois Hoell, Chair, will provide an update on behalf of the Advisory Board.

Lois was not available to attend and provide an update. SBH-ASO provided an update. The SBH-ASO Advisory Board will be reviewing its membership at our February 2022 meeting. Discussed SBH-ASO will be soliciting volunteers from the Advisory Board to review the RFP for the Youth Mobile Crisis Team that the Advisory Board will review RFP's and provide feedback to the Executive Board.

PUBLIC COMMENT

- Lori Fleming, Jefferson County CHIP/BHC, wanted to offer great thanks Jolene for her support and collaboration for Jefferson County and being able to provide information on new programming.

GOOD OF THE ORDER

- Commissioner Gelder noted that the Kitsap County Commissioners voted on creation, development, and operation of new housing using 1/10th of 1% funding (HB 5091). Projection is in the 5-million-dollar range per year. Discussed how to best leverage current programs and expanding new resources.
  - Commissioner Brotherton referenced that Jefferson County utilized funding, specifically for multi-unit affordable housing and subsidized housing projects.
  - Commissioner Ozias discussed that Clallam County may be moving forward to increase housing opportunities.

ADJOURNMENT – Consensus for adjournment at 10:16 a.m.

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS

Commissioner Mark Ozias	Stephanie Lewis, SBH-ASO Administrator	Sonya Miles, Kitsap County Human Services
Commissioner Greg Brotherton	Jolene Kron, SBH-ASO Deputy Admin/Clinical Director	Kate Ingman, CHPW
Commissioner Robert Gelder	Doug Washburn, Kitsap County Human Services	Lisa R. Thomas,
Theresa Lehman, Tribal Representative	Martiann Lewis, SBH-ASO Staff	Lori Fleming, Jefferson County CHIP/BHC
Celeste Schoenthaler, OCH Executive Director	Nicole Oberg, SBH-ASO Staff	Joe Roszak, KMHS
None Excused.	Ileea Clauson, SBH-ASO Staff	G'Nell Ashley, Reflections Counseling Services
		Monica Bernard, KMHS

NOTE: These meeting notes are not verbatim.

Chapter	Number	Title	Last Action Date	Description of Updates
Clinical	CL200	Integrated Crisis Services	11/3/2021	11/3/2021 REVISION: *Added more details surrounding crisis teams' access to crisis plans for Individuals enrolled at their agency, and how crisis plans are shared with Crisis Hotline when ROIs are in place.
Clinical	CL201	Ensuring Care Coordination for Individuals	10/27/2020	11/10/2021 REVISION: Completely rearranged sequence of information contained within policy. * Added more detail srrounding how SBH-ASO staff ensure continuity of care for individuals transition between levels of care
Clinical	CL202	Involuntary Treatment Services	2/3/2021	11/2/2021 REVISION: * Added more specific details surrounding how SBH-ASO manages and reports on "No Bed Reports"
Clinical	CL203	Levels of Care	2/24/2022	2/24/2022 REVISION: *Expanded referrals for emergent level of care to include First Responders, not just law enforceent *Noted that Level 1 outpatient services, managed through block grant procurement process, are exclued from prior authorization requirements (to align with current practice). *Changed Continued Stay Authorization protocol for Level 2 Residential Services, adjusting submission timeline from 5 business days to 3 business days prior to expiration of prior authorization.
Clinical	CL205	Monitoring of Conditional Release, Less Restrictive, Assisted Outpatient Treatment Order	2/10/2022	2/10/2022 REVISION: * Added new requirement for additional treatment services to be funded by SBH-ASO for non-Medicaid individuals on LR/CR Orders * Added language surrounding new requirement for SBH-ASO to Track LRs and refer to MCOs as apprporiate
Clinical	CL206	State Hospital Care Coordination	10/25/2021	10/25/2021 REVISION: *Added more detail regarding SBH-ASO Hospital Liaison work supporting inviduals at WSH and Community Long-term (90/180 day) beds
Clinical	CL209	SBH-ASO Recovery Navigator Program	2/11/2022	2/11/2022 REVISION: Created policy.
Clinical	CL210	SBH-ASO Behavioral Health Housing	11/22/2021	11/22/2021 REVISION: Created policy.
Clinical	CL211	Criiminal Justice Account Funded Therapeutic Court Incentives	10/14/2021	10/14/2021 REVISION: Created policy.
Fiscal	FI503	Out of Network Non-Medicaid Billing	11/2/2021	11/2/2021 REVISION: Created policy.
Quality Management	QM702	Ombuds Services	10/14/2021	10/14/2021 REVISION: *Added details regardin the frequency of SBH-ASO's monitoring activities with the Ombuds
Utilization Management	UM801	Utilization Management Requirements	2/24/2022	2/24/2022 REVISION: * Aligned with changes made in CL203: 1) Adding referrals for emergent level of care to include First Responders, not just law enforceent, 2) Noted that Level 1 outpatient services managed through block grant procurement process are exclued from prior authorization requirements, 3) Continued Stay Authorization protocol for Level 2 Residential Services, adjusting submission timeline from 5 business days to 3 business days prior to expiration of prior authorization.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: INTEGRATED CRISIS SYSTEM **Policy Number:** CL200

Effective Date: 1/1/2020

Revision Dates: 3/4/2020; 10/22/2020; 11/3/2021

Reviewed Date: 5/2/2019

Executive Board Approval Dates: 5/17/2019; 11/1/2019; 11/20/2020

PURPOSE

To provide Salish Behavioral Health Administrative Services Organization (SBH-ASO) with clearly defined standards for the provision of crisis services; the oversight of crisis services; and the expected outcomes for provision of crisis care.

POLICY

Integrated Crisis System (ICS) includes a broad network of triage and referral services that are intended to stabilize the Individual in crisis while utilizing the least restrictive community settings possible. Crisis services include both voluntary and involuntary services and address all relevant behavioral health and substance abuse situations.

PROCEDURE

1. Within the SBH-ASO region, the following services are available to all individuals in the SBH-ASO's Service Area, regardless of ability to pay:

    a. Crisis Triage and Intervention to determine the urgency of the needs and identify the supports and services necessary to meet those needs, dispatch mobile crisis, or connect the individual to services.
        i. Assist in connecting individuals with current or prior service providers, including individuals enrolled with an MCO.
        ii. Crisis Services may be provided without authorization and prior to completion of an Intake Evaluation.
        iii. Services shall be provided by or under the supervision of a Mental Health Professional.
        iv. SBH-ASO crisis subcontractors provide twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, crisis mental health services to Individuals who are within the SBH-ASO's Service Area and report they are experiencing a crisis. Crisis

Subcontractors provide sufficient staff available, including a DCR, to respond to requests for Crisis Services.

b. Behavioral Health Involuntary Treatment Services include investigation and evaluation activities, management of court case finding, and legal proceedings in order to ensure the due process rights of the Individuals who are detained for involuntary treatment.

c. SBH-ASO provides reimbursement to county courts for cost associated with ITA.

d. SBH-ASO provides for inpatient evaluation and treatment services as ordered by the court for individuals who are not eligible for Medicaid.

e. SBH-ASO will monitor or purchase monitoring services for individuals receiving LRA treatment services. SBH-ASO provides for treatment services as ordered by the court for individuals who are not eligible for Medicaid.

2. SBH-ASO provides the following services to Individuals who meet eligibility requirements but who do not qualify for Medicaid, when medically necessary, and within Available Resources:

a. Crisis Stabilization Services include short-term face-to-face assistance with life skills training and understanding of medication effects and follow up services. Services are provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual experiencing a behavioral health crisis.

b. SUD Crisis Services including short term stabilization, a general assessment of the individual’s condition, an interview for therapeutic purposes, and arranging transportation home or to an approved facility for intoxicated or incapacitated individuals on the streets or in other public places. Services may be provided by telephone, in person, in a facility, or in the field. Services may or may not lead to ongoing treatment.

c. Secure Withdrawal Management and Stabilization Services provided in a facility licensed by DOH to provide evaluation and treatment services to Individuals detained by the DCR for SUD ITA. Appropriate care for Individuals with a history of SUD who have been found to meet criteria for involuntary treatment includes: evaluation and assessment, provided by an SUDP; acute or subacute withdrawal management services; SUD treatment; and discharge assistance provided by SUDPs, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to LRA as appropriate for the Individual in accordance with WAC 246-341-1104. This is an involuntary treatment which does not require authorization.

d. Peer-to-Peer Warm Line Services are available to callers with routine concerns who could benefit from or who request to speak to a peer for support and help de-escalating emerging crises. Warm line staff may be peer volunteers who provide emotional support, comfort, and information to callers living with a mental illness.

3. Supportive housing services are a specific intervention for people who, but for the availability of services, do not succeed in housing and who, but for housing, do not succeed in services. Supportive housing services help Individuals who are homeless or unstably housed live with maximum independence in community-integrated housing. Activities are intended to ensure successful community living through the utilization of skills training, cueing, modeling and supervision as identified by the person-centered assessment. Services can be provided flexibly, including in-person or on behalf of an Individual.

4. Supported employment services aid Individuals who have physical, behavioral, and/or long-term healthcare needs that make it difficult for the person to obtain and maintain employment. These ongoing services include individualized job coaching and training, help with employer relations, and assistance with job placement.

Crisis System General Requirements

1. SBH-ASO maintains a regional behavioral health crisis system through its Crisis Provider Network who provides services that meet the following requirements:

    a. Crisis Services will be available to all Individuals who present with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the Individual's health or safety in the SBH-ASO's Service Area.

    b. Crisis Services shall be provided in accordance with current HCA-BHASO contract and regulatory guidelines.

    c. ITA services shall be provided in accordance with the SBH-ASO Involuntary Treatment Act Services Policy. Requirements include payment for all services ordered by the court for Individuals ineligible for Medicaid, and costs related to court processes and Transportation. Crisis services become ITA services when a DCR determines an Individual must be evaluated for involuntary treatment. ITA services continue until the end of the Involuntary Commitment and may be outpatient or inpatient.

2. Crisis Services shall be delivered as follows:

    a. Stabilize Individuals as quickly as possible and assist them in returning to a level of functioning that no longer qualifies them for Crisis Services.

Stabilization Services will be provided in accordance with current HCA-BHASO contract and regulatory guidelines.

b. Provide solution-focused, person-centered, and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, institutionalization, or out of home placement.

c. Coordinate closely with the regional MCOs, community court system, First Responders, criminal justice system, inpatient/residential service providers, Tribal governments and Indian Health Care Providers (IHCP), and outpatient behavioral health providers to operate a seamless crisis system and acute care system that is connected to the full continuum of health services and inclusive of processes to improve access to timely and appropriate treatment for Individuals with current or prior criminal justice involvement.

d. Engage the Individual in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and maintain the Individual's stability.

e. Develop and implement strategies to assess and improve the crisis system over time.

Crisis System Staffing Requirements

1. The SBH-ASO and its Crisis subcontractors comply with staffing requirements in accordance with current HCA-BHASO contract and regulatory guidelines. Crisis subcontractors shall provide sufficient staffing to ensure crisis response timeliness requirements are met. SBH-ASO crisis subcontractors comply with DCR qualification requirements in accordance with current HCA-BHASO contract and regulatory guidelines.

2. Each staff member working with an Individual receiving crisis services must:

    a. Be supervised by a Mental Health Professional or be licensed by DOH.

    b. Receive annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030. The staff member's personnel record must document the training.

    c. Have the ability to consult with one of the following (who has at least one (1) year of experience in the direct treatment of Individuals who have a mental or emotional disorder):
        - A psychiatrist;
        - A physician;
        - Physician assistant; or
        - An ARNP who has prescriptive authority.

d. Incorporate the statewide DCR Protocols, listed on the HCA website, into their practice.

e. Have access to clinicians twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, who have expertise in Behavioral Health issues pertaining to children and families.

f. Have access to at least one (1) SUDP with experience conducting Behavioral Health crisis support for consultation by phone or on site during regular Business Hours.

g. Have access to at least one (1) Certified Peer Counselor with experience conducting behavioral health crisis support for consultation by phone or on site during regular Business Hours.

3. SBH-ASO crisis subcontractors have established policies and procedures for ITA services in accordance with SBH-ASO Involuntary Treatment Act Services Policy.

4. SBH-ASO crisis subcontractors have a written protocol that allows for the referral of an individual to a voluntary or involuntary treatment facility twenty-four hours a day, seven days a week including DCR contact protocol.

Crisis System Operational Requirements

1. Crisis Services shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.

2. Mobile crisis outreach shall respond within two (2) hours of the referral to an emergent crisis and within twenty-four (24) hours for referral to an urgent crisis.

3. Salish Regional Crisis Line (SRCL) is a toll-free line that is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, to provide crisis intervention and triage services, including screening and referral to a network of providers and community resources.

4. SRCL is a separate number from SBH-ASO's customer service line.

5. Individuals have access to crisis services without full completion of Intake Evaluations and/or other screening and assessment processes.

6. Telephone crisis support services are provided in accordance with WAC 246-341-0905 and crisis outreach services are provided in accordance with WAC 246-341-0910.

7. SBH-ASO maintains registration processes for non-Medicaid Individuals utilizing crisis services to maintain demographic and clinical information and establish a medical record/tracking system to manage their crisis care, referrals, and utilization.

    a. For crisis services provided in the SBH-ASO Regional Service Area (RSA), all Providers will conduct eligibility verification for Individuals who are receiving services or who want to receive services to determine financial eligibility. Refer to the SBH-ASO Eligibility Verification Policy.
    b. All contracted crisis providers, including the toll-free crisis line provider, are required to submit a daily SBH-ASO Crisis Log to the SBH-ASO.
    c. All information collected is compiled into a database in order to monitor utilization at both an individual as well as a systems level.

8. SBH-ASO Care Managers and Crisis subcontractors provide information about and referral to other available services and resources for individuals who do not meet criteria for Medicaid or GFS/FBG services (e.g., homeless shelters, domestic violence programs, recovery based programs).

9. Crisis subcontractors document calls, services, and outcomes on the SBH-ASO Crisis Log as well as agency medical record systems. SBH-ASO and the SBH-ASO Crisis subcontractors shall comply with record content and documentation requirements in accordance with WAC 246-341-0900 through WAC 246-341-0920.

10. SBH-ASO Crisis subcontractors shall notify the SBH-ASO by 10am each calendar day of all crisis contacts resolved by 3am that day. The SBH-ASO shall notify the MCO within one (1) business day when an MCO Enrollee interacts with the crisis system.

11. SBH-ASO shall coordinate with the MCO/ASO of record for an Individual upon becoming aware of a change in eligibility status, when we determine that the Individual has Medicaid coverage or loses Medicaid coverage, or moves between the SBH-ASO region and another region.

Integrated Crisis System:

1. Crisis services reflect the following:

    a. Services will include providing crisis telephone screening as defined in WAC 246-341-0910.

    b. Crisis peer support services are be provided in accordance with WAC 246-341-0920.

    c. Crisis outreach staff shall work collaboratively with mental health and substance use disorder treatment services/programs, serving adults and

children in a developmentally and culturally competent manner, ensuring that developmentally and culturally appropriate service/specialists are contacted at all critical junctures.

2. Crisis Workers will utilize an existing crisis plan as available.

   a. SBH-ASO regional crisis teams have access to available crisis plans through their respective agency electronic health record (EHR). Each crisis team serves a specific catchment area and has access to the EHR for individuals enrolled in that catchment.
   b. When a valid Release of Information (ROI) is in place, crisis plans are submitted to the SRCL via encrypted email. These documents are uploaded into the SRCL provider's EHR for the individual. The information is then available during future crisis contacts.

   c. SBH-ASO utilizes Crisis alerts to support crisis planning and the delivery of individualized crisis services. Crisis alert forms are available on the SBH-ASO website. This information is shared with the Salish Regional Crisis Line via the SBH-ASO portal.

3. When there is a question of safety, outreach services shall be provided in coordination with law enforcement or other mental health support.

4. Information regarding the Salish Regional Crisis Line number is available 24 hours a day, 7 days a week, 365 days a year via the SBH-ASO website and SBH-ASO subcontractors.

5. Crisis services are provided in the Individual's language of choice, free of charge. Providers have access to interpreter services and TTY/TDD equipment.

6. Crisis services are available to all persons needing mental health and substance use disorder crisis services regardless of their ability to pay, insurance status, age, sex, minority status, status with the SBH-ASO, allied system of care relationship, or place of residency.

7. Individuals experiencing a psychiatric or substance use disorder crisis are stabilized in the most appropriate, least restrictive setting.

8. Crisis services are inclusive of natural supports (i.e. family, friends co-workers, etc.) of individuals experiencing a crisis. This includes obtaining collateral information from natural supports when available and appropriate.

   a. Crisis services build upon existing systems of crisis provision, reflect innovation, and strive for best practices (quality of care). This includes applying aspects of the Practice Guidelines adopted by SBH-ASO.

9. A "no decline" policy will be enforced for both Designated Crisis Responders and Crisis Outreach Workers.

Note: "No decline" means that when a Designated Crisis Responder or Crisis Outreach Worker is requested by persons identified in Mobile Crisis Outreach (see Mobile Outreach Services 4, below), they may not refuse to provide crisis services regardless of the person's age, culture, or ability to pay.

Mobile Outreach Services:

1. Face-to-face services are provided by crisis outreach when telephone intervention is unsuccessful in stabilizing the individual.

2. Mobile crisis outreach will respond within two (2) hours of the referral to an emergent crisis and within twenty-four (24) hours for referral to an urgent crisis.

3. When clinically indicated or when the service recipient has no means to get to a clinic or emergency room, the crisis response staff will take services directly to the individual in crisis, stabilizing and supporting the person until the crisis is resolved or an appropriate referral is made.

4. SBH-ASO Crisis subcontractors have a written protocol for the transportation of an individual in a safe and timely manner, when necessary.

5. SBH-ASO Crisis subcontractors establish policies and procedures for crisis and ITA services that implement the following requirements:

    a. No DCR or crisis worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's ITA, unless a second trained individual accompanies them.

    b. The clinical team supervisor, on-call supervisor, or the individual professional shall determine the need for a second individual to accompany them based on a risk assessment for potential violence.

    c. The second individual who responds may be a First Responder, a Mental Health Professional, a Substance Use Disorder Professional, or a mental health provider who has received training required in RCW 49.19.030.

    d. No retaliation shall be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.

    e. The Crisis subcontractors have a written plan to provide training, mental health staff back-up, information sharing, and communication for crisis staff who respond to private homes or other private locations.

    f. Every DCR dispatched on a crisis visit shall have prompt access to information about an Individual's history of dangerousness or potential

dangerousness documented in crisis plans or commitment records and is available without unduly delaying a crisis response, as available.

g. SBH-ASO Crisis subcontractors will provide a wireless telephone or comparable device to every DCR or crisis worker, who participates in home visits to provide Crisis Services.

h. ITA decision-making authority lies with the DCR providing the involuntary treatment investigation and is independent of the SBH-ASO.

6. Face to face evaluation and/or other interventions shall be required when requested by:

    a. SBH-ASO Staff
    b. Law Enforcement
    c. Designated Crisis Responder
    d. Hospital Emergency Staff
    e. Mental Health Outpatient Providers
    f. Substance Use Disorder Treatment Services Providers
    g. Detox Staff
    h. Residential Providers
    i. School Teachers/Counselors
    j. Providers of Inpatient Psychiatric Services
    k. Hospital Staff
    l. Primary Care Physicians

Care Coordination Post Crisis

Once the crisis is stabilized, SBH-ASO and its providers will ensure a consistent and appropriate follow-up process for the individual. The SBH-ASO crisis delivery system works with all allied systems of care, to ensure the crisis recipients are kept safe and maintained in the least restrictive environment possible. Crisis services also work with local law enforcement, Tribal and non-tribal IHCPs, community mental health programs, SUD treatment providers, MCOs, hospitals, shelters, and homeless services.

Ancillary Requirements of the SBH-ASO Crisis System

1. Crisis services to Tribal members (AI/AN) will be provided in accordance with Tribal Crisis Agreements and the current HCA-ASO contract.

2. All SBH-ASO Crisis subcontractors use an appropriate method, such as their electronic health record, to record the fact of contact with each person, where, when and which crisis services they received, care coordination provided and their demographic and clinical information.

3. All SBH-ASO Crisis subcontractors provide evidence of and demonstrate an ability to transmit that data to SBH-ASO, per contract terms, to meet all data

requirements of timely and complete reporting of such services and Individual information.

4. Monitoring of the SBH-ASO Integrated Crisis System is under the purview of the Quality Assurance and Compliance Committee (QACC). QACC routinely reviews the following reports, making recommendations for improvement as indicated:
    a. Mobile Crisis Response Timeliness
    b. Crisis Hotline performance metrics
    c. Quarterly Crisis Report
    d. Quarterly Grievance Report
    e. Quarterly Ombuds Report

   QACC will monitor outcomes from those recommendations.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name:	ENSURING CARE COORDINATION FOR INDIVIDUALS	**Policy Number:** CL201
Effective Date:	01/01/2020	
Revision Dates:	10/27/2020; 11/10/2021	
Reviewed Date:	4/16/2019	
Executive Board Approval Dates:	5/17/2019; 11/1/2019; 11/20/2020	

POLICY

SBH-ASO ensures the provision of Care Coordination to individuals who come in contact with the crisis system or other SBH-ASO funded services within the Salish regional service area. SBH-ASO Care Coordination activities promote the coordination, continuity and quality of care.

PROCEDURE

1. SBH-ASO Care Coordination activities are focused on ensuring:

   a) Crisis Services are delivered in a coordinated manner including access to crisis safety plans to assist with coordination of information for individuals in crisis.
      i. SBH-ASO ensures its Crisis Providers share crisis safety plans with the Salish Regional Crisis Line, when releases of information are obtained from individuals.

      ii. SBH-ASO implements strategies to reduce unnecessary crisis system utilization through the review of crisis logs to identify Individuals accessing excessive crisis services with the intent of engaging the Individuals in the development and implementation of crisis prevention plans to enhance the Individual's stability.
         a. Define excessive crisis services
         b. Crisis Providers will assist SBH-ASO in identifying Individuals who would benefit from additional coordination or for whom non-crisis services may be appropriate.

iii. SBH-ASO Care Managers collaborate with MCOs to develop and implement strategies to coordinate care with community behavioral health providers for Medicaid enrollees with a history of frequent crisis system utilization.
   a. SBH-ASO provides each MCO with daily logs of their respective members contact with Regional Crisis System.
   b. Upon MCO request, SBH-ASO Care Managers participate in care coordination activities for MCO enrollees.
   c. SBH-ASO coordinates the sharing of crisis related documentation between Agencies and MCOs upon request.

b) Care transitions are supported by the sharing of information among jails, prisons, inpatient settings, residential treatment centers, detoxification and sobering centers, homeless shelters and service providers for Individuals with complex behavioral health and medical needs.

   i. SBH-ASO participates in meetings across the region to maintain connection to the community, provide information and support, and assist in identifying Individuals requiring additional resources.

c) Continuity of Care for Individuals in an active course of treatment for an acute or chronic behavioral health condition, including preserving Individual-Provider relationships through transitions.
   i. SBH-ASO Care Managers provide care coordination, in partnership with existing providers, for individuals accessing SBH-ASO funded services.

d) Care strategies are evaluated and implemented to reduce unnecessary utilization of crisis services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of recovery-based interventions and mental health advance directives in treatment planning consistent with requirements of contracts.
   i. Examples of these efforts include but are not limited to:
      a. SBH-ASO Leadership facilitate Crisis Providers meetings to review utilization trends, highlight community resources, and facilitate collaborative conversations.
      b. SBH-ASO Care Managers outreach Providers to coordinate and schedule care coordination meetings.
      c. SBH-ASO Care Managers directly engage Individuals in care coordination in instances where Individual/Provider relationships have not been effectively established.

2. SBH-ASO subcontractors screen individuals for Medicaid eligibility and assist in Medicaid enrollment on site or by referral, as appropriate.

3. SBH-ASO collaborates with external entities to address barriers to high-risk non-Medicaid individuals accessing non-crisis behavioral health services. At a minimum,

Individuals identified in SBH-ASO Priority Populations and Waiting Lists Policy are provided with clinically relevant and coordinated care.

a) Individuals also include those referred by community entities such as law enforcement, emergency department or first responders.
b) These individuals are identified at multiple points during clinical contact, including but not limited to intake/assessment, authorization/notification requests, assessment for discharge readiness and/or through direct referral to SBH-ASO.

4. SBH-ASO and its subcontractors work to address barriers to appropriate and coordinated care, if such issues surface. Such barriers may be identified through SBH-ASO Customer Service, SBH-ASO and/or subcontractor care coordination activities, SBH-ASO community engagement, SBH-ASO Quality Assurance and Compliance Committee (QACC), and Regional Ombuds activities.

5. SBH-ASO's subcontractors engage individuals in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and to maintain the individual's stability.
   a) Crisis plans are available to each crisis team through their respective agency's respective EHR. All crisis team members have access to this information within their respective catchment area.
   b) Crisis plans submitted to the Salish Regional Crisis Line (SCRL) are added to the individual's record and are available to crisis line staff upon contact with the individual. This information may be shared with another crisis team as indicated.
   c) Additionally, Crisis Alerts may be submitted to the SCRL through the Crisis Alert Platform, fax, or by calling directly. These alerts may be generated by community members, family members, and professionals. Crisis Alerts are accessible to all SCRL staff.

6. SBH-ASO has the capacity to receive Care Coordination referrals from internal and external entities. Upon receipt of a Care Coordination referral:

   a) SBH-ASO Care Managers identify existing providers and supports.
   b) SBH-ASO Care Managers contact the Individual and Provider Agency, in coordination with any appropriate internal and external entities, to maintain continuity of care.
   c) Service-related decisions will be based on individual clinical presentation, risk, and within available resources, in coordination with current established providers.

7. SBH-ASO Care Managers review notification and authorization requests submitted through the Salish Notification and Authorization Program (SNAP). Upon notification of specific services being initiated, such as inpatient treatment, SBH-ASO Care Managers:
   a) Contact the provider to initiate care planning
   b) Seek information related to existing treatment providers

   c) Engage the treatment team in care planning

8. SBH-ASO Care Managers coordinate the transfer of Individual information, including initial assessments, care plans, and mental health advanced directives with other BH-ASOs and MCOs as needed when an Individual moves between regions or gains or loses Medicaid eligibility, to reduce duplication of services and unnecessary delays in service provision, within all applicable privacy regulations.

   a) SBH-ASO subcontractors assist with coordination of service to an individual including collection of releases of information for formal information and/or document sharing.
      i. Adherence to this requirement will be reviewed as per the SBH-ASO Policy Provider Network Selection, Retention, Management, and Monitoring.
   b) SBH-ASO will assist with coordinating care when barriers regarding facilitating of information arise. Subcontractors or outside entities may contact SBH-ASO Care Managers to assist.
      i. SBH-ASO Care Managers will contact all necessary entities/parties to ensure transfer of information occurs in a timely manner, within appropriate privacy regulations, to ensure continuity of care across levels of care or between care settings.

   c) The transfer of this information may be conducted via secure written or oral communication

9. The SBH-ASO collaborates with Child and Transition Age Youth (TAY) service systems as follows:
   a) Convening the regional Children's Long Term Inpatient Program (CLIP) Committee
   b) If requested by a Wraparound Intensive Services (WISe) provider, CLIP facility or other program in the behavioral health system served by the SBH-ASO
   c) Referring potentially CLIP-eligible children to the CLIP Administration
   d) Facilitation of Family Youth System Partnership Roundtable (FYSPRT)
   e) Participation in Regional WISe Managers Meetings.

10. SBH-ASO utilizes GFS/FBG funds to care for Individuals in alternative settings such as, but not limited to, homeless shelters, permanent supported housing, nursing homes, or group homes.
    a) SBH-ASO participates in and/or convenes community meetings to address serving individuals needing services in alternative settings
    b) SBH-ASO participates in meetings across the region to maintain connection to the community, provide information and support, and assist in identifying Individuals requiring additional resources

c) SBH-ASO Care Managers provide case-by case coordination with existing providers to individuals needing care in alternative settings to ensure continuity of care

11. SBH-ASO is responsible for the coordination of assigned Individuals from admission to inpatient care, transfer to a State Hospital, and through discharge. Additional information can be found the SBH-ASO State Hospital Coordination Policy.

12. SBH-ASO shall participate in disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HCA, county, or local public health jurisdiction. The SBH-ASO shall attend state-sponsored training and participate in emergency/disaster preparedness planning when requested by HCA, the county or local public health jurisdiction in the region and provide Disaster Outreach and post-Disaster Outreach in the event of a disaster/emergency.

MONITORING

SBH-ASO Leadership Team and QACC monitor, develop, and implement strategies to assess and improve the care coordination system over time.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: INVOLUNTARY TREATMENT ACT SERVICES

Policy Number: CL202

Effective Date: 1/1/2020

Revision Dates: 11/2/2021

Reviewed Date: 4/16/2019; 2/3/2021

Executive Board Approval Dates: 5/17/2019

PURPOSE

The purpose of this policy is to ensure Involuntary Treatment Act (ITA) Services are provided by Designated Crisis Responders (DCR) to evaluate an individual in crisis and determine if involuntary services are required.

DEFINITIONS

Involuntary Treatment Act (ITA) - "Involuntary Treatment Act (ITA)" are state laws that allow for individuals to be committed by court order to a Facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who Washington State may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to one hundred and twenty (120) hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05 and RCW 71.34).

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

Less Restrictive Alternative Treatment - "Less Restrictive Alternative (LRA) Treatment" means a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585.

POLICY

Salish Behavioral Health Administrative Services Organization (SBH-ASO) will designate DCRs to perform the duties of involuntary investigation and detention in accordance with the requirements of Revised Code of Washington (RCW) Chapters 71.05, 71.34, 71.24.300, and current DCR protocols. This will be done in consultation between the Integrated Crisis System (ICS) Service Providers, the counties, and Salish BH-ASO. Crisis Services become ITA Services when a Designated Crisis Responder (DCR) determines an individual must be evaluated for involuntary treatment. The decision-making authority of the DCR is independent of SBH-ASO's administration.

RCW 71.05 provides for persons suffering from behavioral health disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with RCW Chapter 71.24.

RCW 71.34 establishes behavioral health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions.

PROCEDURE

1. SBH-ASO maintains agreements with Crisis Service Providers in Clallam, Jefferson, and Kitsap Counties to provide services in accordance with the designation noted above.

2. SBH-ASO Crisis Services Providers shall have a sufficient number of staff available twenty-four (24) hours a day, seven (7) days a week, 365 days a year, and sufficient DCRs to respond to requests for behavioral health involuntary treatment services. Crisis staff shall have training in triage and management for individuals of all ages and behavioral health conditions, including SMI, SED, SUDs, and co-occurring disorders.

3. All ITA Services shall be provided by a Designated Crisis Responder (DCR). Crisis Service Providers shall ensure there will be at least one DCR available twenty-four hours a day, seven days a week, three hundred and sixty-five days a year.

4. DCRs performing these duties will have the qualifications and training required to perform these duties.

5. ITA services will be provided in accordance with WAC 246-341-0810. ITA services includes all services and administrative functions required for the evaluation of involuntary detention or involuntary treatment of Individuals in accordance with RCW 71.05, RCW 71.24.300, and RCW 71.34. Requirements include payment for:

a. All treatment services ordered by the court for individuals ineligible for Medicaid
b. Costs related to court processes
c. Transportation to court hearings.

6. Crisis Services become ITA Services when a DCR determines an individual must be evaluated for involuntary treatment. ITA services continue until the end of the Involuntary Commitment and may be inpatient or outpatient.
7. ITA decision-making authority of the DCR shall be independent of SBH-ASO.

8. Under no circumstances shall SBH-ASO Providers deny the provision of Crisis Services, ITA services, or SUD involuntary commitment services to an Individual due to the Individual’s ability to pay.

9. SBH-ASO Providers shall screen individuals and assist in Medicaid enrollment on site or by referral as appropriate.

10. SBH-ASO Providers shall establish policies and procedures for crisis and ITA services that implement the following requirements:

    a. No DCR or crisis worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's ITA, unless a second trained individual accompanies them.

    b. The clinical team supervisor, on-call supervisor, or the individual professional shall determine the need for a second individual to accompany them based on a risk assessment for potential violence.

    c. The second individual who responds may be a First Responder, a Mental Health Professional, a Chemical Dependency professional, or a mental health provider who has received training required in RCW 49.19.030.

    d. No retaliation shall be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.

    e. Shall have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis staff who respond to private homes or other private locations.

    f. Every DCR dispatched on a crisis visit shall have prompt access to information about an Individual’s history of dangerousness or potential dangerousness documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

g. SBH-ASO Providers shall provide a wireless telephone or comparable device to every DCR or crisis worker, who participates in home visits to provide Crisis Services.

11. SBH-ASO Crisis Service Providers shall document calls, services, and outcomes in accordance with record content and documentation requirements in WAC 246-341-0900.

12. For Non-Medicaid Individuals SBH-ASO Providers shall monitor Individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements.

    a. Additional information about LR monitoring requirements and LR treatment services can be found in the SBH-ASO LR/CR Monitoring and Treatment Services Policy

13. For individuals involuntarily committed under RCW 71.05 or 71.34, inpatient psychiatric facilities and secure withdrawal management facilities are required to provide notice of discharge and copies of CRs/LROs/AOTs to the DCR office responsible for the detention and the DCR office in the county where the individual is expected to reside. This notification is required to occur as soon as possible and no later than one (1) business day after the individual's discharge from the inpatient psychiatric facility. The DCR team will coordinate care with the individual's LRA Treatment Provider as soon as they are made aware of the CR/LRO/AOT on the individual.

14. Crisis service providers shall ensure that their DCRs make a report to HCA and SBH-ASO when they determine a person meets detention criteria under RCW 71.05150, 71.05.153, 71.34.700 or 71.34.710 and there are not any beds available at any evaluation and treatment facility, the person has not been provisionally accepted for admission by a facility, and the person cannot be served on a single bed certification or less restrictive alternative.

    The DCR is responsible for submitting an Unavailable Detention Facility Report (No Bed Report) within twenty-four (24) hours if, based on an evaluation of a person they find meets the criteria for detention for involuntary treatment but are unable to detain the person due to a lack of an involuntary bed.

    When a DCR submits an Unavailable Detention Facility Report to the HCA and SBH-ASO, the crisis services provider agency will attempt, regardless of the location, to re-evaluate the individual on a daily basis to determine if they continue to meet criteria for detention, or if a less restrictive alternative is appropriate. If criteria for detention continues to be met, the DCR shall seek an involuntary bed.

   a. Each day that the person continues to meet criteria for detention and the DCR office is unable to find an involuntary treatment bed, an Unavailable Detention Facility Report shall be submitted.
   b. Crisis providers and SBH-ASO must attempt to engage the person in appropriate services for which the person is eligible and report back within seven (7) days to the HCA.
      a. The report, generated by SBH-ASO, must include a description of all attempts to engage the individual, any plans made with the individual to receive treatment, and all plans to contact the individual on future dates about the treatment plan from this encounter.
   c. Crisis providers and SBH-ASO will coordinate with MCOs as needed for Medicaid enrollees.
   d. If needed, Crisis Providers may contact individual's insurance providers or treatment providers to ensure services are provided.

15. Upon request, SBH-ASO will assist and designate at least one person from each Tribe with the Salish RSA, as a Tribal DCR. This designation shall be in accordance with RCW 71.05.020, 71.24.025 and 71.34.020.
    a. SBH-ASO shall enable, within HIPAA privacy guidelines, any Tribal DCR, whether designated by SBH-ASO or by HCA, to shadow with and receive on-the-job training and technical assistance from a DCR employed by a SBH-ASO Contracted Crisis Provider.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: LEVELS OF CARE **Policy Number:** CL203

Effective Date: 1/1/2020

Revision Dates: 12/10/2020; 2/24/2022

Reviewed Date: 10/8/2019

Executive Board Approval Dates: 11/1/2019; 1/15/2021

PURPOSE

To define the criteria and processes for determining medical necessity for mental health and substance use disorder services, for establishing an appropriate Level of Care relative to that necessity, and for obtaining authorization to provide that care.

POLICY

A. Prior to the initiation of voluntary treatment in Community Hospitals, E&T settings, SUD or MH Residential, planned withdrawal management, or outpatient services, individuals must be authorized to receive such services. Eligibility is confirmed by SBH-ASO Mental Health Professionals (MHP) or Substance Use Disorder Professional (SUDP) at every point in time that an authorization for services is requested.

B. Authorization is not required prior to the initiation of crisis services or involuntary behavioral health treatment.

C. Authorization, denial, and adverse authorization determinations are made by the SBH-ASO, based upon a determination of medical necessity, eligibility, and/or availability of resources. For determinations based upon medical necessity a comprehensive evaluation or treatment plan is required. Authorization decisions and notification timelines are as follows:

   1. Psychiatric Inpatient authorizations: Acknowledge receipt within two (2) hours, notice of decision within 12 hours. Post-service (retroactive) authorizations: Decision made within 30 calendar days of receipt, notice of decision within two (2) business days.

   2. Adverse authorization decisions involving an expedited authorization

request: May initially provide notice orally; must provide written notification of the decision within 72 hours of the decision.

3. For denial of payment that may result in payment liability for the Individual, the Individual is notified at the time of any action affecting the claim.
4. If SBH-ASO does not reach service authorization decisions, when supplied with all required information necessary to make a determination, within the timeframes for either standard or expedited service authorizations it is considered a denial and thus, an Adverse Authorization Determination.
   i. If SBH-ASO finds that there are Grievances being reported due to non-timely authorization decisions, then SBH-ASO will utilize the SBH-ASO Leadership Team, Internal Quality Committee (IQC) and Quality Assurance and/or Compliance Committee (QACC) to address the issue and monitor improvement.
5. SBH-ASO tracks authorization decision timelines and produces a quarterly report that is reviewed as part of the Quality and Compliance Committee (QACC).
6. If SBH-ASO subcontractors fail to submit timely authorization requests, SBH-ASO may require development of a Corrective Action Plan (CAP) under the oversight of the SBH-ASO Leadership Team, Internal Quality Committee (IQC) and Quality Assurance and/or Compliance Committee (QACC).

D. Authorization is provided for a *Level of Care* rather than for specific covered benefits available within that Level of Care. SBH-ASO reserves the right to determine the location at which the level of care is provided. The specific services to be rendered are identified during the treatment planning process, which occurs in collaboration with the individual and/or his/her advocate.

E. SBH-ASO designates a Children's Specialist that meets WAC requirements to oversee the authorizations of individuals under the age of twenty-one (21).

F. SBH-ASO designates an Addiction Specialist who is a licensed Substance Use Disorder Professional to oversee the authorizations of individuals with Substance Use Disorders.

G. SBH-ASO ensures that all ASO UM staff making service authorization decisions have been trained and are competent in working with the specific area of service which they are authorizing and managing, including but not limited to, co-occurring mental health and Substance Use Disorders (SUDs), co-occurring behavioral health and medical diagnoses, and co-occurring behavioral health, individuals of all ages with a SUD and who are receiving medication-assisted treatment, and Individuals Intellectual/Developmental Disability (I/DD). UM protocols shall recognize and respect the cultural needs of diverse populations.

H. The SBH-ASO UM staff are trained in the application of UM protocols, and communicating the criteria used in making UM decisions.

1. Authorization reviews shall be conducted by state licensed Behavioral

Health Professionals with experience working with the populations and/or settings under review.

2. The UM system will be under the guidance, leadership, and oversight of the SBH-ASO Medical Director. SBH-ASO will also ensure that any behavioral health actions must be peer-to-peer, that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration or scope that is less than requested must be at least equal to that of the recommending clinician. This also applies to SBH-ASO using a Board-Certified or Board eligible Psychiatrist to review all level of care actions for psychiatric treatment, and a Board-Certified or Board eligible Physician in Addiction Medicine, or a subspecialty in Addiction Psychiatry, must review all Inpatient level of care actions (denials) for SUD treatment.

I. SBH-ASO shall ensure, through contract oversight, that its subcontractors comply with the ASO and HCA UM requirements.

J. Priority populations will have priority for SBH-ASO authorizations for services, within available resources.

PROCEDURE

Levels of Care	Modalities
Level 3 Services	Services provided at Community Hospitals or E&T Facilities
	Secure Withdrawal Management
Level 2 Services	Intensive Inpatient Residential Treatment Services – SUD
	Long Term Care Residential – SUD
	Mental Health Residential
	Recovery House Residential Treatment – SUD
Level 1 Services	Assessment
	Brief Intervention
	Brief Outpatient Treatment
	Case Management
	Day Support
	Engagement and Referral
	Evidenced Based/Wraparound
	Family Treatment
	Group Therapy
	High Intensity Treatment
	Individual Therapy
	Intake Evaluation
	Intensive Outpatient Treatment – SUD
	Medication Management
	Medication Monitoring

	Opioid Treatment Programs (OTPs)/Medication Assisted Treatment (MAT)
	Outpatient Treatment
	Peer Support
	Program of Assertive Community Treatment
	Psychological Assessment/Testing
	Rehabilitation Case Management
	Services/Interim Services
	Special Population Evaluation
	TB Counseling, Screening, Testing and Referral
	Therapeutic Psychoeducation
	Urinalysis/Screening Test
Level 0 Services	Acute Withdrawal Management
	Facility Based Crisis Stabilization Services
	Sub-Acute Withdrawal Management
Services and Supports to which non-Medical necessity criteria apply	Alcohol and Drug Information School
	Childcare Services
	Community Outreach
	Continuing Education
	PPW Housing Support
	Recovery Support Services
	Sobering Services
	Transportation
	Urinalysis for CJTA individuals

Level 3 Services

Services provided at Community Hospitals, E&T Facilities or Secure Withdrawal Management.

Inpatient Psychiatric Hospitalization and Secure Withdrawal Management and Stabilization Treatment

1. ***Length of Stay***. The length of stay for inpatient hospitalizations is subject to the following considerations:
   - **1.1.** Involuntary placements are authorized based on legal status and not medical necessity.
   - **1.2.** The length of voluntary admissions and continuing stay authorizations are based upon medical necessity.
2. ***Admission***. In addition to confirmation of medical necessity, as defined above, authorization for admission to the inpatient level of care is based upon the following clinical findings:
   - **2.1.** The individual's behavior is judged unmanageable in a less restrictive setting

due to **any one of the following**:

2.1.1. Danger to self, e.g., suicidal behavior, self-mutilation;

2.1.2. Danger to others, e.g., homicidal behavior

2.1.3. Danger to property, e.g., arson

2.1.4. Grave disability, e.g., severe psychomotor retardation; or a continued failure to maintain personal hygiene, appearance, and self-care near usual standards;

2.1.5. Severe symptoms unresponsive to, or unmanageable with treatment at a lower level of care (such as due to the presence of command hallucinations or delusions which threaten to override usual impulse control; or a serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors) or

2.1.6. A comorbid medical condition that creates the need for psychiatric treatment to be provided at this level of care (e.g., severe, or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).

2.2. **AND** there is a verified (and documented) failure of treatment at a lesser level of care, or a psychiatrist (or designee), or crisis team/DCR determines that the individual cannot be managed at a lesser level of care due to the severity of symptoms and intensity of treatment required.

2.3. **AND** the individual requires round-the-clock psychiatric care and observation to maintain their safety or health (e.g. impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior that require increased levels of observation)

2.4. Authorization decisions to approve or deny hospitalization must be made within 12 hours of the initial request for hospitalization.

2.5. Involuntary treatment applies to Individuals presenting with risks due to mental health or substance use disorders.

3. ***Continued Stay***. Authorization for stays beyond the initially approved period may occur if, during the initial stay, new psychiatric symptoms of sufficient severity to warrant individual care become evident, **OR** based upon evidence of **<u>all</u>** of the following:

3.1. The individual continues to pose a danger to self, others or property due to the behavioral manifestations of a psychiatric disorder precluding the provision of services at a lesser level of care despite a reduction in the severity of these symptoms (such as an extreme compromise of ability to care for oneself or to adequately monitor their environment with evidence that there could be a deterioration in their physical condition as a result of these deficits; or they continue to manifest a decreased quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may

include impulsive, aggressive, or abusive behaviors)

3.2. The individual requires this level of intensive treatment to stabilize symptoms and behaviors (such as due to continued high risk impulsivity; ongoing medication adjustments that require medical monitoring)

3.3. There is a clear treatment plan with measurable and objective goals; and

3.4. The individual is making progress toward treatment goals, or in the absence of such progress, the treatment plan has been revised to address the issues preventing progress.

3.5. Continued Stay authorization requests must be submitted to the SBH-ASO at a minimum by one (1) business day prior to the expiration of the current authorization period.

3.6. Authorization decisions for approval or denial of continued stay must be made within 12 hours of the continued stay authorization request.

4. ***Individual Authorization Protocol*****.** Initial and extended prior authorizations are required for all voluntary individual hospitalizations.

4.1. Involuntary Treatment Act Detention Notification Protocol

4.1.1. Prospective Authorization is not required for ITA detentions.

4.1.2. Admitting inpatient facility submits notification using the SBH-ASO protocol (see SBH-ASO Supplemental Provider Guide) within twenty-four (24) hours of admission.

4.1.3. Notification of certification will be provided to admitting facility within 2 hours.

4.2. Post Service Certification Requests

4.2.1. An inpatient unit that rendered ITA detention services to an SBH-ASO Individual may submit a retro-certification request.

4.2.2. Certification decisions shall be made within thirty (30) calendar days of receipt of the request.

4.2.3. Notification of certification decision shall be provided within two (2) business days.

4.3. Voluntary Psychiatric Inpatient Authorization Protocol *– within available resources*

4.3.1. Facility or entity referring individual for voluntary psychiatric inpatient care submits an authorization request using the SBH-ASO protocol prior to provision of care.

4.3.2. Authorization decisions for approval, denial based on medical necessity, or adverse authorization decision based on available resources shall be made within 12 hours of the authorization request.

5. ***Discharge****.* Discharge planning starts upon admission. Criteria for discharge from the inpatient level of care include:

5.1. The individual's symptoms and functioning have sufficiently improved so as to no longer warrant 24-hour observation and treatment.

5.2. The individual has demonstrated an unwillingness to actively participate in treatment and fails to meet involuntary treatment criteria.

5.3. The individual withdraws consent for inpatient treatment or fails to meet involuntary treatment criteria.

6. ***Legal Status Changes***. With legal status changes within a treatment episode, the treating facility must complete prospective authorization request within 2 hours of legal status change.

6.1. A new authorization number must be requested to indicate legal status change.

7. ***Inpatient Facility Transfers.*** With changes within a treatment episode, an individual can be transferred from one inpatient facility to another.

7.1. A new authorization number must be requested to differentiate between inpatient facilities.

Level 2 Services

Intensive Individual Residential Treatment Services – SUD,
Long Term Care Residential – SUD, Recovery House Residential Treatment – SUD, Mental Health Residential

Residential Substance Use Disorder Treatment Services – ASAM Levels 3.5, 3.3, 3.1 – *within available resources*

Level of Care authorizations for residential substance use disorder treatment are based on ASAM criteria, financial eligibility, and within available resources:

Level 3.1 – Clinically Managed, Low Intensity Residential Services

Level 3.3 – Clinically Managed, Population Specific, High Intensity, Residential Services. (This level of care not designated for adolescent populations)

Level 3.5 – Clinically Managed, Medium Intensity Residential Services

1. ***Length of Stay***. The initial authorization period is based on assessment of need relative to the determination of medical necessity. Subsequent authorizations for continued stay are based upon assessment relative to the continuing stay criteria.

2. ***Admission***. SBH-ASO shall be responsible for authorizing services for all non-Medicaid Individuals who meet financial eligibility criteria in the SBH-ASO area who are seeking SUD residential services. SUD residential services must be provided

within the levels of care as defined in the WAC 246-341 and as described by the American Society of Addiction Medicine (ASAM) criteria. The following criteria must be met to be eligible for this level of care:

2.1. Need for SUD services is established,

2.2. The specific ASAM criteria for placement is determined (reference is made to specific ASAM Dimensional level of Criteria for specifics around criteria)

2.3. The individual's needs cannot be more appropriately met by a lesser level of care or by any other formal or informal system or support.

3. ***Continued Stay.*** Individuals who require services beyond the initial treatment period must continue to meet medical necessity, financial eligibility and are authorized within available resources. Continued stay eligibility criteria are as follows:

3.1. The individual continues to meet the ASAM placement criteria for the requested residential service level.

3.2. The individual has demonstrated progress toward achieving treatment goals during the initial authorization period.

3.3. The individual's needs cannot be more appropriately met by a lower level of care, or by any other formal or informal system or support.

4. ***Authorization Protocol***. Initial and extended authorizations are required for SUD Residential Level of Care.

4.1. The referring Provider must submit an Authorization request using the SBH-ASO protocol prior to the expected admission date and a maximum of 14 days prior to the expected admission date.

4.2. Provide all required data and information to SBH-ASO to make a determination regarding initial authorization.

4.3. Authorization decisions shall be made within made within five (5) calendar days.

4.4. Continued stay authorization requests must be submitted using the SBH-ASO protocol no less than three (3) business days prior to the expiration of the current authorization period.

5. ***Discharge*** – Discharge planning begins at admission. Individuals are ready for discharge from residential treatment services when

5.1. The individual no longer meets medical necessity requirements determined by a review of ASAM by a SUD or a SUDPT under supervision of a SUDP

supervisor;

5.2. Or if consent for treatment is withdrawn;

5.3. Or loss of financial eligibility or lack of available resources.

Mental Health Residential Treatment Services – *within available resources*

Level of Care authorizations for mental health residential treatment services are based on medical necessity, financial eligibility, and within available resources.

1. ***Length of Stay***. The initial authorization period is based on assessment of need relative to the determination of medical necessity. Subsequent authorizations for continued stay are based upon assessment relative to the continuing stay criteria.

2. ***Admission***. SBH-ASO shall be responsible for authorizing services for all non-Medicaid Individuals who meet financial eligibility criteria in the SBH-ASO area who are seeking MH residential services. An individual must meet **all** of the following criteria before being referred for this level of care:
   - **2.1.** Eighteen years of age or older.
   - **2.2.** Currently receiving outpatient mental health services from an SBH-ASO network provider.
   - **2.3.** Due to a covered mental health disorder, requires 24-hour supervision to live successfully in community settings such as ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities. Or a history of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior, or the person is without means for carrying out the behavior, or with some expressed inability or aversion to doing so.
   - **2.4.** Is ambulatory and does not require physical or chemical restraints.
   - **2.5.** Must have cognitive and physical abilities to enable response to fire alarms.
   - **2.6.** Has not required physical restraint in the past 30 days.
   - **2.7.** Medically stable and free of physical condition(s) requiring medical or nursing care beyond what the residential facility can provide.
   - **2.8.** For Individuals who meet referral criteria, the residential provider shall ensure the Individual receives an intake assessment by a licensed Mental Health Professional (MHP) to determine medical necessity for mental health residential treatment.

   Mental Health Residential Exclusionary Criteria:
   1. Individual has a psychiatric condition that requires a more intensive/restrictive option (such as an inability to avoid self-harming behaviors or command hallucinations that the person is unable to ignore);
   2. Individual is actively suicidal or homicidal;
   3. Individual is chemically dependent on alcohol/drugs and in need of medical

detoxification;

4. Individual has a recent history of arson, serious property damage, or infliction of bodily injury on self or others. This exclusion can be waived based upon the accepting facility's evaluation of individual's functioning.

3. ***Continued Stay.*** Individuals who require services beyond the initial treatment period must continue to meet medical necessity, financial eligibility and are authorized within available resources. Continued stay eligibility criteria are as follows:
   - **3.1.** Admission criteria for residential services continues to be met.
   - **3.2.** The individual must have a treatment plan that identifies need and measurable goals for residential services. The individual must be making progress toward treatment goals.

4. ***Authorization Protocol.*** Initial and extended prior authorizations are required for MH Residential Level of Care.
   - **4.1.** The Provider must submit an Authorization request using the SBH-ASO protocol a minimum of five (5) business days prior to the expected admission date and a maximum of fourteen (14) days prior to the expected admission date.
   - **4.2.** Provide all required data and information to SBH-ASO to make a determination regarding initial authorization.
   - **4.3.** Authorization decisions shall be made within made within five (5) calendar days.
   - **4.4.** Continued stay authorization requests must be submitted using the SBH-ASO protocol three (3) business days prior to the expiration of the current authorization period.

5. ***Discharge***. Discharge planning begins at admission. Individuals are ready for discharge when
   - **5.1.** The individual no longer meets medical necessity requirements;
   - **5.2.** Or if consent for treatment is withdrawn;
   - **5.3.** Or loss of financial eligibility or lack of available resources.

Level 1 Services

Outpatient behavioral health services.

<u>Mental Health Outpatient Services</u> – *within available resources*

Level of Care authorizations for mental health outpatient treatment services are based on

medical necessity, financial eligibility, and within available resources.

Mental Health Outpatient – Standard – *within available resources*

1. ***Length of Stay.*** The initial treatment period is based on assessment of need relative to the determination of medical necessity. Subsequent treatment periods for continued stay are based upon assessment relative to the continuing stay criteria.

2. ***Admission.*** An individual must meet medical necessity before being considered for non-crisis services. Providers rendering outpatient services to non-Medicaid individuals must demonstrate medical necessity on all behavioral health assessments/intakes, as well as continuing stay documents. Individual services may be provided when the Individual meets medical necessity, financial eligibility, and within available resources.

   For outpatient mental health authorizations, the five (5) medical necessity criteria are:

   2.1. The individual has a mental illness as determined by a Mental Health Professional (MHP) in a face-to-face intake/assessment.
   2.2. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The individual must meet the Functional Criteria for Serious Mental Illness (SMI) Adult or Seriously Emotionally Disturbed (SED) Child;
   2.3. The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness. Symptoms may include experiencing significant problems with interpersonal interactions, (although still able to maintain some meaningful and satisfying relationships) or, consistent difficulties in social role functioning and meeting obligations which could lead to further impairments in their health, housing or mental health.
   2.4. The individual is expected to benefit from the intervention; and,
   2.5. The individual's unmet need(s) cannot be more appropriately met by any other formal or informal support.

Continued Stay. Individuals who require services beyond the initial treatment period must continue to meet medical necessity, financial eligibility and are authorized within available resources. The treating entity must establish continuing stay criteria based on the above medical necessity criteria, to include a system that allows for movement along a continuum of care inclusive of discontinuing or reducing treatment services in lieu of alternative services and supports.

3. ***Authorization Protocol.*** Initial and extended prior authorizations* are required for MH Outpatient Standard Level of Care.

   *Note: Prior authorization is not required for services managed through a Federal Block Grant procurement process.

   3.1. The treating Provider must submit an Authorization Request using the SBH-ASO protocol prior to initiating services post Intake/Assessment.

3.2. Provide all required data and information to SBH-ASO in order to make a determination regarding initial authorization.

3.3. Authorization decisions shall be made within five (5) calendar days.

3.4. Continued Stay authorization requests must be submitted using the SBH-ASO protocol a minimum of five (5) business days and no more than ten (10) calendar days prior to the expiration of the current authorization period.

6. ***Discharge***. Discharge from care is based upon one or more of the following:
   - **6.1** Treatment goals have been met and the individual does not require a continuation of services within the current, or another, category of care to maintain the gains or prevent deterioration.
   - **6.2** The individual's needs can be met via other resources within their support system (e.g., Primary Care Provider (PCP), support groups, etc.)
   - **6.3** The individual is not participating in treatment and does not meet criteria for involuntary treatment.
   - **6.4** The individual (or, for a child or youth, the parent/guardian) requests that services be discontinued.
   - **6.5** The individual's primary clinician is responsible for planning/coordinating the transition out of services to ensure an appropriate level of continuing support, given the individual's needs.
   - **6.6** Loss of financial eligibility or lack of available resources.

<u>Behavioral Health Outpatient – LR/CR/AOT</u>

Independent of services provided SBH-ASO will monitor all non-Medicaid LR/CR/AOT Orders.

1. ***Length of Stay.*** Authorized based on legal status and not medical necessity.
2. ***Admission.*** An individual must meet legal status criteria of being on a Less Restrictive, Conditional Release, or Assisted Outpatient Treatment Order before being considered for this non-crisis ASO services. Individual services may be provided when the Individual meets legal status.
3. ***Continued Stay.*** Individuals who require services beyond the initial treatment period must continue to meet legal status criteria.

4. ***Authorization Protocol.*** Initial and extended prior authorizations are required for BH Outpatient LR/CRO Level of Care.
   - **4.1.** The treating Provider must submit an Authorization Request using the SBH-ASO protocol prior to initiating services post Intake/Assessment.

4.2. Provide all required data and information to SBH-ASO in order to make a determination regarding initial authorization.

4.3. Authorization decisions shall be made within five (5) calendar days.

4.4. Continued Stay authorization requests must be submitted using the SBH-ASO protocol a minimum of five (5) business days and no more than ten (10) calendar days prior to the expiration of the current authorization period.

5. ***Discharge.*** Discharge from care is based upon one or more of the following:
   5.1. Resolution of LR/CR/AOT Order.
   5.2. Treatment goals have been met and the individual does not require a continuation of services within the current, or another, category of care to maintain the gains or prevent deterioration.
   5.3. The individual's needs can be met via other resources within their support system (e.g., Primary Care Provider (PCP), support groups, etc.).
   5.4. The individual's primary clinician is responsible for planning/coordinating the transition out of services to ensure an appropriate level of continuing support, given the individual's needs.

Mental Health Outpatient - PACT– *within available resources*

1. ***Length of Stay.*** The initial treatment period is based on assessment of need relative to the determination of medical necessity. Subsequent treatment periods for continued stay are based upon assessment relative to the continuing stay criteria.

2. ***Admission.*** An Individual must meet medical necessity before being considered for non-crisis services. Providers rendering outpatient services to non-Medicaid individuals must demonstrate medical necessity on all behavioral health assessments/intakes, as well as continuing stay documents. Individual services may be provided when the Individual meets medical necessity, financial eligibility, and are authorized within available resources.

   For outpatient mental health PACT authorizations, the five (5) medical necessity criteria are:

   2.1. The individual has a mental illness as determined by a Mental Health Professional (MHP) in a face-to-face intake/assessment.
   2.2. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The individual must meet the Functional Criteria for Serious Mental Illness (SMI);
   2.3. The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness;
   2.4. The individual is expected to benefit from the intervention; and,

2.5. The individual's unmet need(s) cannot be more appropriately met by any other formal or informal support.

AND PACT criteria listed below:

2.6. Individuals admitted to PACT must have a current diagnosis of a severe and persistent mental illness, be experiencing severe symptoms and have significant impairments. The individuals must also experience continuous high service needs, functional impairments and have difficulty effectively utilizing traditional office-based services or other less intensive community-based programs.

2.7. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) and bipolar disorder. Individuals with a primary diagnosis of substance use disorder (SUD), intellectual/developmental disability, brain injury, or personality disorder are not clinically appropriate for PACT services.

3. ***Continued Stay.*** Individuals who require services beyond the initial treatment period must continue to meet medical necessity, financial eligibility and are authorized within available resources. Individuals must also continue to meet PACT criteria.

4. ***Authorization Protocol.*** Initial and extended prior authorizations are required for MH Outpatient PACT Level of Care.
    - **4.1.** The treating Provider must submit an Authorization Request using the SBH-ASO protocol prior to initiating services post Intake/Assessment.
    - **4.2.** Provide all required data and information to SBH-ASO in order to make a determination regarding initial authorization.
    - **4.3.** Authorization decisions shall be made within five (5) calendar days.

5. Continued Stay authorization requests must be submitted using the SBH-ASO protocol a minimum of five (5) business days and no more than ten (10) calendar days prior to the expiration of the current authorization period.

6. ***Discharge.*** Discharge from care is based upon one or more of the following:
    - **6.1.** Treatment goals have been met and the individual does not require a continuation of services within the current, or another, category of care to maintain the gains or prevent deterioration.
    - **6.2.** The individual's needs can be met via other resources within their support system (e.g., Primary Care Provider (PCP), support groups, etc.).
    - **6.3.** The individual is not participating in treatment and does not meet criteria for involuntary treatment.
    - **6.4.** The individual (or the legal guardian) requests that services be discontinued.

6.5. The individual's primary clinician is responsible for planning/coordinating the transition out of services to ensure an appropriate level of continuing support, given the individual's needs.

6.6. Loss of eligibility or lack of available resources.

Psychological Assessment/Testing

Medical necessity criteria for Psychological Assessment/Testing:

1. There is a strong indication that significant, useful information impacting patient care and treatment would be generated from such testing.
2. A detailed diagnostic evaluation has been completed by a licensed behavioral health provider
3. The member is not actively abusing a substance, having acute withdrawal symptoms or recently entered recovery.

The psychological testing outcome could not otherwise be ascertained during:

1. A psychiatric or diagnostic evaluation
2. Observation during therapy
3. An assessment for level-of-care determinations at a mental health or substance-abuse facility

All of the following criteria must be met:

1. The number of hours or units requested for testing does not exceed standard administration time for the instrument selected.
2. The testing techniques are empirically valid and reliable for the diagnoses being considered.
3. The testing techniques do not represent redundant measurements of the same cognitive, behavioral or emotional domain.
4. The testing techniques are validated for the age and population of the member.
5. The testing technique uses the most current version of the instrument.
6. The testing instrument must have empirically-substantiated reliability, validity, standardized administration and clinically-relevant normative data needed to assess the diagnostic question or treatment planning goals.

Psychological testing is not medically necessary for the purposes of diagnosing any of the following conditions, except in instances of complex cases with overlapping symptoms that need differential diagnosing, as more suitable approaches are available:

A. Autism spectrum disorders
B. Attention deficit disorder
C. Attention deficit hyperactivity disorder
D. Tourette's syndrome

Psychological testing is not covered for the following:

A. Testing is primarily for the purpose of non-treatment related issues (e.g., routine evaluation of occupational or career aptitudes, forensic or child custody evaluations)
B. Testing performed as simple self-administered or self-scored inventories, screening

tests (e.g., AIMS, Folestein Mini-Mental Status Exam) or similar tests. These are considered included in an E&M service and are not separately payable as psychological testing.
C. Testing done for educational or vocational purposes primarily related to employment.
D. Testing that would otherwise be the responsibility of the educational system.

Substance Use Disorder Outpatient Services – ASAM Levels 1, 2.1– *within available resources*

Substance Use Disorder Outpatient – Standard– *within available resources*

1. ***Length of Stay.*** The initial treatment period is based on assessment of need relative to the determination of medical necessity. Subsequent treatment periods for continued stay are based upon assessment relative to the continuing stay criteria.

2. ***Admission.*** SBH-ASO recognizes the two, subdivided levels of outpatient services for children and adults, as defined within the ASAM criteria. Providers rendering outpatient services to non-Medicaid Individuals must demonstrate medical necessity as outlined in the current ASAM Level of Care criteria on all behavioral health assessments/intakes, as well as continuing stay documents. Individual services may be provided when the Individual meets medical necessity, financial eligibility, and will be authorized within available resources. Medical necessity is determined by ASAM Level.

3. ***Continued Stay.*** Individuals who require services beyond the initial treatment period must continue to meet medical necessity, financial eligibility and are authorized within available resources. It is appropriate to retain the individual at the present level of care if they continue to meet ASAM Level of Care criteria for this service level. ASAM must be updated within ten (10) business days of the request for continued stay.

Authorization Protocol. Initial and extended prior authorizations* are required for SUD.

*Note: Prior authorization is not required for services managed through a Federal Block Grant procurement process.

Outpatient Standard Level of Care.

3.1. The treating Provider must submit an Authorization Request using the SBH-ASO protocol prior to initiating services post Intake/Assessment.

3.2. Provide all required data and information to SBH-ASO in order to make a determination regarding initial authorization.

3.3. Authorization decisions shall be made within five (5) calendar days.

3.4. Continued Stay authorization requests must be submitted using the SBH-

ASO protocol at a minimum five (5) business days and no more than ten (10) calendar days prior to the expiration of the current authorization period.

4. ***Discharge.*** It is appropriate to transfer or discharge the individual from the present level of care if the individual meets one or more of the following:

4.1. The individual has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care.

4.2. The individual has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated.

4.3. The individual has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.

4.4. Loss of financial eligibility or lack of available resources.

<u>Substance Use Disorder Outpatient – Opiate Treatment Program</u> – *within available resources*

1. ***Length of Stay.*** The initial treatment period is based on assessment of need relative to the determination of medical necessity. Subsequent treatment periods for continued stay are based upon assessment relative to the continuing stay criteria.

2. ***Admission.*** An Individual must meet medical necessity before being considered for non-crisis services. Providers rendering outpatient services to non-Medicaid Individuals must demonstrate medical necessity on all behavioral health assessments/intakes, as well as continuing stay documents. Individual services may be provided when the Individual meets medical necessity as outlined in the current ASAM Level of Care criteria, financial eligibility, and are authorized within available resources.

3. **Continued Stay.** Individuals who require services beyond the initial treatment period must continue to meet medical necessity as outlined in the current ASAM Level of Care criteria, financial eligibility, and authorized within available resources.

4. ***Authorization Protocol***. Initial and extended prior authorizations are required for SUD Outpatient OTP Level of Care.

4.1. The treating Provider must submit an Authorization Request using the SBH-ASO protocol prior to initiating services post Intake/Assessment.

4.2. Provide all required data and information to SBH-ASO in order to make a determination regarding initial authorization.

4.3. Authorization decisions shall be made within five (5) calendar days.

4.4. Continued Stay authorization requests must be submitted using the SBH- ASO protocol a minimum of five (5) business days and no more than ten (10) calendar days prior to the expiration of the current authorization period.

5. ***Discharge.*** It is appropriate to transfer or discharge the individual from the present level of care if the individual meets one or more of the following criteria:

    5.1. The individual has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care.

    5.2. The individual has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated.

    5.3. The individual has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.

Level 0 Services

Acute Withdrawal Management (ASAM 3.7), Sub-Acute Withdrawal Management (ASAM 3.2), Facility Based Crisis Stabilization Services

Facility Based Crisis Triage or Crisis Stabilization Services – *within available resources*

1. ***Length of Stay***. The initial certification period is based on assessment of need relative to the determination of medical necessity as outlined in the current SBH-ASO Level of Care criteria. Subsequent authorizations for continued stay are based upon assessment relative to continuing to meet medical necessity for this level of care.

2. ***Admission***. Crisis stabilization services may be provided when the Individual meets medical necessity (as outlined in the current SBH-ASO Level of Care criteria) financial eligibility, and provided within available resources. In addition to confirmation of medical necessity, notification to the SBH-ASO within twenty-four

(24) hours is required for admission to facility-based crisis triage or crisis stabilization. Services are based upon the individual having met all of the following:

2.1. The individual is currently experiencing a behavioral health crisis and determined by a Designated Crisis Responder (DCR), Hospital Emergency Department, or Law Enforcement/First Responder, that stabilization services are needed.

2.2. Individual is experiencing a behavioral health crisis that cannot be addressed in a less restrictive setting.

3. ***Continued Stay Criteria:*** Individuals who require services beyond the initial treatment period must continue to meet medical necessity, financial eligibility and are authorized within available resources. Authorization for stay beyond the initial certification period is contingent to all of the following criteria:

3.1. Admission criteria and medical necessity as per the SBH-ASO Level of Care criteria continues to be met.

3.2. A less restrictive setting would not be able provide needed monitoring to address presenting problem.

3.3. Stabilization services continue to be needed to reduce symptoms and improve functioning.

3.4. After care planning has been established and discharge planning includes transitioning to a less restrictive setting.

4. Authorization Protocol.

4.1. The treating Provider must submit a Notification request using the SBH-ASO protocol within 24 hours of admittance to the Facility.

4.2. The treating Provider provides clinical update and discharge plan within one (1) business day from Admit using the SBH-ASO protocol.

4.3. Concurrent Authorization decision will be made within one (1) business day of receipt. Continued Stay Authorization Requests must be submitted using the SBH- ASO protocol within one (1) business day before the expiration of the current authorization period.

5. ***Discharge Criteria***: Criteria for discharge from facility-based Crisis Triage or Crisis Stabilization services level of care include one or more of the following:

5.1. Functional status indicates the individual no longer needs 24/7 monitoring and a lower level of care is indicated and available.

5.2. Individual is not making progress toward treatment goals.

5.3. Individual transitions to a more appropriate level of care is indicated.

5.4. Loss of financial eligibility or lack of available resources.

Substance Abuse Withdrawal Management – *within available resources*

Medically Monitored Inpatient Level 3.7: Medically Monitored Withdrawal management shall be delivered by medical and nursing professionals in a 24-hour withdrawal management facility as defined by the current ASAM Level of Care criteria.

1. ***Length of Stay.*** The initial certification period is based on assessment of need relative to the determination of medical necessity. Subsequent authorizations for continued stay are based upon assessment relative to continuing to meet medical necessity for this level of care.

2. ***Admission***. Non-crisis services may be provided when the Individual meets medical necessity, financial eligibility, and are provided within available resources. In addition to confirmation of medical necessity as per ASAM guidelines, notification to the SBH-ASO within twenty-four (24) hours is required for admission to medically monitored withdrawal management.

3. ***Continued Stay.*** Individuals who require services beyond the initial treatment period must continue to meet medical necessity (as per the current ASAM Level of Care criteria), financial eligibility and are authorized within available resources. Authorization for stay beyond the initial certification period is contingent on meeting the criteria for ASAM Level 3.7.

Authorization Protocol.

4.1. Emergent Admissions – Individuals who meet the above criteria for this Level of Care and are referred by one of the following:

- Law Enforcement/First Responder
- Emergency Department
- Designated Crisis Responder (DCR) in consultation with a Substance Use Disorder Professional (SUDP)

4.1.1 The treating Provider must submit a Notification request using the SBH-ASO protocol within 24 hours of admittance to the Facility.

4.1.2 The Facility provides clinical update and discharge plan within one (1) business day from Admit using the SBH-ASO protocol.

4.1.3 Concurrent Authorization decision will be made within one (1) business day from receipt.

4.1.4 Continued Stay Authorization Requests must be submitted using the SBH-ASO protocol within one (1) business day before the expiration of the current authorization period.

4.2 **Planned Admissions** – Prior authorization is required when an individual who meets the above criteria for this Level of Care is not referred by the above listed entities.

4.2.1 The treating Provider must submit an Authorization Request using the SBH-ASO protocol prior to admission.

4.2.2 Provide all required data and information to SBH-ASO to make a determination regarding initial authorization.

4.2.3 Authorization decisions shall be made within seventy-two (72) hours.

4.2.4 Continued Stay authorization requests must be submitted using the SBH-ASO protocol one (1) business day prior to the expiration of the current authorization period.

5. *Discharge Criteria*: Criteria for discharge from Medically Monitored Inpatient services level of care include:

5.1. Functional status indicates the individual no longer needs 24/7 monitoring and a lower level of care is indicated and available.

5.2. Individual is not making progress toward treatment goals.

5.3. Individual transitions to a more appropriate level of care is indicated.

5.4. Loss of financial eligibility or lack of available resources

Clinically Managed Residential Withdrawal Management - ASAM Level 3.2

1. ***Length of Stay.*** The initial certification period is based on assessment of need relative to the determination of medical necessity (as per the current ASAM Level of Care criteria). Subsequent authorizations for continued stay are based upon assessment relative to continuing to meet medical necessity for this level of care.

3. ***Admission.*** Non-crisis services may be provided when the Individual meets medical necessity, financial eligibility, and within available resources. In addition to confirmation of medical necessity as per ASAM guidelines, notification to the SBH-ASO within twenty-four (24) hours is required for admission to withdrawal management.

4. ***Continued Stay.*** Individuals who require services beyond the initial treatment period

must continue to meet medical necessity (according to the current ASAM Level of Care criteria), financial eligibility and within available resources.

5. ***Authorization Protocol.***

5.1. Emergent Admissions – Individuals who meet the above criteria for this Level of Care and are referred by one of the following:

- Law Enforcement/First Responder
- Emergency Department
- Designated Crisis Responder (DCR) in consultation with a Substance Use Disorder Professional (SUDP)

5.1.1. The treating Provider must submit a Notification request using the SBH-ASO protocol within 24 hours of admittance to the Facility.
5.1.2. The Facility provides clinical update and discharge plan within one (1) business day from Admit using the SBH-ASO protocol.
5.1.3. Concurrent Authorization decision will be made within one (1) business day from receipt.
5.1.4. Continued Stay Authorization Requests must be submitted using the SBH-ASO protocol within one (1) business day before the expiration of the current authorization period.

5.2. Planned Admissions – Prior authorization is required when an individual who meets the above criteria for this Level of Care is not referred by the above listed entities.
5.2.1. The treating Provider must submit an Authorization Request using the SBH-ASO protocol prior to admission.
5.2.2. Provide all required data and information to SBH-ASO necessary to make a determination regarding initial authorization.
5.2.3. Authorization decisions shall be made within seventy-two (72) hours.
5.2.4. Continued Stay authorization requests must be submitted using the SBH-ASO protocol one (1) business day prior to the expiration of the current authorization period.

6. Discharge. The individual continues in a Level 3.2 WM program until:
6.1. Functional status indicates the individual no longer needs 24/7 monitoring and a lower level of care is indicated and available.
6.2. Individual is not making progress toward treatment goals.
6.3. Individual transitions to a more appropriate level of care is indicated.
6.4. Loss of financial eligibility or lack of available resources.

Services that do not require medical necessity:

Service	Authorization Criteria	Comments
Alcohol/Drug Information School	• Provided as determined by a Court directed SUD diagnostic evaluation and treatment • Provider must be licensed or certified by the WA DOH	Within Available Resources Not currently funded

	• Program meets requirements of RCW 46.61.5056	
Childcare	• Provided to children of parents in treatment to facilitate completion of the parent's plan for treatment services • Provided by licensed childcare providers • Time limited as per treatment plan	Within Available Resources
Community Outreach – SABG priority populations PPW and IUID	• Provided to PPW and IUID individuals who have been unsuccessful in engaging in services • Goals should include enrolling Individuals in Medicaid • Recovery based, Culturally Appropriate and incorporates Motivational Approaches • Can be multi-agency based	Within Available Resources
Continuing Education and Training	• Provided to BHA or ASO staff as part of program of professional development • Provider of service must be Accredited either in WA State or Nationally • Provider must provide evidence of assessment of participant knowledge and satisfaction with the training.	Within Available Resources
PPW Housing Support Services	• Provided to Individuals meets definition of PPW and support provide to such an individual with children under the age of six (6) • Service provided in a transitional residential housing program designed exclusively for this population.	Within Available Resources
Recovery Support Services	• Provided to Individuals with diagnosed mental illness and/or substance use disorders. • Part of Treatment Plan for Individual • Culturally Appropriate and Diverse Programming • Evidence based • Oriented toward maximizing wellness as defined by the Individual	Within Available Resources Not currently funded
Sobering Services.	• Provided to Individuals with chronic AUD or SUD issues • Agency Based • Voluntary services • Accessible by Walk in Drop off • Provides Screening for medical problems • Provides shelter for sleeping off the effects of alcohol or other drugs • Provides Case management to assist with needed social services.	Within Available Resources Not currently funded
Therapeutic Interventions for Children.	• Provided to individuals with treatable Behavioral health diagnosis • Agency Based • Evidence Based, Culturally Appropriate • Voluntary participation • Part of Treatment Plan for Child	Within Available Resources

	• Not provided as part of Juvenile Rehabilitation Court Order	
Transportation	• Provided to individuals with Behavioral health diagnosis • Agency based • Provided as part of Treatment plan • Provided for individuals to and from behavioral health treatment.	Within Available Resources

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: MONITORING OF CONDITIONAL RELEASE/LESS RESTRICTIVE/ASSISTED OUTPATIENT TREATEMENT ORDERS	**Policy Number:** CL205
Effective Date: 1/1/2020	
Revision Dates: 2/3/2021; 2/10/2022	
Reviewed Date: 7/30/2019	
Executive Board Approval Dates: 11/1/2019; 7/30/2021	

POLICY

Salish Behavioral Health Administrative Services Organization (SBH-ASO) provides funding for monitoring services to eligible non-Medicaid individuals referred for services in accordance with Civil Conditional Releases (CR), Less Restrictive Orders (LRO), or Assisted Outpatient Treatment (AOT) guidelines.

SBH-ASO provides funding for behavioral health services to Individuals on CR, LRO or AOT who are ineligible for Medicaid to ensure adherence with requirements of the designated order.

Legal status does not preclude the individual's financial responsibility for outpatient services.

PROCEDURE

1. SBH-ASO subcontracts with LRA Treatment Providers to ensure the availability of CR, LRA and AOT monitoring and treatment services.
    a. An LRA Treatment Provider means a provider agency that is licensed by DOH to monitor, provide/coordinate the full scope of services required for LRA treatment, agrees to assume this responsibility, and houses the treatment team.

    b. Monitoring of less restrictive alternative treatment includes, at a minimum, the following:
        i. Assignment of a care coordinator;
        ii. An intake evaluation;
        iii. A psychiatric evaluation;

iv. A schedule of regular contacts with the provider of the less restrictive alternative treatment services for the duration of the order;
v. A transition plan addressing access to continued services at the expiration of the order;

c. Less restrictive alternative treatment may additionally include requirements to participate in the following services:
i. Medication management;
ii. Psychotherapy;
iii. Nursing;
iv. Substance abuse counseling;
v. Residential treatment;
vi. Support for housing, benefits, education, and employment.

2. Inpatient psychiatric or secure withdrawal management facilities are required to contact the LRA Treatment Provider to request the Provider assume responsibility of the non-Medicaid CR/LRO/AOT. This contact must be a written request and is expected to occur prior to the individual's discharge from the facility.

3. Following receipt of a CR/LRA/AOT order and a request to assume responsibility of monitoring said order, SBH-ASO LRA Treatment Providers shall screen individuals for Medicaid eligibility, and if appropriate, assist with Medicaid enrollment.

4. For Individuals residing in the Salish RSA, who are not eligible for Medicaid, the LRA Treatment Provider will notify SBH-ASO via the Salish Notification and Authorization Program (SNAP) to request authorization for monitoring services or monitoring with treatment services.

5. The LRA Treatment Provider is responsible for providing monitoring services for the duration of the court order.
   a. LRAT Treatment Providers shall submit monthly reporting to SBH-ASO, to include adherence with the court order, any violation of the conditions of the CR/LRO/AOT, consideration to pursue revocation, attempts to contact/engage the individual, consideration for release, and any coordination required. This report is submitted to SBH-ASO via online form.
   b. These reports will be monitored by SBH-ASO Care Managers, who may provide coordination with LRA Treatment Providers as indicated. Any identified issues with provider reporting will be referred to the SBH-ASO Clinical Director.

6. Individuals on an AOT are not able to be revoked. If the individual refuses to comply with the conditions of the AOT, the LRA Treatment Provider should coordinate with the Designated Crisis Responder (DCR) office regarding the violation(s) to determine if there are grounds for a new evaluation for detention.

7. DCRs shall maintain a system which tracks CRs/LROs/AOTs, as well as ensuring LRA Treatment Providers are informed of the process for extending a CR/LRO/AOT.

8. LRA Treatment Providers shall request an extension, if clinically appropriate, from the responsible DCR office three to four (3 to 4) weeks prior to the expiration of the CR/LRO/AOT.

9. An LRA Treatment Provider assigned to monitor an individual on a CR/LRO/AOT may not discharge the individual while on the CR/LRO/AOT.

REVOCATION OF LR/CR ORDERS

Revised Code of Washington (RCW) 71.05 and 71.34 establishes criteria for revocation procedures.

COORDINATION OF CARE

In order to ensure integrated, well-coordinated, and medically necessary services are delivered to individuals on a CR/LRO/AOT, LRA Treatment Providers shall coordinate with DCRs and other allied professionals in the community. LRA Treatment Providers are required to adhere to SBH-ASO Ensuring Care Coordination Policy and Procedure.

SBH-ASO responds to requests for participation, implementation, and monitoring of Individuals receiving services on conditional release consistent with RCW 71.05.340.

SBH-ASO TRACKING OF LRA ORDERS ISSUED BY SUPERIOR COURTS

SBH-ASO is responsible for tracking LRA orders that are issued by Superior Courts operating in Clallam, Jefferson and/or Kitsap Counties.

- For Medicaid managed care enrolled individuals, this tracking responsibility includes notification to the Individual's MCO of the LRA order.

- For out-of-region individuals who will be returning to their home region, upon notification from the regional superior court, SBH-ASO will notify the home region BH-ASO of the LRA order.

- Upon receipt of notification of an LRA order for a Salish resident from another BH-ASO, SBH-ASO is responsible for:
  - Notifying the appropriate MCO of the LRA Order (if applicable)
  - Tracking LRA Order, Coordinating with the Individual and the LRA Treatment Provider. Monitoring and treatment services will be provided for in accordance with this policy for non-Medicaid individuals.

SBH-ASO Clinical Director shall review the LRA Order Tracking Log at least quarterly. Any concerns regarding SBH-ASO Care Manager adherence to this policy shall be reviewed by the Salish Leadership Team.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: STATE HOSPITAL CARE COORDINATION	**Policy Number:** CL206
Effective Date: 1/1/2020	
Revision Dates: 5/14/2020; 10/25/21	
Reviewed Date: 7/30/2019	
Executive Board Approval Dates: 11/1/2019; 1/15/2021	

PURPOSE

To establish standards to ensure the provision of Care Coordination to non-Medicaid Individuals who are discharging from a State Hospital.

POLICY

The Salish Behavioral Health Administrative Services Organization (SBH-ASO) shall work with the State Hospital's discharge team(s) and community partners to identify potential placement options and resolve barriers to placement, and to assure that Individuals will be discharged back to the community after the physician/treatment team determines the Individual is ready for discharge.

PROCEDURE

The SBH-ASO is responsible for coordination for assigned Individuals from admission through discharge. An SBH-ASO Care Manager will act in the role of liaison for all non-Medicaid Individuals.

A. SBH-ASO is responsible for coordinating discharge for assigned Individuals, which may include American Indian/Alaskan Native fee for service individuals, and works to complete the work in alignment with requirements of the State Hospital MOU or Working Agreement.
   a. SBH-ASO Liaison participates in meetings and staffings as scheduled to coordinate discharge.
   b. SBH-ASO Liaison works to identify existing agency relationships and facilitates care coordination with treatment providers and supports during discharge planning.
   c. SBH-ASO Liaison coordinates care with the Peer Bridger program to facilitated continuity in transitions of care.

B. The SBH-ASO liaison works to ensure individuals are medically cleared, if possible, prior to admission to a State Psychiatric Hospital or 90/180 Community Civil Commitment Facility.
C. The SBH-ASO liaison uses best efforts to divert admissions and expedite discharges by using alternative community resources and mental health services, within available resources.
D. The SBH-ASO Care Managers coordinate care for any inpatient admission to identify additional resources and discharge supports to divert from state hospital and/or long-term inpatient placement.
    a. Diversion activities include:
        i. An SBH-ASO Care Manager is assigned upon admission to develop a discharge plan and explore alternative options of care.
        ii. The SBH-ASO generates a weekly report of individuals whose inpatient care episode exceeds 20 days. This report is reviewed by the Liaison in consultation with Clinical Director and/or Medical Director to explore alternative options for care.
        iii. The SBH-ASO Liaison is assigned to provide additional coordination to explore alternative options to long-term inpatient care.

1. The SBH-ASO liaison works with the State Hospital discharge team to identify potential placement options and resolve barriers to placement, to assure that individuals will be discharged back to the community after the physician/treatment team determines the individual is ready for discharge.
    a. SBH-ASO makes a good faith effort to schedule prescriber and other provider appointments within seven calendar days of an Individual's discharge. Appointment times are communicated back to the Facility, including for Individuals discharging from the State Hospital's Forensic Units.
2. The SBH-ASO and its Providers monitor and track Individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements (see SBH-ASO Monitoring of Conditional Release, Less Restrictive, Assisted Outpatient Treatment Orders Policy).
3. The SBH-ASO coordinates with Providers to offer behavioral health services to Individuals who are ineligible for Medicaid to ensure compliance with LRA requirements.
    a. SBH-ASO Liaison provides review of court reporting of LR/CR and coordinates care with the appropriate entities to provide continuity of care.
4. The SBH-ASO responds to requests for participation, implementation, and monitoring of Individuals receiving services on conditional release consistent with RCW 71.05.340. The SBH-ASO coordinates with Providers to facilitate access to mental health services to Individuals who are ineligible for Medicaid to ensure compliance with conditional release requirements (RCW 10.77.150 and 71.05.340).

1. Non-Medicaid Conditional Release Individuals in transitional status in Pierce or Spokane County will transfer back to the region they resided in prior to entering the State Hospital upon completion of transitional care. Individuals residing in the Salish RSA prior to admission and discharging to another RSA will do so according to the agreement established between the receiving RSA and the SBH-ASO. The Agreements shall include:
    a. Specific roles and responsibilities of the parties related to transitions between the community and the State Hospital.
    b. Collaborative discharge planning and coordination with cross-system partners such as residential facilities, community MH or SUD providers, etc.
    c. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Salish RSA.
    d. SBH-ASO/Providers shall screen individuals and assist in Medicaid enrollment in partnership with State Hospital financial services.
    e. When Individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the SBH-ASO partners with Providers to:
        a) Coordinate with DSHS Aging and Long-Term Services Administration (ALTSA) Home and Community Services (HCS) and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the HCA website.
        b) Coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement when the Individual meets access to care criteria.

2. The SBH-ASO implements a program that follows program and reporting standards found in the Peer Bridger Exhibit of the HCA BH-ASO contract.

SBH-ASO POLICIES AND PROCEDURES

Policy Name:	SBH-ASO Recovery Navigator Program: R.E.A.L. Program	**Policy Number:**	CL209
Effective Date:	11/1/2021		
Revision Dates:			
Reviewed Date:			
Executive Board Approval Dates:			

PURPOSE

To define the program, eligibility, and services covered by the Regional Navigator Program (RNP) within available resources. The Recovery Navigator Program (RNP) policy is to ensure consistent application of program standards.

DEFINITIONS

R.E.A.L. Program: The Recovery Navigator Program in the Salish BH-ASO is titled REAL (Recovery, Empowerment, Advocacy, and Linkage) Program.

Outreach Support/Care Manager: R.E.A.L. Program staff with lived experience provides intensive, field-based coordination support to assist participants access services that meet their identified needs in participants Individual Intervention Plan (IIP).

Recovery Coach: R.E.A.L. Program staff with lived experience that spends the majority of their time in the field responding and engage participants referred to the R.E.A.L. Program.

POLICY

Salish Behavioral Health Administrative Services Organization (SBH-ASO) administers the R.E.A.L. Program for Clallam, Jefferson and Kitsap counties in accordance with Washington Health Care Authority (HCA) Recovery Navigator Uniform Standards and HCA-ASO Contract. R.E.A.L. Program subcontractors will render services in accordance with SBH-ASO Contract requirements.

PROCEDURE

1. The SBH-ASO employs a Regional Recovery Navigator Administrator (RNA) who in concert with SBH-ASO Clinical Director, ensures subcontractors are compliant with program standards. The SBH-ASO Regional RNA will maintain a Regional Resource Guide to identify local, state, and federally funded community based services. The SBH-ASO Regional RNA will provide regular and routine technical assistance and training related to compliance with program standards.

2. The SBH-ASO R.E.A.L. Program embraces and advances the following core principles:

    a. Law Enforcement Assisted Diversion (LEAD), e.g. Let Everyone Advance with Dignity (LEAD) core principles (www.leadbureau.org).
        i. Harm Reduction Framework
        ii. Participant-identified and driven
        iii. Intensive Case Management
        iv. Peer Outreach and Counseling
        v. Trauma-Informed Approach.
        vi. Culturally competent services

3. The Recovery Navigator Program in the Salish BH-ASO is titled the R.E.A.L. (Recovery, Empowerment, Advocacy, and Linkage) Program and provides community-based outreach services throughout the region. The R.E.A.L. Program is expected to provide:
    a. field based engagement and services
    b. Expected response time to referrals for the Salish region is sixty (60) to ninety (90) minutes.
    c. Services are ideally provided face-to-face. If barriers exist, virtual or telephone visits may be utilized.
    d. There is no specified time limitation for participation in the R.E.A.L. Program. Timelines are individually self-determined.
    e. Participation is a voluntary and is non-coercive.
    f. Staff with lived experience with substance use disorder.
    g. Staff that reflects the visible diversity of the community served, e.g. Black Indigenous and People of Color (BIPOC) peers, trans peers, LGBTQ peers, peers with visible and non-visible disabilities.
    h. Engagement in and facilitates Cross Agency Coordination with Golden Thread Service Coordination as indicated in the Uniform Program Standards.
    i. Engagement/education in Overdose Prevention and Response.

   j. Does not require abstinence from drug or alcohol use for program participation.

4. The priority population of the R.E.A.L. Program includes Individuals:
   a. With substance use needs and/or co-occurring (substance use and mental health
   b. with substance use needs and/or co-occurring (substance use and mental health) needs
   c. who are at risk of arrest and/or have frequent contact with first responders (including law enforcement and emergency medical services), and/or
   d. who could benefit from being connected to supportive resources and public health services when appropriate.

5. The R.E.A.L. Program subcontractors will provide referrals to crisis services (e.g. voluntary and involuntary options), as needed.

6. The R.E.A.L. Program subcontractors will provide the following services to youth and adults with behavioral health conditions, including:
   a. Community-based outreach;
   b. Brief Wellbeing Screening;
   c. Referral services;
   d. Needs assessments;
   e. Connection to services; and
   f. Warm handoffs to treatment recovery support services along the continuum of care.

   Additional services to be provided as appropriate, include, but are not limited to:
   a. Long-term intensive outreach support/care management.
   b. Development of Individual Intervention Plan.
   c. Recovery coaching.
   d. Recovery support services.
   e. Treatment.

7. The R.E.A.L. Program referral process:
   a. Law Enforcement is considered a priority referral and R.E.A.L. Program subcontractors will accept all referrals, including those from community members, friends, and family.
      i. For counties with multiple R.E.A.L. Program subcontractors, referral will be based on referent or individual choice and assessed needs.

a. R.E.A.L. Program subcontractors will coordinate and transition individuals upon request.

ii. There is “no wrong door” for an individual to be referred to R.E.A.L. Program.

b. Referrals may be completed by direct access phone number, online referral form, in-person, or other means as indicated.

i. During business hours, R.E.A.L. Program staff will accept referral and coordinate appropriate response.

a. All responses are expected to occur where the individual is at, including well-known locations, shelters, or community-based programs.

b. Expected in-person response time will be one hour to one and a half hours.

ii. After-hours referrals can be left by voicemail. REAL Program staff will provide follow up on the next calendar day.

8. The R.E.A.L. Program Involuntary Discharge protocol:

a. Individuals may be involuntarily discharged from the program due to lack of contact.

i. There will be at least 5 attempted contacts over a 60-day period prior to program discharge.

ii. If contact is made after that 60-day timeframe, there will be no barriers to re-engaging with the R.E.A.L. Program.

b. Individuals may be discharged if expected incarceration of more than 1 year

c. Individuals presenting significant safety risk to team members (e.g., threats to staff or agency with plan and means) may be discharged.

d. Upon discharge, appropriate referrals to other community resources will be assessed.

9. The R.E.A.L. Program Staff Training Plan includes:

a. Prior to First Contact:

i. LEAD CORE Principles

ii. CPR and Medical First Aid

iii. Safety Training

iv. Confidentiality, HIPAA, and 42 CFR Part 2 training

v. Harm reduction

vi. Trauma- informed responses

vii. Cultural appropriateness

viii. Conflict resolution and de-escalation techniques

ix. Crisis Intervention

x. Introduction to Regional Crisis System

xi. Overdose Prevention/Naloxone Training, Recognition, and Response
xii. Local Resources, e.g., meal programs, hygiene/showers, veterans, domestic violence, bus passes, transportation, medical providers, behavioral health, furniture, clothing, tents/tarps, etc.

b. Within 90 days:
i. Diversity training
ii. Suicide Prevention
iii. Outreach strategies
iv. Working with American Indian/Alaska Native individuals
v. Basic cross-system access, e.g., Program for Assertive Community Treatment (PACT), Wraparound with Intensive Services (WISe), Housing and Recovery through Peer Services (HARPS), Community Behavioral Health Rental Assistance Program (CBRA), Program for Adult Transition to Health (PATH), Foundational Community Supports (FCS), etc.—Regional Specific
vi. Gather, Assess, Integrate, Network, and Stimulate (GAINS)
vii. Ethics
viii. Benefits Training
ix. Housing and Homelessness
x. Opiate Substitution Treatment/Medication Assisted Treatment (OST/MAT) options
xi. Working with People with Intellectual/Developmental Disorders
xii. Early intervention/prevention
xiii. Ombuds
xiv. Cross-training between Law Enforcement and REAL PROGRAM Outreach/Care Managers (LEAD National Support Bureau WA State)
xv. Building relationships (LEAD National Support Bureau WA State)
xvi. Shared Decision-Making Processes for Services

c. Additional Trainings Recommended:
i. Peer Certification Training (Optional)
ii. SSI/SSDI Outreach, Access, and Recovery (SOAR) Training (Optional)
iii. Mental Health First Aid
iv. Vicarious Trauma/Secondary Trauma
v. Stigma
vi. Motivational Interviewing
vii. Government to Government Training for collaborating with Tribes
viii. Crisis Intervention Training (CIT)

The R.E.A.L. Program Operational Workgroup:

The R.E.A.L. Program Operational Work Group (OWP) will partner the R.E.A.L. Program providers with Law Enforcement agencies, court agencies, fire department, EMS, and other community support programs to review day-to-day operations.

The R.E.A.L. Program Policy Coordinating Group:

The R.E.A.L. Program Policy Coordinating Group (PCG), facilitated by the R.E.A.L. Program providers Project Manager, will be composed of community leadership who are authorized to make decisions on behalf of their respective offices.

R.E.A.L. Program Reporting Requirements

Monthly submission of the R.E.A.L. Program Logs by the 10th of the month following month of service to the SBH-ASO via Provider Portal or other agreed method. SBH-ASO will require supplemental data reporting for enrolled case management individuals.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: SBH-ASO Behavioral Health Housing Program	**Policy Number:** CL210
Effective Date: 7/1/2021	
Revision Dates:	
Reviewed Date:	
Executive Board Approval Dates:	

PURPOSE:

To establish standardized procedures regarding the utilization of Housing and Recovery through Peer Services (HARPS) and/or Community Behavioral Health Rental Assistance (CBRA) funds by Salish Behavioral Health Administrative Services Organization (SBH-ASO) subcontractors.

POLICY:

SBH-ASO exercises responsibility over contracted HARPS and CBRA funds for the purpose of assisting individuals in securing Permanent Supportive Housing (PSH) within and throughout the Salish Region. The SBH-ASO is the primary contact for any HARPS and CBRA program related questions or concerns.

Definitions:

Housing and Recovery through Peer Services (HARPS): The HARPS program provides housing-related peer services and Bridge subsidies to individuals with behavioral health disorders who are homeless or at risk of becoming homeless with priority given to Individuals exiting treatment facilities.

Bridge subsidy: HARPS Bridge subsidies are short-term funding to help reduce barriers and increase access to housing for individuals with behavioral health disorders.

Community Behavioral Health Rental Assistance (CBRA): Housing subsidies provided by the Department of Commerce for individuals with behavioral health and long-term housing needs in accordance with the CBRA Guidelines.

Procedure:

Housing Program Facilitation:

Subcontractors for HARPS and CBRA shall have policies and procedures outlining:

1. The purpose of rental subsidies and how those subsidies can be used.
    a. HARPS Bridge subsidy (GFS)
    b. HARPS SUD subsidy (GFS-SUD)
    c. CBRA (Dept. of Commerce) subsidy
2. Program eligibility criteria
    a. How to verify eligibility
    b. Priority populations
    c. Required documentation to verify eligibility
        i. Screening
        ii. Risk Assessment
        iii. Verification of behavioral health diagnosis
        iv. Verification of risk of homelessness
3. Housing program support principles
    a. Permanent Supported Housing (PSH)
    b. Landlord outreach
    c. Privacy requirements as identified in the contract

HOUSING AND RECOVERY THROUGH PEER SUPPORTS (HARPS)

1. HARPS Housing Bridge Subsidy:
    a. SBH-ASO administers short-term Bridge subsidies intended for individuals with serious mental illness or substance use disorders. Housing subsidies are encouraged to be available to priority populations as follows:
        i. Individuals who are not eligible for Medicaid services through the Foundational Community Supports supportive housing program and who are experiencing a serious mental health, substance use, or co-occurring disorders (mental health and substance use disorder)
        ii. Individuals who are released from or at risk of entering:
            1. Psychiatric inpatient settings
            2. Substance use treatment inpatient settings
            3. Who are homeless, or at risk of becoming homeless
                a. Broad definition of homeless (couch surfing included)

    b. SBH-ASO administers SUD specific Bridge subsidy funds to serve individuals with substance use disorders. SUD specific funds are to be exhausted prior to use of Bridge subsidies for the SUD population. Housing subsidies are encouraged to be available to Individuals in the region that meet eligibility as priority populations.

2. HARPS Housing Bridge Subsidy Guidelines**:** HARPS programs are encouraged to have housing subsidy policies in place to address appeals, denials, and the following guidelines:

a. The HARPS Bridge subsidy is short-term funding intended to help reduce barriers and increase access to housing. Individuals exiting withdrawal management, inpatient substance use disorder treatment facilities, residential treatment facilities, state hospitals, evaluation and treatment (E&T) facilities, local psychiatric hospitals, and other inpatient behavioral healthcare settings could receive up to 3 months of assistance.

b. HARPS Bridge subsidies are temporary in nature and should be combined with other funding streams, whenever possible, to leverage resources to assist individuals in obtaining and maintaining a permanent residence. HARPS teams are encouraged to utilize long-term housing subsidies available through the CBRA program.

c. HARPS Bridge subsidies are estimated at approximately $500 per person per month for up to three (3) months per calendar year.

d. Allowable expenses for HARPS Bridge subsidy:
    i. Monthly rent and utilities, and any combination of first and last months' rent for up to three (3) months. Rent may only be paid one month at a time, although rental arrears, pro-rated rent, and last month's rent may be included with the first month's rent payment.
    ii. Rental and/or utility arrears for up to three months. Rental and/or utility arrears may be paid if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit. The HARPS Bridge subsidy may be used to bring the program participant out of default for the debt and the HARPS Peer Specialist will assist the participant to make payment arrangements to pay off the remaining balances.
    iii. Security deposits and utility deposits for a household moving into a new unit.
    iv. Move-in costs including but not limited to deposits and first months' rent associated with housing, including project- or tenant-based housing.
    v. Application fees, background and credit check fees for rental housing.
    vi. Lot rent for an RV or manufactured home.
    vii. Costs of parking spaces when connected to a unit.
    viii. Landlord incentives (provided there are written policies and/or procedures explaining what constitutes landlord incentives, how they are determined, and who has approval and review responsibilities). Subcontractor policies must be submitted to SBH-ASO for review.
    ix. Reasonable storage costs.
    x. Reasonable moving costs such as truck rental and hiring a moving company.
    xi. Hotel/motel expenses for up to 30 days if unsheltered households are actively engaged in a housing search and no other shelter option is available.
    xii. Temporary absences. If a household must be temporarily away from his or her unit, but is expected to return (e.g., participant violates conditions of their DOC supervision and is placed in confinement for 30 days or re-hospitalized), HARPS may pay for the households rent for up to 60 days. While a household is temporarily absent, he or she may continue to receive HARPS services.
    xiii. Rental payments to Oxford houses or Recovery Residences on the Recovery Residence Registry located at Workbook: Residence/Oxford House Locations (wa.gov)

3. HARPS Housing Service Team Guidelines:
    a. Housing and Recovery through Peer Services (HARPS) Teams' caseload size.
        i. The case mix must be such that the HARPS Teams can manage and have the flexibility to provide the intensity of services required for each individual according to Medical Necessity.
        ii. HARPS Housing Specialists must have the capacity to provide multiple contacts per week with individuals exiting or recently discharged from inpatient behavioral healthcare settings, making changes in a living situation or employment, or having significant ongoing problems maintaining housing. These multiple contacts may be as frequent as two to three times per day, seven days per week, and depend on individual need and a mutually agreed upon plan between individuals and program staff. Many, if not all, staff must share responsibility for addressing the needs of all individuals requiring frequent contact.
    b. HARPS Teams must have the capacity to rapidly increase service intensity and frequency to an individual when his or her status requires it or is requested.
        i. HARPS Teams must have a response contact time of no later than two (2) calendar days following discharge from a behavioral healthcare inpatient setting, such as an Evaluation & Treatment center, Residential Treatment Center, Withdrawal Management facility, or psychiatric hospital, including state hospitals.
    c. Operating as a continuous supportive housing service, HARPS Teams must have the capability to provide support services related to obtaining and maintaining housing. This will include direct contact with landlords on behalf of the participant. Services must minimally include the following:
        i. Hospital Liaison Coordination: The SBH-ASO's Hospital Liaison must actively coordinate the transition of individuals from behavioral healthcare inpatient treatment center discharge to the HARPS Team in the community of residence to minimize gaps in outpatient health care and housing.
        ii. Service Coordination: Service coordination must incorporate and demonstrate basic recovery values. The individual will have choice of his or her housing options, will be expected to take the primary role in developing their personal housing plan, and will play an active role in finding housing and decision-making.
        iii. Crisis Assessment and Intervention Coordination: Behavioral health crisis assessment and intervention must be available 24-hours per day, seven days per week through the SBH-ASO's Crisis System. Services must be coordinated with the assigned treatment provider. These services include telephone and face-to-face contact.

    d. Supportive housing services should include the following, as determined by medical necessity:
        i. Assess housing needs, seek out and explain the housing options in the area, and resources to obtain housing. Educate the individual on factors used by landlords to screen out potential tenants. Mitigate negative screening factors by working with the individual and landlord/property manager to clarify or explain factors that could prevent the individual from obtaining housing. Ongoing support for both the individual and landlord/property manager to resolve any issues that might arise while the individual is occupying the rental.

ii. Each HARPS participant will be assigned a Peer Specialist or Housing Specialist who will assist in locating housing and resources to secure housing. The primary responsibilities of the Peer Specialist are to work with the individual to find, obtain and maintain housing to promote recovery, locate and secure resources related to housing and utilities, offer information regarding options and choices in the types of housing and living arrangements, and advocate for the individual's tenancy needs, rights (including ADA Accommodations), and preferences to support housing stability. Service coordination also includes coordination with community resources, including self-help and advocacy organizations that promote recovery.
iii. Each participant receiving HARPS services must have an individualized, strengths-based housing plan that includes action steps for when housing related issues occur. As with the treatment planning process, the individual will take the lead role in setting goals and developing the housing plan.

e. Housing Search and Placement: Includes services or activities designed to assist households in locating, obtaining, and retaining suitable housing. Services or activities may include tenant counseling, assisting households to understand leases, securing utilities, making moving arrangements, representative payee services concerning rent and utilities, and mediation and outreach to property owners related to locating or retaining housing.

f. Housing Stability: Includes activities for the arrangement, coordination, monitoring, and delivery of services related to meeting the housing needs of individuals exiting or at risk of entering inpatient behavioral healthcare settings and helping them obtain housing stability. Services and activities may include developing, securing, and coordinating services including:

i. Developing an individualized housing and service plan, including a path to permanent housing stability subsequent to assistance.
ii. Referrals to Foundational Community Supports (FCS) supportive housing and supported employment services
iii. Seeking out and assistance applying for long-term housing subsidies
iv. Affordable Care Act activities that are specifically linked to the household stability plan
v. Activities related to accessing Work Source employment services
vi. Referrals to vocational and educational support services such as Division of Vocational Rehabilitation (DVR)
vii. Monitoring and evaluating household progress
viii. Assuring that households' rights are protected
ix. Applying for government benefits and assistance including using the evidence-based practice SSI/SSDI through SSI/SSDI Outreach, Access, and Recovery (SOAR)

g. Education Services Linkage: Supported education related services are for individuals whose high school, college or vocational education could not start or was interrupted and made educational goals a part of their recovery (treatment) plan. Services include

providing support with applying for schooling and financial aid, enrolling and participating in educational activities, or linking to supported employment/supported education services.

h. Vocational Services Linkage: These services may include work-related services to help an individual's value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers. These activities should also be part of the individual's recovery (treatment) plan or linkage to supported employment.

i. Activities of Daily Living Services: Services to support activities of daily living in community-based settings include individualized assessment, problem solving, skills training/practice, sufficient side-by-side assistance and support, modeling, ongoing supervision (e.g., prompts, assignments, monitoring, encouragement), environmental adaptations to assist individual in gaining or using the skills required to access services, and providing direct assistance when necessary to ensure that individuals obtain the basic necessities of daily life.

j. Social and Community Integration Skills Training: Social and community integration skills training serves to support social/interpersonal relationships and leisure-time skill training. Services may include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure individuals' time, increase their social experiences, and provide them with opportunities to practice social skills, build a social support network, and receive feedback and support.

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

   i. Promote self-determination

   ii. Model and teach self-advocacy

   iii. Encourage and reinforce choice and decision-making

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

   v. "Sharing the journey" (a phrase often used to describe individuals' sharing of their recovery experience with other peers). Utilizing one's personal experiences as information and a teaching tool about recovery

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

l. Substance Use Disorder Treatment Linkage: If clinically indicated, the HARPS team may refer the individual to a DBHR-licensed SUD treatment program.

4. HARPS Teams will not suggest or provide medication prescription, administration, monitoring and documentation.

5. The HARPS Team should work with the treatment team:

   a. To establish a peer relationship with each participant

   b. To assess an individual's housing needs and provide verbal and written information about housing status.

   c. The community treatment team physician or psychiatric Advanced Registered Nurse Practitioner (ARNP) may review that information with the individual, HARPS Team Members and, as appropriate, with the individual's family members or significant others

   d. Provide direct observation, available collateral information from the family and significant others as part of the comprehensive assessment

   e. In collaboration with the individual, assess, discuss, and document the individual's housing needs and behavior in response to medication, monitor and document medication side effects, and review observations with the individual and treatment team

6. HARPS Team Members must participate in the HARPS monthly administrative conference call. This call occurs on the last Monday of each month from 10 AM to 11 AM.

COMMUNITY BEHAVIORAL HEALTH RENTAL ASSISTANCE (CBRA)

The SBH-ASO receives funds from the Department of Commerce for long-term rental subsidies intended for high-risk individuals with behavioral health conditions and their households.

1. Program Eligibility
   a. Eligibility is limited to adults (and their households) who have a diagnosed behavioral health condition, are eligible for services from an approved long-term support program and demonstrate a need for long-term subsidy (for example, Foundational Community Supports)
   b. Contractors shall commit to prioritizing subsidies for priority populations, identified as individuals who are discharging or needing to discharge form a psychiatric hospital or other psychiatric inpatient setting
2. Contractors shall comply with all of the requirements in the most up-to-date version of the **Community Behavioral Health Rental Assistance Program Guidelines**.

Reporting

Monthly reports will be submitted to SBH-ASO by the 10th of the following month through the Provider Portal SFT.

1. HCA HARPS Subsidy Log for Bridge (GFS) and SUD (GFS SUD)
    a. HARPS Participant Log (for HARPS Service Team only)
2. CBRA Subsidy Log (HMIS roster with financial information, at minimum)
3. CBRA: Accurate and timely data entry into the Homeless Management Information System (HMIS) database

Billing

Monthly invoices must be submitted by the 10th of the following month through the Provider Portal SFT or directly to the SBH-ASO Fiscal Analyst.

Billing must be in accordance with contract budget.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: CRIMINAL JUSTICE TREATMENT ACCOUNT (CJTA) FUNDED THERAPEUTIC COURT INCENTIVES	**Policy Number:** CL211
Effective Date: 9/1/2021	
Revision Dates:	
Reviewed Date:	
Executive Board Approval Dates:	

POLICY

Salish Behavioral Health Administrative Services Organization (SBH-ASO) supports utilization of CJTA funds to provide incentives for eligible participants who meet Therapeutic Court program guidelines. Providing incentives for eligible individuals participating in Therapeutic Court programs is a recognized best practice to encourage motivation, participation, and attendance.

PROCEDURE

1. SBH-ASO Incentive Guidelines for Therapeutic Courts
   a. "Incentives" refer to any monetary or service benefit provided to program participants to retain them in the service or prevention program.
   b. Incentives should be the minimum amount necessary to meet program goals
   c. Before the Program: Therapeutic Courts may not use discretionary grant funds to make direct payments to individuals to induce them to enter treatment or prevention programs.
   d. During the Program: Therapeutic Courts may use discretionary grant funds for "wrap-around services" (non-clinical supportive services) that intend to:
      i. Improve an individual's access to and retention in treatment that is deemed essential to meeting program goals as they relate to the target population
      ii. Improve access to and retention in prevention programs
      iii. Meet recovery benchmarks

   Therapeutic court programs may provide incentives to eligible participants within established guidelines.

2. Incentive Parameters for Therapeutic Court Programs:
    a. Determine which individual or position within the Therapeutic Court program will manage distribution of the incentives.
    b. Therapeutic Court programs will establish guidelines to support equitable and consistent practices of awarding incentives to eligible participants, including the following:
        i. Who is eligible to receive an incentive?
        ii. Criteria for an eligible participant to receive an incentive.
        iii. Therapeutic Court program decision making process to award incentives.
        iv. When incentives are awarded.
        v. Where incentives are awarded.
        vi. Frequency that incentives can be awarded.
        vii. The dollar amount of incentives ($5, $10, $15, $20, etc.).
        viii. Appropriate incentives relative to the progress or milestone reached by the participant.
        ix. Which types of incentives (food, gas, coffee, events, etc.) will be awarded.
    c. Decisions made by Therapeutic Court panels/committees to award incentives will adhere to established guidelines.

3. Submitting documentation to SBH-ASO for reimbursement of CJTA funds:
    a. Therapeutic Court programs may pre-purchase incentives (gift cards) in various denominations to be awarded to eligible participants.
    b. All pre-purchased incentives must not exceed funding guidelines and must be expended within the contract period.
    c. Dissemination of pre-purchased incentives will be tracked on the Incentives Log that provides the following information:
        i. Eligible participant's name
        ii. Date incentive was awarded
        iii. Dollar amount of the incentive
        iv. Type of incentive (food, gas, coffee, event, etc.)
        v. Reason for awarding the incentive (program attendance, progress on treatment goals, support group attendance, etc...)
        vi. Signatures of both receiving individual and dispersing staff.
    d. Incentives awarded that are greater than $30.00 in value require submission of an itemized receipt and must be included on the CJTA billing form submitted with the invoice.
    e. Submit invoices and supporting documents (including receipts) to Salish BH-ASO no more than 45 days after the month in which an incentive is awarded.
    f. Maintain Incentives logs for review upon request by SBH-ASO.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name:	OUT OF NETWORK NON-MEDICAID BILLING	**Policy Number:** FI503
Effective Date:	1/1/2022	
Revision Dates:		
Reviewed Date:		
Executive Board Approval Dates:		

PURPOSE

To outline the process by which out of network, non-contracted inpatient and residential behavioral health facilities submit claims to the Salish Behavioral Health Administrative Services Organization (SBH-ASO) for reimbursement.

POLICY

Claims billed to the SBH-ASO from out of network behavioral health inpatient and residential facilities must be submitted to SBH-ASO using the SBH-ASO Census and Invoice Form.

PROCEDURE

For instances in which a Salish Individual is served by an out of network inpatient or residential behavioral health provider, SBH-ASO will accept the submission of paper or electronic claims, using HIPAA compliant submission methods. Non-contracted behavioral health inpatient and residential facilities can submit claims for reimbursement utilizing the following methods:

1. UB-04 Billing Claim Form and SBH-ASO Census and Invoice Form
   or
2. SBH-ASO Census and Invoice Form

Claims can be submitted via mail to:

Salish Behavioral Health Administrative Services Organization
Attn: Utilization Manager
614 Division St. MS-23
Port Orchard, WA 98366

Or claims can be submitted via encrypted electronic transmission.

The following are the requirements for SBH-ASO to process any claims submitted for out of network behavioral health service providers:

1. Authorization must be obtained prior to rendering a service which requires prior authorization.

2. Notification must be submitted within the timeframes outlined in SBH-ASO Policy CL203 – Levels of Care for services which require notification.

    a. For involuntary treatment service requests, retroactive notification/authorization submissions may be accepted.

3. Claims must be submitted in accordance with timely filing standards of 12 months of the date of service.

For information regarding SBH-ASO allowable services, please see HCA Service Encounter Reporting Guide (SERI).

I. Professional Services delivered in an inpatient setting

Professional services rendered during inpatient behavioral healthcare stay are billed to the Health Care Authority (HCA). Facility must notify SBH-ASO Staff that professional services were rendered during an SBH-ASO covered stay. SBH-ASO Staff will submit an eligibility ticket to HCA MMIS Provider One system and notify Facility to proceed with billing.

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: OMBUDS SERVICES **Policy Number:** QM702

Effective Date: 01/01/2020

Revision Date(s): 10/14/2021

Reviewed Date: 08/01/2019; 2/23/2021

Executive Board Approval Dates: 11/1/2019

PURPOSE

To define the roles and responsibilities of Ombuds Services. The Ombuds help ensure Individual and Medicaid rights are upheld, that Individuals have access to information and referral, advocacy, and assist in navigating grievances and appeals processes. Ombuds, if requested, also provide assistance with the State Administrative Hearing process. The Ombuds have unencumbered access to the Behavioral Health Agencies (BHAs) that are contracted with Salish Behavioral Health Administrative Services Organization (SBH-ASO).

POLICY

SBH-ASO administers Ombuds services for all Individuals in its defined service area, regardless of an Individuals ability to pay, including Medicaid eligible members.

PROCEDURE

1. SBH-ASO ensures the Regional Ombuds:
   a. Are provided by Individuals with lived experience.
   b. Has separation of personnel functions from the SBH-ASO. (e.g., hiring, salary, and benefits determination, supervision, accountability, and performance evaluations)
   c. Maintains independent decision making that includes all activities, findings, recommendations and reports.
   d. Are responsive to the age and demographic character of the region and assists and advocates for Individuals with resolving grievances at the lowest possible level;

e. Are independent from Contracted Services providers such as BHAs.

f. Receive Individual, family member, and other interested party grievances;

g. Are accessible to Individuals, including a toll-free, independent phone line for access;

h. Can access service sites and records relating to the Individual with appropriate releases so that it can reach out to Individuals, and to assist the Individual through the Grievance and Appeals process and at the Individual's request, assist or represent the Individual with the State Administrative Hearing process;

i. Receives training and adheres to confidentiality consistent with the current HCA- BH-ASO contract, WAC 182-538D-0262 and RCW 71.05, 71.24 and 70.02;

j. Continues to be available to advocate and assist the Individual through the grievance, appeal, and the Administrative Hearing processes;

k. Involves other persons, at the Individual's request;

l. Coordinates and collaborates with allied systems' advocacy and Ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared Individuals. Engages local advocacy groups, and SBH-ASO's network providers.

m. Provides reports, feedback, grievance data and formalized recommendations at least biannually to Quality Assurance and Compliance Committee (QACC), SBH-ASO Advisory and Executive Board, and to the HCA.

n. Are integrated into the overall SBH-ASO quality management process to create opportunities for improvements and changes to the behavioral health system that are reflective of Individual voice and experience as appropriate.

2. SBH-ASO providers collaborate with the Ombuds service staff and ensure that provider staff understand the role of the Ombuds service. The provider:

   a. Ensures unencumbered and timely access to provider staff involved in Ombuds Service inquiry or investigation, including access to private office space as requested;

   b. Ensures current Ombuds service materials are continuously available to Individuals and are posted in a conspicuous place so that Individuals and family members have access at every service location without special request;

   c. Assists in problem resolution and make best efforts to resolve concerns and grievances at the lowest possible level, except where to do so would not be reasonable;

   d. Makes every effort to ensure no discriminatory, disciplinary, or retaliatory action is taken against a provider or Individual for any communications

made or information given or disclosed to aid the Ombuds service staff in completing their duties and responsibilities.

3. Monitoring
    a. Annual administrative and fiscal review
    b. Review of quarterly reports at QACC
    c. Bi-annual presentation of contacts and trends to Behavioral Health Advisory Board.
    d. On-going consultation on a case-by-case basis with SBH-ASO Staff.

Any concerns regarding performance or contract non-compliance will be addressed in accordance with SBH-ASO Policy: Provider Network Selection and Management.

SBH-ASO POLICIES AND PROCEDURES

Policy Name: UTILIZATION MANAGEMENT REQUIREMENTS	**Policy Number:** UM801
Effective Date: 01/01/2020	
Revision Dates: 12/16/2020; 2/24/2022	
Reviewed Date: 07/26/2019;	
Executive Board Approval Dates: 11/1/2019; 1/15/2021	

PURPOSE

To provide an overview of the Utilization Management Requirements for Salish Behavioral Health Administrative Services Organization (SBH-ASO). The SBH-ASO has a utilization management program (UMP) to ensure the application of resources in the most clinically appropriate and cost-effective manner.

POLICY

Utilization Management (UM) activities will be conducted in a systematic manner by qualified staff to ensure the appropriateness and quality of access to and delivery of behavioral health services to eligible Individuals in the Salish Regional Service Area (RSA). SBH-ASO ensures all UM activities are structured to not provide incentives for any person or entity to deny, limit, or discontinue medically necessary behavioral health services to any individual.

PROCEDURE

SBH-ASO Behavioral Health Medical Director provides guidance, leadership, and oversight of the Utilization Management (UM) program for Contracted Services used by Individuals. The following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the Behavioral Health Medical Director to oversee:

1. Processes for evaluation and referral to services.
2. Review of consistent application of criteria for provision of services within available resources and related grievances.
3. Review of assessment and treatment services against clinical practice standards. Clinical practice standards include, but are not limited to,

evidenced-based practice guidelines, culturally appropriate services, and discharge planning guidelines and activities, such as coordination of care.

4. Monitor for over- and under-utilization of services, including Crisis Services.
5. Ensure resource management and UM activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary behavioral health services.

SBH-ASO maintains UM protocols for all services and supports funded solely or in part through General Fund State (GFS) or Federal Block Grant (FBG) funds. The UM protocols comply with the following provisions:

1. Policies and procedures that establish a standardized methodology for determining when GFS and FBG resources are available for the provision of behavioral health services. The processes and methodology include the following components:

    i. An aggregate of spending across GFS and FBG fund sources under the Contract.
    ii. For any case-specific review decisions, the SBH-ASO maintains Level of Care Guidelines for making authorization, continued stay, and discharge determinations. The Level of Care Guidelines address GFS and Substance Abuse Block Grant (SABG) priority population requirements. SBH-ASO utilizes American Society of Addiction Medicine (ASAM) Criteria to make placement decisions for all SUD services.
    iii. SBH-ASO monitors reports (such as spending and authorization reports) at a minimum of monthly to address under- or over-utilization patterns with providers to avoid unspent funds or gaps in service at the end of a contract period due to limits in available resources.
        A. The SBH-ASO Leadership Team reviews spending at least quarterly to identify any needed budget adjustments
    iv. SBH-ASO provides education and technical assistance to address issues related to quality of care, medical necessity, timely and accurate claims submission, or aligning service utilization with allocated funds to avoid disruption in service or unspent funds at the end of a contract year. This occurs in quarterly Integrated Provider Meetings, quarterly Quality and Compliance Committee Meetings, and monthly Crisis Provider Meetings. Technical assistance is provided to individual providers on an as needed basis, upon request, or in alignment with corrective action plans.
    v. SBH-ASO issues corrective actions with providers, as necessary, to address issues regarding compliance with state and federal regulations or ongoing issues with patterns of service utilization.

vi. A process to make payment denials and adjustments when patterns of utilization deviate from state, federal, or Contract requirements (e.g., single source funding).
   A. In addition to monitoring for under or over utilization as noted above in (iii), the SBH-ASO Leadership Team will evaluate utilization patterns for deviations from expected norms on at least a semi-annual basis. If concerns are identified by the SBH-ASO Leadership Team, the SBH-ASO Contracts Administrator will initiate contact with the identified provider(s) to address concerns. Remediation may include Corrective Action, payment adjustments or denials and/or initiating contract termination in accordance with the SBH-ASO contract provisions, if appropriate.

vii. SBH-ASO information systems enables paperless submission, automated processing, and status updates for authorization and other UM related requests through the Salish Notification Authorization Program (SNAP)..

viii. SBH-ASO maintains information systems that collect, analyze and integrate data that can be submitted for utilization management purposes.

2. SBH-ASO monitors provider discharge planning to ensure providers meet requirements for discharge planning. This is accomplished by:
   i. Monthly review of Discharge Planner Report from in region Evaluation and Treatment Centers.
   ii. SBH-ASO Care Managers begin coordinating discharge upon an individual’s admission and elevate barriers to discharge to the SBH-ASO Leadership Team.

3. SBH-ASO provides ongoing education to its UM staff in the application of UM protocols including the criteria used in making UM decisions. UM protocols address the cultural needs of diverse populations.

4. SBH-ASO UM staff making service authorization decisions have been trained in working with the specific area of service which they are authorizing and managing. This occurs during on-going SBH-ASO Clinical Meetings as well as SBH-ASO Data and Development Meetings for SNAP.

5. SBH-ASO employs mechanisms to ensure consistent application of UMP review criteria for authorization decisions.

   i. SBH-ASO has mechanisms in place for an annual assessment of interrater reliability of all clinical professionals and non-clinical staff involved in UM determinations.

6. Policies and procedures related to UM comply with and require the compliance of subcontractors with delegated authority for UM requirements described in this section.

7. SBH-ASO sub-contractors must:
   i. Keep records necessary to adequately document services provided to all individuals for all delegated activities including quality improvement, utilization management, and Individual Rights and Protections.
   ii. Develop clear descriptions of any administrative functions delegated by the SBH-ASO in the Subcontract. Administrative functions are any obligations, other than the direct provision of services to individuals, and include but are not limited to utilization/medical management.

8. Authorization reviews are conducted by state licensed Behavioral Health Providers with experience working with the populations and/or settings under review.

9. SBH-ASO has UM staff with experience and expertise in working with individuals of all ages with SUD and who are receiving medication assisted treatment (MAT).

10. Actions including any decision to authorize a service in an amount, duration, or scope that is less than requested will be conducted by:
    iii. A physician board-certified or board-eligible in psychiatry or child and adolescent psychiatry;
    iv. A physician board-certified or board-eligible in addiction medicine, a subspecialty in addiction psychiatry; or
    v. A licensed, doctoral level clinical psychologist.

11. The SBH-ASO ensures any behavioral health actions must be peer-to-peer, that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration, or scope that is less than requested must be at least equal to that of the recommending clinician. In addition:

    vi. A physician board-certified or board-eligible in psychiatry must review all inpatient level of care actions (denials) for psychiatric treatment.

    vii. A physician board-certified or board-eligible in addiction medicine or a subspecialty in addiction psychiatry, must review all inpatient level of care actions (denials) for SUD treatment.

12. SBH-ASO ensures Appeals are evaluated by providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the Individual's condition or disease.

13. SBH-ASO does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to an Individual.

14. SBH-ASO maintains written job descriptions of all UM staff. SBH-ASO staff that review denials of care based on medical necessity shall have job descriptions that describe required education, training, non-restricted license, including HIPAA training compliance.

15. SBH-ASO has a sufficient number of behavioral health clinical reviewers available to conduct denial and appeal reviews or to provide clinical consultation on complex case review and other treatment needs.

16. SBH-ASO does not penalize or threaten a provider or facility with a reduction in future payment or termination of Participating Provider or participating facility status because the provider or facility disputes the SBH-ASO's determination with respect to coverage or payment of health care services.

17. SBH-ASO informs providers in writing the requirements for Utilization Management (UM) decision making, procedure coding, and submitting claims for GFS and FBG funded services.

Medical Necessity Determination

1. SBH-ASO collects all information necessary to make medical necessity determinations. For services and supports that do not have medical necessity criteria, SBH-ASO will utilize other established criteria.

2. SBH-ASO will determine which services are medically necessary according to the definition of medically necessary services based on established criteria.

3. SBH-ASO's determination of medical necessity shall be final, except as specifically provided in SBH-ASO Policy - Grievance System.

Authorization of Services

1. SBH-ASO provides education and ongoing guidance and training to Individuals and Providers about its UM protocols (UMP), including ASAM criteria for SUD services and SBH-ASO Level of Care Guidelines, including admission, continued stay, and discharge criteria.

2. SBH-ASO will consult with the requesting Provider when appropriate.

Utilization Management Monitoring
The SBH-ASO ensures that all notifications for authorization decisions adhere to timeframes outlined in SBH-ASO Policy - Notice Requirements. The SBH-ASO requires monitoring of all contracted providers through a process that includes but is not limited to:

1. **Monitoring Reports for each contracted provider that includes:**
   a. Authorization and denial data
   b. Over- and under-utilization of services
   c. Appropriateness of services
   d. Other data as identified

2. **Review of Monitoring Reports**
   a. The Internal Quality Committee (IQC) will review these reports.
      i. Data will be reviewed by the committee to determine:
         1. Adherence to authorization and notification content and timelines.
         2. Adherence to the benchmarks provided in UM review areas listed above.
   b. Recommendations will be provided regarding those not meeting established benchmarks.
   c. This report will be provided to the Behavioral Health Medical Director prior to QACC (Quality Assurance and Compliance Committee) meetings for review and comments.

3. **Review of data at Quality Assurance and Compliance Committee:**
   QACC will review the reports to determine the necessary action to take when:
      1. SBH-ASO, its delegate, or its subcontractors do not meet the benchmarks established in the reports.
      2. SBH-ASO or its delegate does not meet the content requirements and timelines for authorizations and notifications.

SERVICE TYPE ANDESCRIPTION	Prior Authorization Required?	Authorization Process
ACUTE INPATIENT CARE – MENTAL HEALTH AND SUBSTANCE USE DISORDER • Acute Psychiatric Inpatient • Evaluation and Treatment • Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital • Secure Withdrawal Management * INDIVIDUALS ADMITTED ON AN ITA ARE REVIEWED FOR CHANGE IN LEGAL STATUS, CONFIRMATION OF ACTIVE TREATMENT AND TRANSITION OF CARE NEEDS.	**No,** if ITA. ITA admissions require notification only within 24 hours followed by concurrent review within 1 business day. **Yes**, if Voluntary. Voluntary Admission requires prior authorization.* **Initial: 3-5 days, depending on medical necessity*	**A. Involuntary ITA Certification:** 1. **Initial:** Submission of *SBH-ASO Notification/Authorization Request Form* for ITA treatment services to include admission documents and court order. ITA certification limited to court date plus one (1) day, not to exceed 7 days. 2. **Continued Stay:** Submission of *SBH-ASO Notification/Authorization Request Form* for ITA treatment services at least by the preceding business day prior to expiration of the authorized period. Hospital provides clinical update, legal status and discharge plan as necessary during legal status changes or extensions. ITA certification limited to court date plus one (1) day, not to exceed 7 days. 3. **Retrospective Review:** Hospital submits *SBH-ASO Notification/Authorization Request Form* for ITA retrospective review and required documents. **B. Mental Health Voluntary** 1. **Prospective/Initial Review:** Submission of *SBH-ASO Notification/Authorization Request* Form for Voluntary Inpatient treatment services a. Subject to Eligibility, Medical Necessity, and Availability of Resources. 2. **Continued Stay:** Submission of *SBH-ASO Notification/Authorization Request Form* at least by the preceding business day prior to expiration of the authorized period. Hospital provides clinical update and discharge plan as necessary during legal status changes or extensions. a. Subject to Eligibility, Medical Necessity, and Availability of Resources.

<table>
<tr><th>SERVICE TYPE AND DESCRIPTION</th><th>Prior Authorization Required?</th><th>Authorization Process</th></tr>
<tr><td>CRISIS LINE AND CRISIS INTERVENTION
Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.
• Services may be provided prior to intake evaluation.
• Services do not have to be provided face to face.
• Crisis Hotline services</td><td>No</td><td>N/A</td></tr>
<tr><td>WITHDRAWAL MANAGEMENT
(IN A RESIDENTIAL SETTING)

• ASAM 3.7 WM
• ASAM 3.2 WM

*IF INDIVIDUAL IS ADMITTED UNDER ITA, SEE ABOVE ACUTE INPATIENT CARE – MENTAL HEALTH AND SUBSTANCE USE DISORDER</td><td>No, if <u>Emergent</u> – requires notification only within 24 hours followed by concurrent review within one business day.

Yes, if <u>planned</u> – requires prior authorization and concurrent review to determine continued stay.

Initial: 3-5 days</td><td>A. <u>Emergent* Admission</u>:
1. Notification: Submission SBH-ASO Notification/Authorization Request Form for Withdrawal Management.
a. All services delivered are subject to Eligibility, Medical Necessity, and Availability of Resources.
2. Continued Stay: Facility submits SBH-ASO Notification/Authorization Request Form including clinical update within one (1) business day prior to expiration of current authorization period.
a. Subject to Eligibility, Medical Necessity and Availability of Resources.
B. <u>Planned Admission</u>:
1. Prospective Review: SBH-ASO Notification/Authorization Request Form for Withdrawal Management.
a. Subject to Eligibility, ASAM, Medical Necessity, and Availability of Resources.
* Must include referral from Designated Crisis Responder, Emergency Department, or Law Enforcement/First Responder. See SBH-ASO P&P Level of Care for details of Emergent Admission.</td></tr>
</table>

SERVICE TYPE AND DESCRIPTION	Prior Authorization Required?	Authorization Process
CRISIS STABILIZATION IN A CRISIS STABILIZATION OR TRIAGE FACILITY Services provided to individuals who are experiencing a mental health crisis. • 24 hours per day/ 7 days per week availability. • Services may be provided prior to intake evaluation. • Service provided in a facility licensed by DOH and certified by DBHR or in a home-like setting, or a setting that provides for safety of the person and the mental health professional. • Service is short term and involves face-to-face assistance with life skills training and understanding of medication effects. • Service provided as follow up to crisis services; and to other persons determined by mental health professional to be in need of additional stabilization services • Additional mental health or substance use disorder services may also be reported the same days as stabilization when provided by a staff not assigned to provide stabilization services.	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review within one business day. Note SBH-ASO does not provide for planned admission to Crisis Stabilization.	A. **Emergent Admission*:** **Notification:** Submission *SBH-ASO Notification/Authorization Request Form*. a. All services delivered are subject to Eligibility and Medical Necessity and Availability of Resources. 1. **Continued Stay:** Facility submits *SBH-ASO Notification/Authorization Request Form* including clinical update within one (1) business day prior to expiration of current authorization period. a. Subject to Eligibility, Medical Necessity and Availability of Resources. ii. **Planned Admission:** a. SBH-ASO does not provide for planned admission for Facility-Based Crisis Stabilization. * *Must include referral from Designated Crisis Responder, Emergency Department, or Law Enforcement/First Responder. See SBH-ASO P&P Level of Care for details of Emergent Admission.*

SERVICE TYPE AND DESCRIPTION	Prior Authorization Required?	Authorization Process
RESIDENTIAL TREATMENT • MH Residential • ASAM 3.1 • ASAM 3.3 • ASAM 3.5	**Yes** – requires prior authorization and concurrent review to determine continued stay. *****MH-** *up to 30 days for initial authorization depending on medical necessity.* ***SUD-** *ASAM 3.5 – up to 15 days for initial authorization depending on medical necessity.* *ASAM 3.3 – up to 30 days for initial authorization depending on medical necessity.* *ASAM 3.1 – up to 30 days for initial authorization depending on medical necessity.*	**A. Prior Authorization:** 1. **Prospective Review:** *SBH-ASO Notification/Authorization Request Form*. a. Subject to Eligibility, Medical Necessity and Availability of Resources. 2. **Continued Stay:** a. *SBH-ASO Notification/Authorization Request Form* three (3) business days prior to expiration of current authorization period. b. Subject to Eligibility, Medical Necessity and Availability of Resources. **2. Retrospective Review:** a. SBH-ASO reserves the right to perform retrospective reviews to ensure continued stays met medical necessity criteria.

<table>
<tr><th>SERVICE TYPE AND DESCRIPTION</th><th>Prior Authorization Required?</th><th>Authorization Process</th></tr>
<tr><td>OUTPATIENT PROGRAM
Service modalities delivered in accordance with Outpatient Behavioral Health Treatment. Including:
• Brief Intervention Treatment
• Day Support
• Family Treatment
• Group Treatment Services
• High Intensity Treatment
• Individual Treatment Services
• Medication Monitoring
• Medication Management
• Peer Support
• Therapeutic Psychoeducation
• Case Management
• Opiate Treatment Program
• SUD Outpatient Treatment</td><td>Yes –requires prior authorization per monthly service package

No - <u>Prior authorization is not required for services managed through a Federal Block Grant procurement process.</u></td><td>A. <u>Prior Authorization:</u>
1. Prospective Review: Submission SBH-ASO Notification/Authorization Request Form.
a. Subject to Eligibility, Medical Necessity and Availability of Resources.

2. Retrospective Review:
a. SBH-ASO reserves the right to perform retrospective reviews to ensure continued stays met medical necessity criteria.</td></tr>
<tr><td>INTAKE/ASSESSMENT SERVICE</td><td>Yes - requires prior authorization.

No - <u>Prior authorization is not required for services managed through a Federal Block Grant procurement process.</u></td><td><u>A. Prior authorization</u>:
1. Submission of request to SBH-ASO.
a. Subject to Eligibility and Availability of Resources.</td></tr>
</table>

SERVICE TYPE AND DESCRIPTION	Prior Authorization Required?	Authorization Process
HIGH INTENSITY OUTPATIENT/COMMUNITY BASED SERVICES - PROGRAM OF ASSERTIVE COMMUNITY TREATMENT (PACT)	**Yes** - Prior Authorization required. *Initial: 90 days for initial authorization depending on medical necessity.*	**A. Prior Authorization:** 1. **Prospective Review:** Submission of *SBH-ASO Notification/Authorization Request Form*. a. Subject to Eligibility, Medical Necessity and Availability of Resources. 2. **Continued Stay:** a. Submission of *SBH-ASO Notification/Authorization Request Form* no later 5 business days prior to expiration of current authorization period. b. Subject to Eligibility, Medical Necessity, and Availability of Resources 3. **Retrospective Review**: a. SBH-ASO reserves the right to perform retrospective reviews to ensure continued stays met medical necessity criteria.
PSYCHOLOGICAL ASSESSMENT AND/OR PSYCHOLOGICAL TESTING	**Yes.** Prior Authorization required.	Prior authorization request submitted to Salish BH-ASO. SBH-ASO to review financial eligibility, medical necessity, level of care and Availability of Resources.

The requirements and processes for the authorization of SBH-ASO contracted services are dependent on the individual meeting financial eligibility criteria, medical necessity criteria, and the availability of SBH-ASO resources. SBH-ASO reserves the right to reduce, suspend, or terminate an authorization due to changes in financial eligibility, changes in medical necessity, and availability of resources.

WASHINGTON STATE UNIVERSITY

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

WA Behavioral Health Communication Framework Workgroup
December 2021 Project Summary & Recommendations

The William D. Ruckelshaus Center is a neutral resource for collaborative problem solving in the State of Washington and the Pacific Northwest, dedicated to assisting public, private, tribal, non-profit, and other community leaders in their efforts to build consensus and resolve conflicts around difficult public policy issues. It is a joint effort of Washington State University hosted and administered by WSU Extension and the University of Washington hosted by the Daniel J. Evans School of Public Policy and Governance. For more information, visit: www.ruckelshauscenter.wsu.edu

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DISCLAIMER

The following project summary was prepared by the William D. Ruckelshaus Center, a joint effort of the University of Washington and Washington State University whose mission is to act as a neutral resource for collaborative problem solving in the State of Washington and Pacific Northwest. University leadership and the Center's Advisory Board support the preparation of this and other reports produced under the Center's auspices. However, the key observations contained in this Addendum are intended to reflect the statements and opinions of the Washington Behavioral Health Communication Framework Workgroup, and the recommendations are those of the Center's team. Those observations and recommendations do not represent the views of the universities or Advisory Board members.

WA Behavioral Health Communication Framework Workgroup December 2021 Project Summary & Recommendations

This brief summarizes the Washington Behavioral Health Communication Framework Workgroup's progress ('Ruckelshaus Workgroup' or 'Workgroup') throughout 2020 and 2021. As of December 2021, this Workgroup has met together at least monthly since September 2020. The Workgroup included twenty-one members over the course of the facilitations, including County Commissioners and county senior staff, a Washington State Association of Counties ('WSAC') executive, Health Care Authority ('HCA') leadership and one Behavioral Health Administrative Services Organization ('BH-ASO') director.

Prior to these joint meetings, the Ruckelshaus Center ('Center') facilitated five separate county/BH-ASO Workgroup meetings and two separate HCA Workgroup meetings between the summer and fall of 2020.

The Center's facilitation is now complete - the Ruckelshaus Workgroup has achieved their goal of designing a consensus-based Communication Framework to support future team-based problem-solving efforts involving both statewide/systemic and county-specific/regional behavioral health policy design and program implementation issues. The Workgroup expects to begin the launch of their Communication Framework during the first quarter of CY2022.

No written summary can adequately convey the shared personal experience of twenty-one people working together for twenty months towards a common goal. The Workgroup hopes to convey their experience through examples, demonstrations, discussion, trainings and storytelling to other counties, BH-ASOs, HCA staff and partners, and others serving the behavioral health continuum – so that teams might apply the framework in ways that will help them experience similar trust-building through their collaborative work efforts, as they work with the HCA to solve behavioral health integration challenges, and open new communication channels between counties and state agencies.

Brief Historical Context: Behavioral Health Delivery & Financing Changes in Washington State

Washington is transforming the way that Medicaid services are delivered and reimbursed, including integration between physical and behavioral health (mental health and substance use disorder) care delivery[1]. Behavioral health integration has been a significant endeavor, involving transformative

[1] Systemic Medicaid transformation in Washington includes four overarching goals: reduce avoidable intensive services and settings; improve population health; accelerate transition from fee-for-service to value-based reimbursement and ensure per capita cost growth is kept below national trends. For further information, please note the WA Health Care Authority's numerous website links on State Innovation Model grants, establishment of Accountable Communities of Health, Section 1115 demonstration waiver and Delivery System Reform Incentive Payment program history.

change. Partnerships and relationships within and between organizations and sectors have been tested during policy and implementation changes over recent years that have impacted responsibility, accountability, funding flexibility, collaboration, and communication.

The model of behavioral health delivery and financing in Washington state has shifted several times in recent years. Prior to 2016, Medicaid enrollees with co-occurring physical and behavioral health conditions navigated between separate systems to care for their needs. Managed Care Organizations ('MCOs') oversaw their physical care requirements, as well as mild to moderate behavioral healthcare needs. Regional Support Networks ('RSNs') oversaw care (via mental health agencies) for those meeting criteria for serious mental illness, or serious emotional disturbances. County governments managed substance use disorder services via County Substance Use Coordinators. In addition to service delivery, administration and funding were also fragmented. The HCA contracted with the MCOs, while the Department of Social and Health Services (DSHS) oversaw specialty behavioral health services through the RSNs and counties. The RSNs managed both federal and state contracts to deliver care and support for Medicaid and safety-net populations and contracted with community mental health providers to deliver mental health care. Substance use disorder services were administered at county levels via grants and fee-for service funding.

This earlier RSN/county model allowed for some flexibility of funding streams, and the counties retained a large share of responsibility and oversight in the system; but care was uncoordinated for those with co-occurring conditions. In addition, lack of information system interoperability between RSNs, counties and MCOs made coordination of care unlikely. Providers were unable to support people 'holistically'. On a systemic basis, Medicaid enrollees and others continued to suffer from chronic problems of access to behavioral health providers.

BHO Service Examples

Mental Health:

Intake Evaluation
Individual Treatment Services
Crisis Services
Group Treatment Services
Brief Intervention/Treatment
Family Treatment
Peer Support
Medication Management/Monitoring

Substance Use Disorders:

Assessment
Brief Intervention
Withdrawal Mgmt (Detoxification)
Outpatient Treatment
Inpatient Residential Treatment
Opiate Substitution Treatment
Referral to Treatment
Intensive Outpatient Treatment
Case Management

Washington state began transitioning to a fully integrated care model in 2014. Legislation to advance whole person care included replacing RSNs with Behavioral Health Organizations ('BHOs'). BHOs were meant to be a temporary model to allow regions in Washington to begin integrating the purchase of physical health, mental health, and substance use disorder services between 2016 and 2019. Subsequent legislation advanced clinical integration and mandated access to additional recovery support services. Task force recommendations suggested full implementation of integration statewide by 2020. BHOs replaced RSNs in nearly all counties by April 2016 and began purchasing and administering behavioral health services for Medicaid enrollees under managed care on a regional basis.

Under fully integrated managed care, MCOs coordinate care across the continuum of physical and behavioral health services. Each region contracts with multiple MCOs, based on competitive bid. In the interim, BHOs replaced the existing RSNs, and became financially 'at risk' for both substance use

disorder and mental health services. BHO's temporary status was meant to transition management of behavioral health to MCOs.

The transition from RSNs to BHOs significantly changed the way that counties and behavioral health providers operated. BHOs had to expand their provider networks and develop integrated data systems, as they were now financially 'at risk'. Substance use disorder providers had to join MCO contracts within regions.

The latest organizational change involved transition from BHOs to fully integrated managed care. Washington's ten designated regions implemented fully integrated managed care on different timelines, which impacted regional/county behavioral health entities. County commissioners determined when to adopt fully integrated managed care within each region. In addition, the state planned for the management of the continuum of crisis services for all statewide residents (not just Medicaid enrollees), including regional crisis hotlines and mobile crisis outreach teams. Originally, the RSNs (and later the transitioned BHOs) received both Medicaid and other public funding to manage and administer these crisis services. As the state moved towards fully integrated managed care, there was recognition that managing crisis functions would require a single regional entity, as splitting funding and functions between MCOs and others within a region would be problematic.

The state ultimately contracted with one BH-ASO per region. The BH-ASOs manage crisis services for everyone, regardless of insurance status; some non-crisis behavioral health services for uninsured populations; regional functions, including ombudsman and community behavioral health advisory boards, and funding from block grants and criminal justice treatment account funds. Fully integrated MCOs are required to contract with the BH-ASOs for crisis services for Medicaid enrollees, including coordination and data-sharing requirements.

Why is this history important? These significant changes to delivery and financing models evolved over a relatively short period of years. The roles, responsibilities and authority of counties and other participants in Washington's behavioral health system have altered considerably. Prior funding flexibility has been constrained, as entities have fewer funding streams to blend to provide services – to Medicaid enrollees, the uninsured and those with other insurance status. The behavioral health support and care system doesn't operate in a vacuum - interconnected services, including support and funding responsibility for related county-based criminal justice services have changed along with these delivery system transitions, and can end up competing with funding for more traditional behavioral health services. Fewer pots of money are left to fund additional services. The counties' relationships with the HCA (and others) have been strained as these delivery system changes have created additional system stressors.

In addition, many of the state employees that oversaw behavioral health services at DSHS' Division of Behavioral Health and Recovery (DBHR) consolidated and transitioned to the HCA in 2018, while many of the folks who were in licensing and certification shifted to the Department of Health. Just prior to these organizational changes, DSHS/DBHR streamlined five Washington Administrative Code chapters regulating behavioral health into one, merging the regulatory framework and language for mental health, substance use disorder and co-occurring treatments. These consolidations were implemented to streamline service delivery and improve care access. During this time, the state also modified the definition of 'mental health professional' to allow provider flexibility and improve access to care, eliminate some agency training requirements and allow for certain documentation exemptions while ensuring patient safety standards. Further regulatory changes were enacted after DBHR's

organizational transition to the HCA and DOH, as part of the efforts to integrate physical and behavioral healthcare. These big changes and compounding stress factors within and across Washington's behavioral health system sometimes intensified communication gaps and challenges to existing relationships between the HCA and counties.

Intergovernmental challenges between counties and state agencies often emerge when complex policies are designed and implemented. In addition, the nature of public healthcare policy and underlying federal/state funded partnerships involves complex program regulations and rules. These can further confuse different entities' perceptions of roles, authority, responsibilities, and relationships in the context of care and support delivery within local jurisdictions. Creating time and space to build strong communications pathways often takes a back seat when system transitions and reorganizations occur.

Finally, behavioral health services involve a complex continuum – delivery, federal and state requirements, participant relationships and related nuance are difficult to fully understand, without full time expertise. County commissioners and staff are interested in supporting all their constituents, without regard to type of healthcare insurance. Few elected officials have the time to become experts in behavioral health unless they happen to work within the field. The HCA must navigate between federal program and funding requirements, state oversight responsibilities, regional and local needs and federal and state regulations that may be unaligned. All parties lack adequate staffing capacity, and behavioral health provider shortages are chronic and long-standing. In addition, COVID-19 is increasing the demand and need for behavioral health services well beyond pre-pandemic times, as well as illuminating outcomes disparities – especially negative impacts on marginalized communities.

Engagement Initiation and Purpose

The HCA and WSAC approached the Ruckelshaus Center in Spring 2020 to first assess a subset of county elected officials and staff, ASOs, WSAC representation and HCA leaders, and (if appropriate) design and facilitate an impartial process to help interested parties work towards collaboration and consensus-building. The parties felt that existing communication gaps and related challenges could greatly benefit from an agreed-to Communication Framework to help further integration success, strengthen relationships, and create a partnership structure to jointly tackle behavioral health integration issues – including challenges involving both policy development and program implementation.

The parties recognized the need for a more productive and satisfying path forward, predicated on rebuilding trust and creating a mutual, workable Communication Framework and underlying commitment to each other that has the potential to outlast individual tenure, turnover, election cycles and systems change.

The Center facilitated twenty-one individuals to design a consensus-based Communication Framework to reach these collaborative goals. This Workgroup included county commissioners and staff representation from several geographically and demographically diverse regions, a BH-ASO, the WSAC executive and a group of HCA leaders with varying behavioral health expertise[2]. The members included county officials and others with diverse stories of relationship challenges with the HCA – varying degrees of behavioral health systems and implementation exposure over time – and from urban, rural and frontier geographies with diverse population needs. Some Workgroup members

[2] A roster of workgroup members is included in Attachment A.

shifted in or out of the Workgroup over the course of the twenty months. Several people retired and were replaced by others. One elected official lost her re-election bid.

The Workgroup was kept small, to maintain effective progress throughout 100 percent virtual facilitation, as the engagement began soon after the pandemic broke out in the U.S. in early 2020. The most important condition of the group was to work closely together in good faith to develop the relationships and trust to build and test an agreed-to Communication Framework. The intent was (and is) to broadcast the framework statewide after development. In fact, the Workgroup never met 'live', but was able to meet the goal of framework completion by the end of 2021. As noted, the Workgroup has begun to implement plans to educate and inform other counties, BH-ASOs and other parties (beginning in the first calendar quarter of 2022) about the benefits of using the Communication Framework to work collaboratively with the HCA on a wide range of behavioral health and related challenges, from proactive systemic issues and change, to regional and county-specific problems.

The Communication Framework is not itself a problem-solving methodology. Rather, it helps create the space and structure to apply agreed-to venues, principles, and attributes to positively change the collaborative process, and allow for a high degree of authentic teamwork to problem-solve. The framework assumes that parties will enter the process in good faith and respect, with the willingness to improve relationships and build trust over time. For newer participants, the framework provides a more streamlined way to learn about the complexities of behavioral health, better serve Washington residents, and be a relevant partner in positive systems change. The twenty months that the Ruckelshaus Workgroup spent together was, in effect, a demonstration of this framework. They took on the iterative work to develop the framework through a series of facilitated meetings, exercises, real time testing and open discussions to learn from each other, change their perspectives, build trust, and achieve collaborative results.

The Communication Framework is flexible and is expected to be improved over time. Ideally, the Workgroup believes that eventual process (and outcomes) success will be measured by the greater goal of a cultural shift in teaming collaboratively to improve systems from a person (citizen)-centered perspective, and not based solely on the structure of any specific framework.

Workgroup Process: Initial Assessment and Emerging Themes

The Center conducted individual assessment interviews of county elected officials and staff, a WSAC executive, and a BH-ASO director during Spring 2020. Similar assessment interviews of HCA leaders were conducted during Summer 2020[3].

Individual assessment interviews accomplish multiple goals. First, the interviews allow different parties to identify relevant issues around the engagement theme and vet their diverse perspectives and experience. Second, the interviews encourage people to envision what a successful project outcome might look like, as well as the related benefits – in this case, developing an effective Communication Framework and its positive impact on behavioral health integration and person-centered outcomes. Third, the interviews allow for a candid discussion of issues and perception of history, as well as relationships between involved parties. Finally, the Center uses the information and opinions heard to assess the potential for collaborative success, as well as to design an effective convening process.

[3]Copies of both versions of assessment questions are included in Attachment B.

Assessment interview feedback broadly fell into the following themes:

- Organizational and program(s) history and evolution
- Physical and behavioral health integration vison
- Integration experience to-date
- Process history: Strengths and gaps
- Status quo risks
- Systemic impacts and concerns
- Relationships between counties, BH-ASOs and the state (HCA and prior Department of Social and Health Services history)
- Collaborative workgroup expectations and willingness to participate in good faith

In general, the assessment interview responses involved issues embedded in the evolution of behavioral health delivery and payment models over a relatively brief history – from RSNs to BHOs, to the current MCO and BH-ASO model. As noted, this evolution, combined with state agency organizational changes, federal deadlines and other relevant factors involved complicated and complex policy implementation requirements. The changes in delivery models over time and resulting systemic stressors for counties and the HCA are described more fully in the prior section.

The assessment feedback also identified county and tribal uniqueness with respect to differing population needs, workforce capacities and access to care, partner relationships, and how these and other factors have been impacted by the delivery/financing model and structural changes over time. It was interesting to note the learned experiences relayed about tribal relations and engagement over time. These lessons ultimately served as an important precedent when developing the framework's expected applications and value.

The assessment feedback indicated a strong desire from all parties to improve communication. Most expressed concern about the sizable amount of work ahead to continue to integrate physical and behavioral care. Others relayed stories about the unintended consequences of legislative action that didn't fully include counties in the process of policy deliberation. Many participants spoke of the ripple effects of the changing delivery models on county and BH-ASO funding flexibility, and the resulting burden of constraints that impact capacity to pay for interrelated services – for example, Involuntary Treatment Act court costs and services. Others, from counties, BH-ASOs and the HCA recalled the loss over the years of individual relationships and trust that had been built and nurtured, but sidelined due to lack of communication focus, strained timelines, program demands and staff turnover.

Examples of Diverse Interview Responses

- County payer-agnostic (all population) vs. HCA Medicaid focus
- Lack of universal vision
- Destigmatizing people/services
- Blending funding streams
- Capacity building
- Matching investments to policy
- COVID telehealth improvements
- Reserve balance issues
- Strong HCA tech assistance history
- Time constraints on sharing local perspectives
- Integration success indicators
- Acute challenges vs. systemic patterns
- HCA turnover
- Lack of county expert knowledge
- Loss of behavioral health providers

Several participants approached the concept of a consensus-based framework with varying degrees of skepticism, based on their experience with the program history - but they recognized the need for

improved relationships and communication to feel like they could deal with upcoming challenges related to the complexities of behavioral health integration. Several were concerned with the broader systems interconnections and impacts between behavioral health and other community-based service utilization and access, including county jails and low-income housing.

Although participants had varying images of realistic project success, all expressed a willingness for collaboration to create a consensus-based Communication Framework - to help parties build trust, work through policy and implementation challenges, mitigate future conflict, and fulfill a vision of integration success to improve individual's outcomes in Washington state.

The assessment responses emphasized a genuine desire to 'turn a corner' and leverage some recent examples of positive county/HCA interaction to rebuild trusted relationships. These examples were often rooted in frustration, without a defined process to proceed in a collaborative manner. Their success was often based on individual parties' (sometimes including the state's Medicaid Director) commitments to take personal command over a particular problem, whether local or regional (none of the shared examples were systemic). A significant amount of time and energy went into working through these problems on an acute basis, signaling both the interest in rebuilding relationships, as well the need for a type of framework to help effectively structure these and other important and burdensome issues.

Participants demonstrated both a positive and realistic perspective related to issue complexity, program history, future integration workload, co-learning benefits and the need to shift towards genuine collaboration to further integration goals - to improve holistic care, behavioral health access, capacity and outcomes, and decrease outcomes disparities. Participants were willing during the assessment interviews to commit to the focused time needed to build something significant together.

Workgroup Process: Separate Workgroup Facilitations

The Center began a series of Workgroup facilitations with separate county/BH-ASO and HCA working groups. The assessment interviews revealed an apparent need to begin working separately with these groups, to help them identify the similarities and differences between their principles and values, as well as their desired framework vision. These initial meetings began in Spring 2020 (county/BH-ASO workgroup) and Summer 2020 (HCA workgroup). Five county/BH-ASO meetings and two HCA meetings were held virtually. These meetings were designed to follow a similar pattern with each group:

- Development of Workgroup working structure, virtual facilitation rules of engagement and exploration of participant's needs (including meeting frequency and timing)
- Structured exercises and discussions to explore the group's understanding of the purpose and need for a communication framework.
- Collective teamwork to identify and categorize foundational qualities and attributes of a successful communication framework.
- Collaborative efforts to begin to convert those qualities and attributes into potential framework principles.

These early meetings produced a separate series of foundational qualities, attributes, and principles to help each of the two working groups define their own versions of successful Communication Framework components. In addition, the structured exercises and discussions helped align each group's foundational components with their initial framework vision, goals, and objectives.

Each working group defined more than 50 foundational qualities and attributes they felt should support a successful Communication Framework. Each group then categorized their attributes for further discussion and storytelling (note sidebar).

Examples of HCA's 50+ identified attributes ranged from 'assume good will', 'present with empathy' and 'use of respectful non-verbal communication skills' in the Positive Working Relationships category; 'honor history/traditions, be future facing for solutions' in the Acknowledge Past category; 'individual/community/tribal focus' in the Mission/Purpose category, and 'no preconceived notions or conclusions', 'follow up on items', 'inquire for clarity' and 'problem solving focus – focus on achievement of goals' in the Productive Meeting Goals category.

Examples of County/BH-ASO's 50+ identified attributes ranged from 'Come prepared to meetings', 'understand issue scope, sequence & priority' and 'when and how to engage knowledgeable staff' in the Foundational Tenets category; 'personal accountability/understanding', 'freedom to push back to learn specifics', 'transparent conversations' and 'celebrate successes' in the Desired Relationship category; 'allow for vulnerability', 'availability', 'learn from each other' and 'communication investment on all sides' in the Relationship Building category; 'respect local value re: systems design & management', 'avoid blindsiding', 'planning when transitioning staff' and 'respect different goals' in the Potential Pitfalls category, and 'a yes instead of a no bias', 'right scope & sequence', and 'building together – not just negotiation' in the Results/Outcomes category.

Many of the attributes that each of the initial working groups independently chose were similar. Common attributes included qualities each group felt were important to rebuild trust and credibility, recognize past failures, work towards better future solutions, maintain a common vison, and generally seek a more humane and collaborative process to team as partners, rather than negotiate as adversaries. In addition, the desire for a person-centered perspective to drive underlying system change and operational problem solving was frequently discussed.

CATEGORIES OF ATTRIBUTES

County/BH-ASO Working Group:

- Foundational Tenets
- Desired Engagement
- Relationship Building
- Potential Pitfalls
- Results/Outcomes

HCA Working Group:

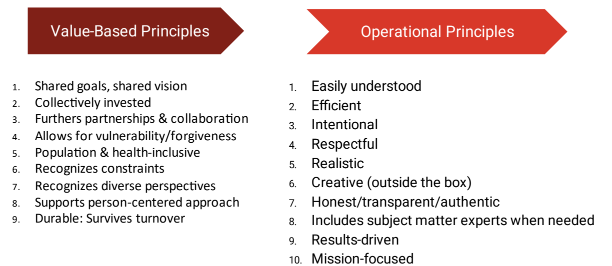
- Positive Working Relationships
- Acknowledge Past & Positive Future Direction
- Mission/Purpose
- Productive Meeting Goals

Workgroup Process: Combining the Two Working Groups

The two working groups were combined into one Ruckelshaus Workgroup in September 2020. A series of facilitated, structured exercises helped the group share their foundational ideas, including their model qualities and attributes, as well as reaching agreements on Workgroup focus and engagement responsibilities. From this stage forward, monthly Workgroup sessions made liberal use of breakout group discussions and large group debrief formats, to allow for appropriate prompting, participant voice and equity of idea-sharing, and a positive learning environment. The Workgroup decided early to limit their meetings to once a month for only two hours. While this extended the duration of the total engagement, the time in between meetings was often used to engage individually with workgroup members, plan interventions when appropriate, and adjust the planned

focus of upcoming meetings. On occasion, other parties were invited to join meetings, to share their lived experience, or provide additional subject matter expertise. This took on significant importance in later testing phases.

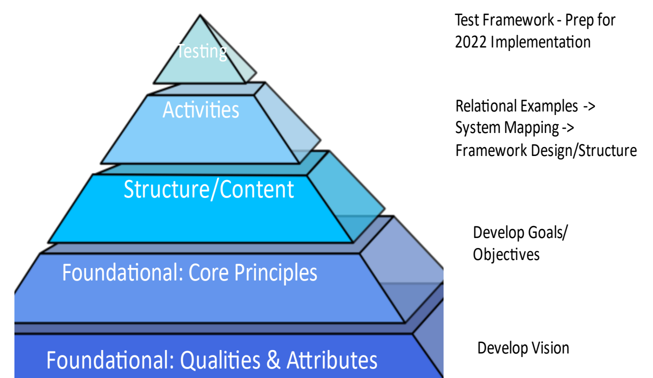
The group's sharing of their prior qualities and attributes helped define their core communication principles. These included both value-based and operational components to help design the Communication Framework. A high-level summary of the Workgroup's framework principles is noted in the sidebar graphic[4].



Subsequent Workgroup meetings began to focus on subject matter content (based on lived experience, history of program and systems change, and stratification of past and projected issues into framework categories). This preliminary work helped build and eventually test collective needs, framework structure and integrity. This content was based on the stories and memories that each Workgroup member brought to the collaboration. A series of 'learning' circles' were planned to give Workgroup members the chance to host different issues that would elicit both breadth and depth of discussion to help test the framework needs. For example, one early learning circle focused on the importance of physical/behavioral health integration (from an individual holistic perspective). The ensuing discussion opened a wide diversity of perspectives on systems design, program implementation, unintended consequences, capacity constraints, tribal history and mental health parity.

Another learning circle focused on different perspectives on measuring integration 'success', beyond program metrics. This discussion gave participants a broader understanding of the diversity of program vision, service gaps, different partner/contractor roles and responsibilities, future funding streams, different county needs, the broad scope of the behavioral health continuum, and HCA's role relative to behavioral health and non-Medicaid populations.

Many participants commented that the sharing of different viewpoints within the Workgroup around the history of a specific issue helped them broaden their understanding, empathy, and ability to creatively brainstorm together. These shared learning exercises were one example of the use of facilitated systems thinking tools (mental models) to help the Workgroup progress through both sequential and iterative processes to maintain momentum towards a tested framework design[5]. Continued monthly meetings attempted to balance process and content, with growing emphasis on content as the teamwork progressed.



[4] Note that these embedded graphics were originally developed for 'slide' visuals used during Workgroup facilitations and may be difficult to read in this confined report format. Please use your 'View-Zoom' function in Microsoft Word (or similar application) to expand your view to 200%.
[5] Other employed systems-thinking tools included behavior over time graphs, connection circles, causal mapping, components of stock-flow maps and systems archetypes.

The Workgroup proceeded on a path to finalizing framework design and moved towards testing. Their momentum was demonstrated on a monthly graphic - a progress 'pyramid' tracked their collaboration and kept them focused on their design efforts and discussion purpose (Note: embedded graphic on the prior page).

Throughout these engagement stages, the Workgroup was simultaneously refining their goals, objectives, and vision, based on their foundational components work (qualities, attributes, and principles). This part of the process was iterative – many discussions looped back to the central points to test the purpose, meaning and intent of the framework. It was often helpful to structure these conversations around the types of issues that might benefit from the framework's use. Those issues were often redefined through 'What'-'Why'-'Who'-'How' conversations:

- 'What' is the real problem or issue?
- 'Why' should this issue be on our collective radar?
- 'Who' will need to be involved to plan for and potentially solve this issue?
- 'How' should the issue be applied to relevant framework model components?

This phase allowed the Workgroup to invest the up-front time to benefit later conversations, when they eventually structured the final framework venues, communication loops and strategic questions to ask. This also began the process of thinking about the types of tools they might need to develop to support the framework.

Communication Framework: Value & Benefits

The Workgroup considered the value and benefits that a new Communication Framework might offer. A version of the existing multi-level tribal/state engagement model helped define the breadth of functions that an effective framework might support. The Workgroup believed that solving the types of issues identified (either county-specific/regional, or systemic) will often require strategic advocacy to build coalitions to approach policy and/or decision makers. The framework can be used to help build those collaboratives to seek solutions or systems change. For example:

- If an existing county/regional/tribal operational problem is identified that the HCA has the authority and means to independently correct - the framework can help facilitate that process (for example, correcting the consequences of changes to provider contracting impacting a particular region).
- If the HCA knows that the legislature has appropriated new funding for a portion of the behavioral health continuum (or is leveraging federal funding), the framework can help parties improve preparation for tight implementation deadlines to roll out program improvements – using a much-improved communications process. In this case, the parties can use the framework to proactively plan for and avoid downstream unintended consequences. For example, responding to potential 988 crisis line implementation expectations and associated crisis response system issues; or ripple effects from judicial rulings, such as Washington Supreme court's Blake decision.

- If an issue is thought to be systemic, the framework helps parties test that assumption, evaluate the issue based on agreed-to principles, prioritize it based on the same principles, and identify the internal or external partners that may be needed to help craft the longer-term solution. The Workgroup agreed that the HCA, as the single-state Medicaid agency would be the logical advisor for this planning. Examples of internal/external partners might include other state agencies (WA Department of Health), the legislature, federal agencies/departments (Centers for Medicare and Medicaid Services; Substance Abuse and Mental Health Services Administration). Such issues could require the proposal of federal Medicaid waivers, new state plan amendments, or new legislation.
- The framework may be used to support collaborative advocacy to evaluate larger systemic issues that are barriers to achieving program and integration vision and outcomes, and propose systems change. Work began to align HCA and WSAC legislative steering committee calendars across session years and to start to build collective legislative strategy.

In April 2021, a smaller sub workgroup was formed with six volunteers: three HCA officials, two county commissioners and one BH-ASO director. The Workgroup had reached a point that required additional meeting time beyond once a month; in particular, to convene a group of detail-minded participants to work through the 'nuts and bolts' of finalizing the framework design. This sub workgroup met eleven times between April and November 2021 to work through the many framework details. They relayed their suggestions to the full Workgroup on a regular basis, where discussions led to consensus. During the project's last several months, this sub workgroup was opened to anyone from the Workgroup who wished to join the meetings. This helped keep the discussions fresh with diverse perspective.

Finally, the Workgroup took the opportunity to 'pressure test' the framework in real-time. Examples from Clallam County's provider contracting process were demonstrated by their regional BH-ASO and County Commissioner – the Workgroup used framework concepts to test for communications gaps and address several external 'shocks' that occurred outside of the framework's boundaries. The test included a Workgroup debrief with corrective action points for both the HCA and county.

The test highlighted several important points:

- If other parties (internal or external) with influence aren't aware of the framework and/or are unwilling to work with the improved communication process, they can negatively impact or delay issue resolution. The Workgroup expects a longer-term effort to educate people about the framework's benefits, and how they can engage in productive and collaborative problem-solving efforts, to reduce the probability of external shocks to the process.
- The framework may not fit all the issues that surface; but it does have the capability of providing useful guard rails that can keep an issue from moving off track from resolution. The framework should be adaptive and improved over time to address as many types of issues as possible.
- Lessons learned from existing conflicts should be quickly evaluated as a team, and improvement steps implemented as soon as possible. For example, assumptions of new policy implementation requirements may cause misinterpretation, especially evident during tight deadlines. A quick contracting checklist, or other universal tool might help all parties quality-control their processes in advance of implementation, to avoid unnecessary misinterpretation.

The Workgroup's expectation is that the framework will need to be demonstrated, taught, and reinforced to pass along important lessons learned throughout the twenty-month collaborative process. Time and patience will help guide other willing county, BH-ASO and HCA participants to experience their own trust and capacity building, as the Communication Framework is used to help structure collaborative problem-solving. As willing legislators, providers, Accountable Communities of Health, MCOs, other state agencies and other behavioral health partners gain exposure to and experience within the framework, partners should experience fewer external shocks. The Workgroup expects that WSAC can provide a significant role with both the educational aspect (exposure to the framework, to inform existing County Commissioners and staff, as well as the large percentage of newer elected officials who are unfamiliar with behavioral health issues), as well as noted legislative strategic efforts.

Workgroup Process: The Two Communication Framework Elements

The two Communication Framework graphics follow in Attachment C. Although these graphics are simple in design, successful application of the Communication Framework will require consistent effort and teamwork from all participants, to develop new meeting and discussion patterns that intentionally break from existing meeting agendas and status quo formats.

County-Specific/Regional Issues Communication Framework:

The county-specific/regional framework is based on a communication flow that deliberately uses (mostly) existing meeting structures; the group wanted to avoid, if possible, unnecessarily adding more meetings to partner's already crowded calendars. The Workgroup looked at a wide range of existing behavioral health-related meetings, to identify those that could potentially match the needs of the framework design, partner and issue requirements for effective collaboration, and participation mix. In some cases, these existing meetings may require agenda and process changes. Other meetings are already semi-structured, allowing for flexibility.

This portion of the framework identifies four existing meetings that can provide the input, expertise, collaboration, brainstorming, and feedback loops needed to identify and test county-specific/regional issues (non-systemic), as well as provide momentum and accountability to team problem-solving functions:

- The **monthly BH-ASO meetings** are key to this part of the framework. In addition to their awareness and knowledge about local behavioral health issues, the BH-ASO directors also serve as a logical 'collection point' for issue/problem input from:
    - County ASO directors and Beacon Health (serving as the BH-ASO in three of the ten regions);
    - additional related communication from County Commissioners (who often hear of issues from the public, providers, and others), and
    - the Association of County Human Services ('ACHS'), an affiliate of WSAC, and co-chaired by one of the Ruckelshaus Workgroup members.

The Workgroup identified certain communication 'gaps' when developing this flowchart. The group felt that bringing Beacon Health Options into more conversations would benefit collaborative problem-solving results, as well as tighten relationships between county elected officials, county staff and Beacon in the three regions they serve[6].

[6] Beacon serves as BH-ASO in the following regions: Pierce (Pierce County), Southwest (Clark, Klickitat and Skamania Counties), and North Central (Chelan, Douglas, Grant and Okanogan Counties).

The monthly BH-ASO full-day meetings are an efficient way to identify what may be county-specific or regional issues and bring them to the BH-ASO/HCA meeting the following day.

- The 'next day' **BH-ASO/HCA meeting** can serve first as an evaluation point for each raised issue. The team can discuss the context of each issue and determine if it is truly county-specific or regional; if the issue is systemic, the team can move the issue to the framework's second process. In some cases, issues may include both county-specific/regional and systemic components. The team will need to determine (with or without external guidance) if one or both of the framework's two processes will fit best. These decisions will likely consider urgency, expected scope of resolution requirements, and resource capacity.

The Workgroup discussed constructing simple scheduling/prioritization tools and lists that can support the maintenance of resolution steps, accountability, and responsibility for these efforts, provide visibility of progress, and generally support the framework principles and attributes developed in the Workgroup facilitations.

The problem-solving process itself is dependent on the scope of the issue, team agreement on context and cause, and evaluation of the pros/cons of potential solutions and downstream consequences. Again, the problem-solving process is embedded within the framework's communication flow and venues, but not specifically prescribed by the Communication Framework. Some issues can be resolved simply and efficiently with minimal intervention; others require complicated steps involving multiple parties and consensus-building. Regardless, the framework provides the means to raise, evaluate and vet the issues, share diverse opinions and perspectives, and create feedback loops that keep the team informed through resolution to avoid missteps, communication gaps and misunderstandings.

- The **individual BH-ASO/HCA meetings** (county ASOs and Beacon) are relatively new and less structured. The HCA began these meetings as a learning experience, to share information between the parties. The Workgroup felt these would be ideal collaboration spaces to share frank and open discussion to identify both regional opportunities and challenges in a smaller group setting. The meeting frequency will likely need to be adjusted over time, but the content could add valuable input to share at the monthly BH-ASO meetings, and then at the following BH-ASO/HCA meeting.
- The existing every other month **ACHS meetings** (noted above) bring county administrative, planning and service delivery staff together to discuss county implementation around state executive and legislative actions involving behavioral health and intellectual/developmental disabilities services. The HCA has been attending these meetings this past year. The Workgroup felt that this group's 'ground-level' perspective would help provide valuable input to the BH-ASO/HCA next day meeting issue content and perspective. Isabel Jones currently serves as a behavioral health co-chair with ACHS, as well as having participated as one of our framework Workgroup members for the past twenty months.

These four existing meetings make up the 'bones' of the county-specific/regional issue framework. The Workgroup agreed that this portion of the Communications Framework in no way prevents County Commissioners or others from direct contact with the HCA or others – rather, it is intended to provide a logical structure and communication flow that is meant to create more efficient and effective outcomes, avoid communication gaps, and maintain a shared level of visibility and accountability to support a collaborative process. As noted, the meetings' agendas, content and issue

resolution processes should remain flexible and adaptable – and changes to the Communication Framework are expected and welcomed over time.

Workgroup Examples of Emerging and Ongoing Complex Issues

- 988 Crisis Lifeline implementation and changes to WA crisis response system
- Impacts of 1/10th of 1% sales tax and differing county applications
- Impacts from the WA Supreme Court Blake decision
- CMS payment disconnect with WA-defined Eval & Treatment centers
- Behavioral Health Navigator program for student suicide prevention and support
- HB1310: Police use of force
- Quality of crisis response
- Small BH provider capacity and turnover
- Variability of BH treatment & interventions
- Re-org of health boards
- Opportunities include new legislative investments

Systemic Issue Communication Framework Steps

The second framework applies if the BH-ASO/HCA meeting team evaluates an issue or opportunity and determines it is systemic in nature. The Workgroup concluded that the existing quarterly **legislatively mandated behavioral health 'coordination' meetings** will be revised to accommodate this systemic work using the framework's collaborative principles. The HCA will work to redesign these meetings to address these systemic opportunities and issues and host the meetings. Meeting frequency may be reconsidered, to match the intensity and breadth of the expected work.

Rather than proceed with another communication flowchart, the Workgroup concluded that a strategic planning framework would best fit communication needs around systemic issues. The Workgroup developed a set of guiding steps within the framework to help structure, evaluate, and prioritize an appropriate strategic approach to address the systemic issue or opportunity:

- Evaluate the issue: Appropriate time will be invested to examine 'what is the problem/issue/opportunity?' from diverse team perspectives. Where does the issue fall on the overarching behavioral health continuum? Is the issue proactive or reactive (or both)? Is the issue urgent? If so, to whom? What's the probable impact(s) on individuals/communities/providers/community partners/budgets and costs?
- Prioritize the issue(s): It's unlikely that many major systemic issues can be tackled at once. The Workgroup suggests building framework tools that can help prioritize issues and opportunities, based on impact to individuals and communities, collective capacity to invest the time, external partner (e.g., CMS; legislature) interest and support and other relevant factors.
- Who should be at the table? The Workgroup discussed a mix of diverse perspectives, lived experience, subject matter expertise and funding authority, among other considerations. Once again, the Workgroup reminded themselves that re-centering around a person-centered perspective/impact is an important litmus test for collective action.
- Convening partners and parties: Any convening should be consistent with the principles and attributes of successful communication that the Workgroup developed. Consensus-building processes sometimes require a facilitative role – not necessarily a third party, but certainly persons experienced in process design; facilitative methods, structures and exercises, and

skilled in conflict resolution/intervention practices. The scope of the issue and breadth of the strategic partnership will help determine the time and effort requirements, as well as the need for differing levels of skills and expertise.

- Solution/agreement seeking: Which parties have the authority to enable the systemic changes proposed? Which partnerships need to be tapped? What are the administrative, legislative, judicial, or other options to move the strategy forward? The Workgroup determined that the HCA would be the lead partner to research potential and likely strategic options[7], but the HCA may seek guidance from others (e.g., other WA state agencies; other state's Medicaid agencies; third party experts; federal partners). How will the strategic process be documented to maintain responsibility, accountability, transparency, and other shared communication attributes? How can feedback loops be used to help maintain momentum, collaboration, and trust between team members? Will the process have resilient backup strategies in case external shocks temporarily upset progress? How can team members build in both flexibility and durability to maintain trust and confidence throughout potentially longer-term strategies? What are the best collaborative methods that can be employed to broadcast 'wins', admit and manage mistakes, and work with the media? How can the team use lessons learned to augment trainings for policymakers and elected officials, to keep them current and the systemic issues relevant?

The Workgroup believes that this process is not expected to be linear. It should have built-in feedback loops and process checks to help keep a potentially longer-term process on track. A significant amount of dedicated project management may be required but should be consistent with the defined Communication Framework principles and attributes. Many of the concepts and partnerships suggested in the county-specific/regional framework may apply to systemic issues. It will likely make sense to link the revised legislatively mandated coordination meetings with input from some of the groups identified in the prior framework section.

<u>Workgroup Process: Planning for 2022 Communication Framework Roll-Out</u>

The Workgroup has initiated the planning process for framework implementation. Roll-out is expected to begin in the first calendar quarter of 2022. The Communications Framework was introduced to a group of county-elected officials and staff at WSAC's Annual Statewide County Leader's Conference in Spokane in November 2021. Executive Director Eric Johnson moderated a panel (Commissioner Mark Ozias, Sindi Saunders, and Kevin Harris) who introduced the twenty-month process and the Communication Framework to audience members. Commissioners Jill Johnson and Chris Branch added Workgroup comments and perspective during the subsequent Q&A session. Interest was high.

The Workgroup is in the process of reaching out to introduce the Communication Framework concepts and structure to the five key groups identified in the graphic representations. Key meetings during the first quarter of 2022 have been identified, and Workgroup members are expecting to build a set of discussion and talking points, as well as presentation stories to convey their shared experience to others[8]. WSAC and HCA legislative teams will work on aligning legislative calendars. Workgroup

[7] The Health Care Authority is the 'single state agency' for Medicaid and is the primary point of contact with federal partners such as CMS. Many systemic issues (and program or systems change) require Medicaid state plan amendments, different versions of federal waivers, or other initiatives that are highly dependent on this state/federal relationship.

[8] For example, the Workgroup suggested versions of the general framework statements in Attachment D.

members are enthused and looking forward to sharing their experience and work with counties, BH-ASOs, other HCA staff and others who serve throughout the behavioral health continuum.

Our thanks and gratitude to all Ruckelshaus Workgroup members for their participation, leadership, enthusiasm, and collaboration throughout the past twenty months. We look forward to hearing of your continued Communication Framework progress and success.

Ruckelshaus Center Recommendations

The 2020/2021 Communication Framework Workgroup collectively produced great energy, effort, and results. From a facilitative perspective, the Workgroup maintained a consistent effort throughout a slower, deliberate process. Comments throughout and at the end of the engagement were heartening – team members felt happy with the end results and appreciated the process to help guide them from a prior (and sometimes) contentious program history toward a genuine trusted and credible partner relationship. They have no illusions about the hard work ahead – but look forward to conveying their shared experiences to others, to help embed the collaborative communication principles they worked hard to achieve to improve behavioral health services to Washingtonians, and enact meaningful systems change.

The following Ruckelshaus Center recommendations are suggested to augment the positive progress and results that the Workgroup achieved:

a. Build a consistent 'de-brief' mechanism into each of the framework's component meetings for quality improvement purposes. While this requires an additional investment in time, it will help the teams remain nimble and adaptive, especially if the de-briefs are scheduled soon after each meeting ends. This may be especially important in the early stages of implementing the framework, as most existing meetings will experience some degree of modification, or a more significant re-design (e.g., current quarterly legislatively mandated meetings).
b. When facilitating the larger meetings (more than 20 participants), make intentional and frequent use of breakout groups (regardless of virtual or in-person meeting status), as we did in the first half of this engagement. This will help develop initial trust – most people are more comfortable speaking frankly in smaller groups. As confidence builds and people mix between breakout groups (with time for larger group debriefs to share smaller group work), begin to phase in progressively larger breakout groups, until the value of the full group's discussion outweighs the value of using breakouts.
c. Be intentional about improving and adapting the Communication Framework:
    - Calendar 'tune-up' meetings with a core workgroup or framework steering committee on a regular basis (perhaps quarterly to begin) to review progress, consider adjustments, celebrate wins and evaluate bottlenecks and barriers.
    - Prepare practical examples of 'wins' and 'losses' to evaluate and brainstorm process improvements, which may include meeting modifications, facilitative improvements, identifying continuing patterns of communication gaps and other lessons learned.
    - Seek diverse opinions on recommended improvements before implementing them.
    - Create a forum to efficiently update everyone on modifications, including 'why' and 'how' statements. For example, consider a twice a year Communication Framework Bulletin for broad distribution. This could also serve as education updates for newer staff and newly elected officials.

d. Leverage WSAC's capacity to build an education plan to update existing County Commissioner's knowledgeable about behavioral health, less experienced Commissioners, and newly elected officials to promote interest and subject matter context. Teach elected officials how to engage, work with and leverage the framework concepts.
e. Identify a key set of legislators and staffers who are most knowledgeable of behavioral health systems and issues; develop a separate introductory demonstration of the Communication Framework for them.
f. Engage willing tribal support to help add important issue/opportunity evaluation from a tribal/state and tribal/community behavioral health perspective. Tribal mental models and systemic evaluation are compatible in many ways and can add valuable context and diversity of thought to systemic issues.
g. Build framework tools that can be universally used or adapted to meet issue and process requirements. For example:
    - A checklist of communication-based steps for policy implementation rollouts.
    - An issues inventory list for county-specific/regional issues to maintain and document progress, responsibilities and milestones reached.
    - A systems-mapping and/or cause & effect mapping tool to help the team fully evaluate systemic issues. Mapping helps to identify root causes, interdependencies, potential unintended consequences, and possible points of leverage to trigger larger systems impacts. This may also help the team prioritize certain systemic issues, if teamwork invested in one issue has significant impacts on others (see systems-thinking questions in 'i' below).
    - A minimum checklist of media or legislative exposure talking points to promote consistency between team members when describing the Communication Framework. The Workgroup agreed to two general framework statements, noted in Attachment D.
    - A tool that helps the group screen issues for urgency, based on agreed-to concepts. The Workgroup had several discussions about a simple 'red-yellow light' type of tool that elevates urgent (red light) issues and prepares the group for issues of upcoming concern (yellow light). Developing consensus-based rules can support agreement about re-prioritizing issues when necessary.
h. For those issues that may not 'fit' the framework, consider use of a conflict-resolution process or steps that can help parties test their willingness to collaborate (or at least come to an acceptable joint resolution over the issue). This may also be helpful when interventions are sometimes required during longer-term processes.
i. Use systems-thinking tools and habits to help expand the systemic framework team's thorough evaluation of an issue, to identify root causes and interconnectivity to gain productive team momentum, refine prioritization competencies and broaden options for lasting solutions. For example, questions to consider include:
    - How are differing attitudes and beliefs advancing or hindering efforts to achieve desired results?
    - Has the issue been considered fully? Have we resisted the urge to come to a quick conclusion? Are we all aligned in seeing the 'big picture'? Have we openly tested our theories and shared assumptions with others, to improve performance?
    - Have we identified the many parts of our behavioral health system and structure to understand the whole, and how our system's relationships affect behavior?

- Have we considered the unintended consequences of a proposed action, and the trade-offs to consider? What are the short and long-term consequences, and are we willing to accept short-term pain for long-term gain?
- Do we understand the circular nature of complex cause and effect relationships?
- What indicators should we expect to see as we look for progress? Are we pausing enough to assess the effects of our current plan and work together?
- Are we identifying how elements of our system have changed over time? How quickly are they changing, and what patterns or trends have emerged?
- How have our own perspectives changed over time? How has that influenced our decision-making?
- How can we use what we know about our behavioral health system to identify possible leverage actions? Where might a small change have a long-lasting and desired effect?

j. When it’s appropriate to use a facilitator for systemic issue evaluation and prioritization (either internal or external), seek out people who are skilled in facilitating strategic planning efforts.

k. Consider developing a team member agreement that includes commitment to the Communication Framework’s principles and process. For example, other workgroups have developed Declarations of Cooperation, or Memoranda of Collaborative Intent. This is not intended to add a legally binding component to the process, but to instead solicit further commitment of ‘buy-in’ from engaged parties. In addition, this could represent a creative tool to further framework durability.

Attachment A – Roster of WA Behavioral Health Communication Framework Team Members (including retired)

Team Member	Organization
Jessica Blose	Health Care Authority/WA State Opioid Treatment Authority
Chris Branch	Okanogan County Commissioner
Teresa Claycamp	Health Care Authority/Division of Behavioral Health and Recovery
Diana Cockrell	Health Care Authority/Division of Behavioral Health and Recovery
Jessie Dean	Health Care Authority/Office of Tribal Affairs
Dr. Charissa Fotinos	Health Care Authority/Interim Medicaid Director
Edna Fund	Lewis County Commissioner
Eric Johnson	Washington State Association of Counties
Jill Johnson	Island County Commissioner
Isabel Jones	King County/Behavioral Health and Recovery Division
Michael Langer	Health Care Authority/Division of Behavioral Health and Recovery
Ruth Leonard	Health Care Authority/Medicaid Programs Division
Alice Lind	Health Care Authority/Medicaid Programs Division
MaryAnne Lindeblad	Health Care Authority/Medicaid Director
Sarah Mariani	Health Care Authority/Division of Behavioral Health and Recovery
Jason McGill	Health Care Authority/Medicaid Program's Division
Mark Ozias	Clallam County Commissioner
Melodie Pazolt	Health Care Authority/Division of Behavioral Health and Recovery
David Reed	Health Care Authority/Division of Behavioral Health and Recovery
Sindi Saunders	Greater Columbia BH-ASO
Keri Waterland	Health Care Authority/Division of Behavioral Health and Recovery

Attachment B

WASHINGTON STATE UNIVERSITY

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

WA Behavioral Health Communication Framework
Questions: Counties and BH-ASOs

1. *Please describe your position, professional background and organization/constituents as they relate to physical/behavioral health integration in your community. What are your (organization's) most important responsibilities relative to integration goals?*
2. *Imagine your community's ideal health status beyond the finite Demonstration timeline and existing barriers. What would integration success look like from your perspective in 5-10 years? How would you gauge that success?*
3. *How would you describe your current relationship with the Health Care Authority, and with other stakeholders? What specific past events led to any change in those relationships?*
4. *What are some positive examples of behavioral health integration to-date (in either your community or others)?*
5. *Which key components/processes have been missing in building relationships and trust between parties throughout this process?*
6. *What are you most concerned about right now relative to integration issues? What are the risks of remaining 'status quo'?*
7. *Has your own thinking around integration issues and the need for collaboration evolved since the 1115 Waiver began? How?*
8. *What expectations do you have about entering a collaborative process? What do you hope to achieve? What concerns do you have?*
9. *Who else should I speak to with respect to these issues, if and when this initial group expands? Why?*
10. *Are there other questions I should have asked? Do you have any additional questions for me?*

WASHINGTON STATE UNIVERSITY

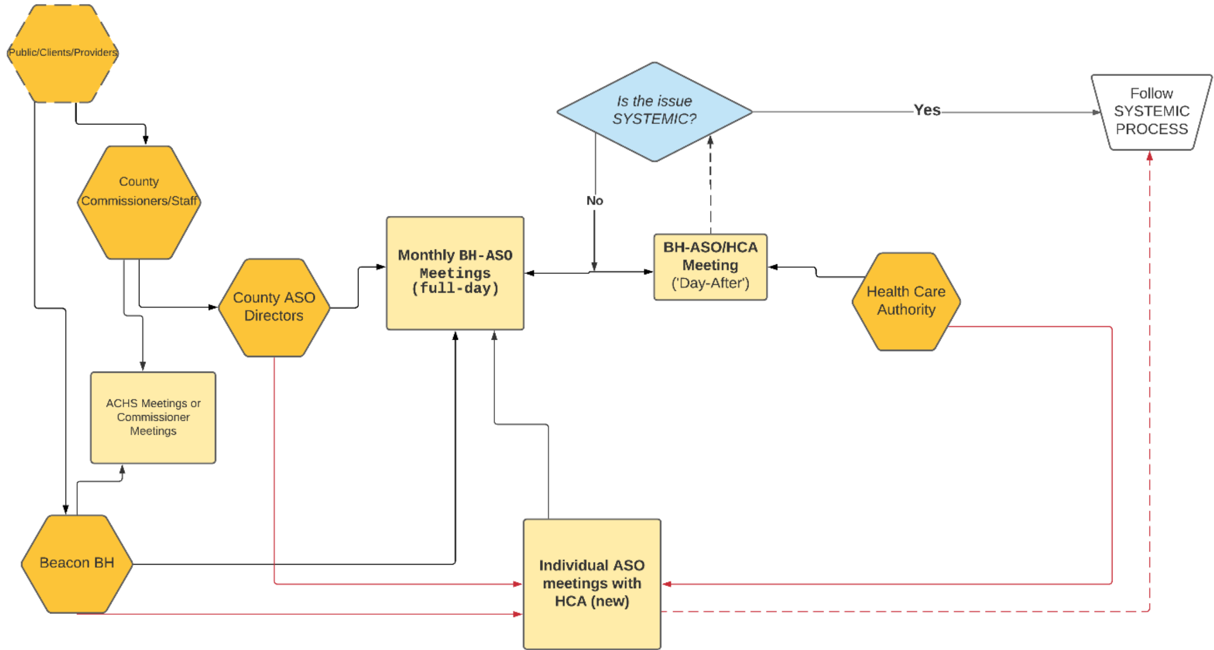
THE WILLIAM D. RUCKELSHAUS CENTER

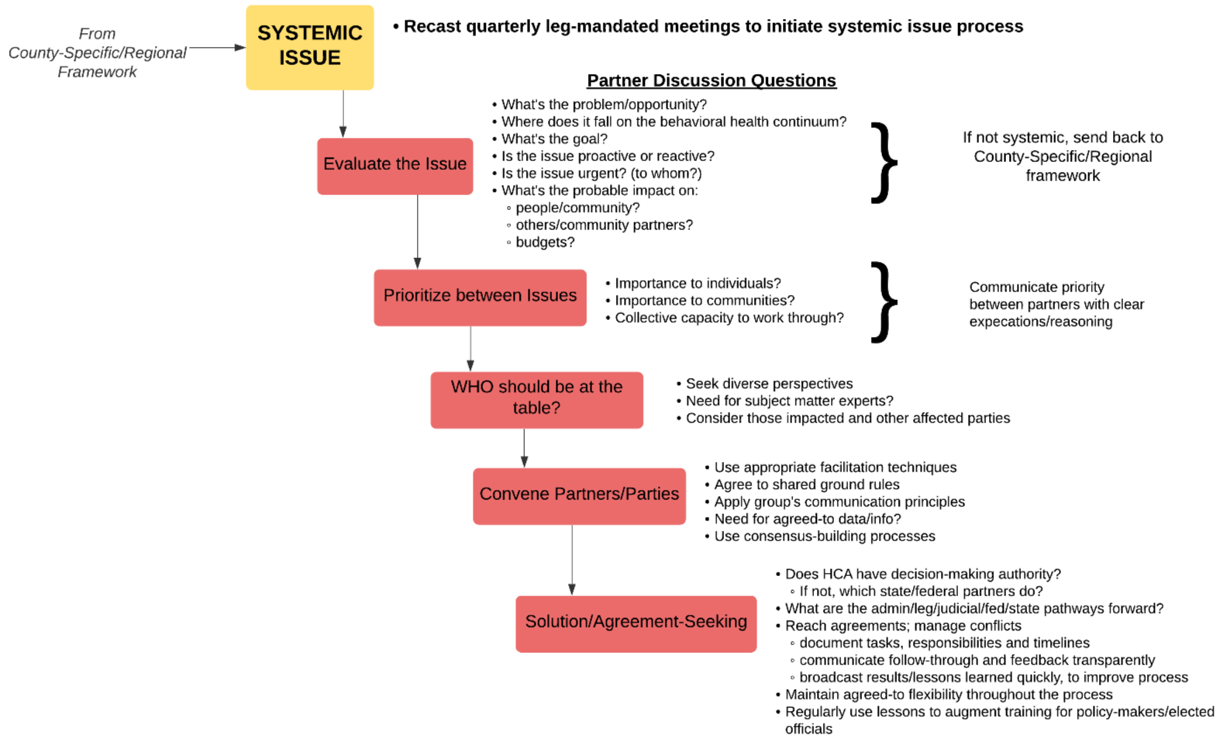
UNIVERSITY OF WASHINGTON

WA Behavioral Health Communication Framework
Questions: Health Care Authority

1. *Please describe your position, professional background and organization/constituents as they relate to physical/behavioral health integration. What are your (organization's/team's) most important responsibilities relative to integration goals?*
2. *Imagine our state's and communities' ideal health status beyond the finite Demonstration timeline and existing barriers. What would integration success look like from your perspective in 5-10 years? How would you gauge that success?*
3. *How would you describe your current relationship with counties, and with other stakeholders, including the MCOs, ACHs and relevant legislators? What specific past events led to any change in those relationships?*
4. *What are some positive examples of behavioral health integration to-date (either statewide or within specific communities)?*
5. *Which key components/processes have been missing in building relationships and trust between parties throughout this process?*
6. *What are you most concerned about right now relative to integration issues? What are the risks of remaining 'status quo'?*
7. *Has your own thinking around integration issues and the need for collaboration evolved since the 1115 Waiver began? How?*
8. *What expectations do you have about entering a collaborative process? What do you hope to achieve? What concerns do you have?*
9. *Who else should I speak to with respect to these issues, if and when this initial group expands? Why?*
10. *Are there other questions I should have asked? Do you have any additional questions for me?*

Attachment C




SYSTEMIC ISSUE COMMUNICATION FRAMEWORK STEPS
WA BH Communication Framework Workgroup
From County-Specific/Regional Framework
SYSTEMIC ISSUE
• Recast quarterly leg-mandated meetings to initiate systemic issue process
Partner Discussion Questions
Evaluate the Issue
• What's the problem/opportunity?
• Where does it fall on the behavioral health continuum?
• What's the goal?
• Is the issue proactive or reactive?
• Is the issue urgent? (to whom?)
• What's the probable impact on:
◦ people/community?
◦ others/community partners?
◦ budgets?
If not systemic, send back to County-Specific/Regional framework
Prioritize between Issues
• Importance to individuals?
• Importance to communities?
• Collective capacity to work through?
Communicate priority between partners with clear expecations/reasoning
WHO should be at the table?
• Seek diverse perspectives
• Need for subject matter experts?
• Consider those impacted and other affected parties
Convene Partners/Parties
• Use appropriate facilitation techniques
• Agree to shared ground rules
• Apply group's communication principles
• Need for agreed-to data/info?
• Use consensus-building processes
Solution/Agreement-Seeking
• Does HCA have decision-making authority?
◦ If not, which state/federal partners do?
• What are the admin/leg/judicial/fed/state pathways forward?
• Reach agreements; manage conflicts
◦ document tasks, responsibilities and timelines
◦ communicate follow-through and feedback transparently
◦ broadcast results/lessons learned quickly, to improve process
• Maintain agreed-to flexibility throughout the process
• Regularly use lessons to augment training for policy-makers/elected officials
Final Workgroup Version as of 12/31/21

Attachment D

General Framework Statement Draft: What it is

The behavioral health communication framework creates a collaborative structure to help counties, BH-ASOs and the Health Care Authority to:

- *Work collaboratively and flexibly to help solve county-specific, regional and statewide (systemic) behavioral health integration issues that require teamwork.*
- *Help build and expand trusted relationships that outlast leadership, management and elected official turnover.*
- *Grow into a long-standing partnership culture that is inclusive, transparent and accountable.*
- *Change and improve behavioral health status and systems for the benefit of all Washingtonians.*

General Framework Statement Draft: What it is not

The behavioral health communication framework is not:

- *A problem-solving process (it is a communications framework that enables problem-solving)*
- *Meant to address 100% of all behavioral health problems in our state*
- *A guarantee for 100% successful resolution, or a process to always avoid conflict*
- *A means to play 'gotcha'*

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION EXECUTIVE BOARD MEETING

Providing Behavioral Health Services in
Clallam, Jefferson and Kitsap Counties

DATE: **Friday, May 27, 2022**

TIME: **9:00 AM – 11:00 AM**

LOCATION: **VIRTUAL ONLY:** **We will use the ZOOM virtual platform.**

Recommend participation by either computer or ZOOM app on your mobile phone. Please use this link to download ZOOM to your computer or phone: https://zoom.us/support/download.

LINK TO JOIN BY COMPUTER OR PHONE APP:

Join Zoom Meeting:
https://us06web.zoom.us/j/81341751167?pwd=VVhsSkQ0Q0V0UnRmRDI4dStHZ3d6Zz09

Meeting ID: 813 4175 1167

Passcode: 592067

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

Dial by your location: 1-253-215-8782

Meeting ID: 813 4175 1167

Passcode: 592067

AGENDA

Salish Behavioral Health Administrative Services Organization – Executive Board

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of SBH-ASO Executive Board Minutes for March 18, 2022 (Attachment 5)
6. Action Items
   a. Advisory Board Recommendations Regarding R.E.A.L Program RFP
   b. Advisory Board Recommendations Regarding Co-Responder RFP
7. Informational Items
   a. 9-8-8 and HB1477 Update
   b. Youth Mobile Crisis Team RFP Update
   c. New Programs Update (Attachment 7.c)
   d. Behavioral Health Advisory Board (BHAB) Update
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHAB	Behavioral Health Advisory Board
BH-ASO	Behavioral Health Administrative Services Organization
CAP	Corrective Action Plan
CMS	Center for Medicaid & Medicare Services (federal)
COVID-19	Coronavirus Disease 2019
CPC	Certified Peer Counselor
CRIS	Crisis Response Improvement Strategy
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DCR	Designated Crisis Responder
DDA	Developmental Disabilities Administration
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
FIMC	Full Integration of Medicaid Services
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
MAT	Medical Assisted Treatment
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OPT	Opiate Treatment Program
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QUIC	Quality Improvement Committee
RCW	Revised Code Washington
R.E.A.L.	Recovery, Empowerment, Advocacy, Linkage
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SABG	Substance Abuse Block Grant
SAPT	Substance Abuse Prevention Treatment
SBH-ASO	Salish Behavioral Health Administrative Services Organization
SUD	Substance Use Disorder
TAM	Technical Assistance Monitoring
UM	Utilization Management
VOA	Volunteers of America
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Full listing of definitions and acronyms

Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

Friday, May 27, 2022

Action Items

A. ADVISORY BOARD RECOMMENDATIONS REGARDING R.E.A.L PROGRAM RFP

SBH-ASO named its Recovery Navigator Program the R.E.A.L Program. This program provides community-based teams to respond to referrals from law enforcement, first responders, and community members to support individuals with substance use or co-occurring needs. The priority population includes individuals who have had challenges being successful in traditional treatment settings and have had contact with the legal/justice system. This program is staffed by individuals with lived experience to engage individuals in need.

The RFP for Years 2 and 3 of R.E.A.L. Program funding was released on March 8th and closed on April 14, 2022. The R.E.A.L. Program RFP review was completed by the SBH-ASO Advisory Board Committee on May 6th.

Based upon available funding, population, and regional geography, the maximum number of R.E.A.L Teams per county was established as follows: Kitsap County (2), Jefferson (1) and Clallam (2).

The Committee reviewed eight proposals. All proposers attended interviews and were able to present their experience with peer programs and vision for this program to the Committee. There were two (2) proposals from Kitsap County, two (2) proposals from Jefferson County, and four (4) proposals from Clallam County. After significant deliberation, the Committee was able to agree on recommendations to move forward.

The Committee recommends the following agencies for the contract period July 1, 2022 - June 30, 2024:

- Clallam County: Peninsula Behavioral Health and Reflections Counseling Services Group
- Jefferson County: Discovery Behavioral Health
- Kitsap County: Agape Unlimited and West Sound Treatment Services

B. ADVISORY BOARD RECOMMENDATIONS REGARDING CO-RESPONDER RFP

Behavioral Health Co-Responder funding provides for a single team, a licensed mental health professional paired with law enforcement officer or first responder (Fire/EMS), to respond to behavioral health emergencies within the community. The RFP released March 18th, closed April 21st, and provides for a single year of funding, July 1, 2022- June 30, 2023.

There was one response received. The Advisory Board Committee reviewed the proposal and recommended contracting with Poulsbo Fire Department.

Informational Items

A. 9-8-8 AND HB1477 UPDATE

In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 which changes the National Suicide Prevention Lifeline (NSPL) hotline and Veteran's Crisis Line numbers from 800-numbers to the 3-digit number, 9-8-8. This national change will go fully into effect on July 16, 2022.

In 2021, the Washington State Legislature passed HB1477. In addition to Washingtonians being able to utilize the 3-digit number when wishing to reach the National Suicide Prevention Lifeline (NSPL), HB1477 directed significant changes to and expansion of the behavioral health crisis response system.

HB1477 established the Crisis Response Improvement Strategy (CRIS) Committee and CRIS Steering Committee. Staff will provide a high-level summary of the on-going work of the CRIS Committee related to Washington State Crisis System Redesign.

B. YOUTH MOBILE CRISIS TEAM RFP UPDATE

As noted during the March Executive Board Meeting, SBH-ASO terminated its procurement of the Youth Mobile Crisis Outreach Team in late January following new information being shared by the HCA on their development of a new program model.

SBH-ASO continues to collaborate with HCA regarding their development of the model for Youth Mobile Crisis Outreach Teams. Staff will update the Board on the nature of on-going conversations with HCA and anticipated timelines for releasing a revised RFP.

C. NEW PROGRAMS UPDATE

Expansion of Assisted Outpatient Treatment

In 2022, the Legislature passed SHB1773 which directed the expansion of existing RCW regarding Assisted Outpatient Treatment. This bill also directed BH-ASOs to employ an "Assisted Outpatient Treatment Program Coordinator" to oversee system coordination. SBH-ASO's July 2022 Revenue Amendment with HCA will include additional funding to support the addition of this staff.

Youth Inpatient Navigator Team

The Fiscal Year 2023 Budget, passed by the legislature, included funding to expand upon a pilot program called "Youth Inpatient Navigator" which currently has only been operating in one Regional Service Area.

The purpose of this new program is to develop a regional multidisciplinary team designed to improve access to and coordination of services for children and youth experiencing behavioral health crises. Youth boarding in emergency departments secondary to lack of placement are the priority focus of the multidisciplinary team.

The budget proviso directs that every Regional Service Area have a one of these multidisciplinary teams. The HCA outreached ASOs and requested that three (3) regions volunteer for the coming fiscal year, as this program will be phased in across the state over the next three fiscal years. SBH-ASO volunteered to join the first year of expansion as this would allow for increased influence on implementation and increased technical assistance. Draft contract language is attached. Staff is evaluating whether this program should be subcontracted or managed internally.

D. BEHAVIORAL HEALTH ADVISORY BOARD UPDATE

Lois Hoell, Chair, will provide an update on the Advisory Board's activities.

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

Friday, March 18, 2022
9:00 a.m. - 11:00 a.m.
VIRTUAL ONLY: ZOOM Virtual Platform

CALL TO ORDER – Commissioner Greg Brotherton, Chair, called the meeting to order at 9:03 a.m.

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – None.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS –

Kimberly Hendrickson noted submission of a public statement to the SBH-ASO prior to today's meeting regarding preparations for 9-8-8 and future collaboration. Kimberly urged commissioners to make local preparations for 9-8-8, noting that the work being done by the CRIS is moving slowly, but the 9-8-8 rollout will be rapid. The city of Poulsbo would like to work more collaboratively with KMHS and SBH-ASO when communities' expectations change after 9-8-8 is implemented this Summer.

APPROVAL of AGENDA – Commissioner Brotherton

Briefly discussed amendment of the 3/18/2022 meeting agenda to include the Executive Session as informational item 7.h.

MOTION: Tribal Representative Theresa Lehmann moved to approve the agenda as amended. Commissioner Gelder seconded the motion. Motion carried unanimously.

APPROVAL of MINUTES –

Commissioner Brotherton noted an error in the January 21, 2022 minutes. House Bill 1591 was listed in the minutes as 5091. A correction will be made accordingly.

MOTION: Commissioner Gelder moved to approve the meeting notes as amended for the January 21, 2022 meeting. Commissioner Ozias seconded the motion. Motion carried unanimously.

ACTION ITEMS

- **REVIEW AND APPROVAL OF SBH-ASO POLICIES AND PROCEDURES**

HCA/BHASO Contractual changes, HCA TEAMonitor Review recommendations, and overall SBH-ASO growth and process improvements, necessitated Policy and Procedure updates. A spreadsheet has been included which summarizes the changes made to these Policies and Procedures.

The following policies have been included for the Board's approval:

CL200 Integrated Crisis System
CL201 Ensuring Care Coordination for Individuals
CL202 Involuntary Treatment Act Services
CL203 Levels of Care

CL205	Monitoring of Conditional Release, Less Restrictive and Assisted Outpatient Treatment Orders
CL206	State Hospital Care Coordination
CL209	SBH-ASO Recovery Navigator Program
CL210	SBH-ASO Behavioral Health Housing
CL211	Criminal Justice Treatment Account Funded Therapeutic Court Incentives
FI503	Out-of-Network Non-Medicaid Billing
QM702	Ombuds Services
UM801	Utilization Management Requirements

SBH-ASO Staff provided an overview of attachments 6.a.1, 6.a.2, and 6.a.3, which contain twelve new and revised Policies and Procedures for Board review and approval. Policy updates were prompted by contract amendments put forth by the Health Care Authority.

Inquiry regarding redundancy in policy language related to Involuntary Treatment contained in UM801. SBH-ASO Staff responded that policy and procedure language intentionally mirrors contract language.

Discussion of both ease and challenges in drafting new policies. SBH-ASO staff noted challenges with writing the Recovery Navigator Policy related to balancing required language from the uniform program standards with language that aligns with cultural norms in the region. SBH-ASO aimed to keep policy language general as a Policy Coordinating Group led by community leadership will shape program policies going forward.

Inquiry about how HARPS (Housing and Recovery through Peer Services) and CBRA (Community Behavioral health Rental Assistance) are utilized in the communities as rental assistance. SBH-ASO Staff reviewed how the SBH-ASO Behavioral Health Housing Program, which encompasses both HARPS and CBRA, is administered in each county via Coordinated Entry.

MOTION: Tribal Representative Theresa Lehmann moved to approve all policy changes as presented in the Review and Approval of SBH-ASO Policies and Procedures. Commissioner Ozias seconded the motion. Motion carried unanimously.

INFORMATIONAL ITEMS

➢ UPDATE ON STATUS OF RFPS

Youth Mobile Crisis Team

During the December 2021 Executive Board Meeting, staff briefed the Board on the new Youth Mobile Crisis Outreach funding that was added to SBH-ASO's revenue contract, effective 11/1/21. The briefing included a summary of SBH-ASO's plan to release an RFP in January 2022 for a Kitsap County Youth Mobile Crisis Outreach Team and to add funding to Clallam and Jefferson County crisis agencies to enhance their youth focused crisis services.

SBH-ASO released the Youth Mobile Crisis Outreach Team RFP on January 14, 2022. During the HCA/ASO Leadership Meeting on January 27th, HCA shared that they were in the early phases of developing the statewide model for youth mobile crisis outreach teams. The information HCA shared regarding several of the desired core elements of this model are notably different from the current scope of the crisis system under Integrated Managed Care. SBH-ASO

opted to terminate the procurement process until additional information about the HCA's new model is available to be evaluated.

Discussion of the youth mobile crisis team model outlined by the HCA in January 2022 and how it differs from the current scope under Integrated Managed Care (IMC). Changes would include the ASO providing services to Medicaid members currently served by the MCOs. The model proposed by the HCA does not align with the current structure outlined by the legislation during the development of IMC. Additionally, the length of engagement and follow-up after treatment outlined by the HCA model exceeds the current norm of 7-14 days.

<u>Recovery Navigator/R.E.A.L. Program</u>

The RFP for Years 2 and 3 of R.E.A.L. Program funding was released on March 8th and will close on April 14, 2022. An Advisory Board RFP Review Sub-committee has been formed and their recommendations will be presented to the Executive Board during the May 27th Board Meeting.

Inquiry as to whether there have been any updates to contract language for years 2 and 3 to bring it closer to legislative intent. Staff shared that there have not been any significant changes in contract language. The HCA has clarified that services provided by the Regional Navigator Program are support services and not treatment services, and thus do not have the same regulations. This distinction is reflected in the subcontracting requirements outlined in the current RFP.

<u>Behavioral Health Co-Responder</u>

Behavioral Health Co-Responder funding provides for a single team, a licensed mental health professional paired with law enforcement officer or first responder (Fire/EMS), to respond to behavioral health emergencies within the community. The RFP is scheduled for release by March 18th and provides for a single year of funding, July 1, 2022- June 30, 2023.

Eligible applicants include law enforcement and first responder agencies operating within Clallam, Jefferson and/or Kitsap Counties.

Inquiry regarding anticipated responses from all three counties. Due to the limited contract period and funding amount, it is difficult to estimate agency interest across all three counties. Discussion of potential for agencies that already have a co-response to leverage this funding opportunity to expand existing programs.

The Co-Responder RFP closes on April 21st. The RFP was sent to all jurisdictions including tribal law enforcement.

Expression of appreciation to Lois Hoell and the Advisory Board for supporting these RFPs.

- **<u>BRIEFING FROM COMISSIONER OZIAS ON RUCKELSHAUS WORKGROUP</u>**

Commissioner Ozias will brief the Board on the progress made by the Washington Behavioral Health Communication Framework Workgroup or "Ruckelshaus Workgroup". The December 2021 Project Summary and Recommendations Report has been attached. Attachment C, which is the third to last page in the report, is a visual of the communication framework.

Commissioner Ozias provided an overview of the Ruckelshaus workgroup, comprised of county commissioners from across the state and high-level administrative staff from the Healthcare Authority and a BH-ASO Representative. The goal of the workgroup is to develop the framework for a more formal way to communicate and problem solve across agencies.

Commission Ozias reviewed Attachment C and provided examples of potential Regional or Systemic challenges that could work through the flowchart.

- **SBH-ASO STAFFING UPDATE**

Per the directive in SB 5476 and the additional Recovery Navigator Administrator Funding from HCA, SBH-ASO began recruitment for an additional Care Manager/Program Supervisor in September 2021. SBH-ASO is excited to welcome Melinda Garcia to the team. Melinda started with SBH-ASO on February 28, 2022.

Another staffing change at SBH-ASO includes the resignation of Care Manager, Martiann Lewis. After 5 years of dedicated service, Martiann will be departing SBH-ASO in mid-April.

This departure prompted an evaluation of current SBH-ASO Team credentials and expertise. SBH-ASO must hire a licensed mental health professional, as the 2 remaining Care Managers are substance use disorder professionals. It is also preferrable to add a team member with children's program experience. SBH-ASO is currently recruiting for a Children's Care Manager and Systems Coordinator.

Gratitude expressed for Martiann's service at the Salish BH-ASO.

Question regarding opportunity to train existing staff to meet credentialing requirements. Currently the SBH-ASO needs to recruit a Licensed Mental Health Professional due to clinical and utilization management contract requirements. Currently, there are no existing staff members that would satisfy this requirement.

Discussion about the delay in rollout of the Youth Mobile Crisis Program RFP providing an opportunity for a new staff member with children's programming background to support the creation of that program.

- **EVALUATING SBH-ASO INFRASTRUCTURE IMPROVEMENTS**

SBH-ASO's operating budget is comprised of administrative funding provided in HCA, MCO and Department of Commerce contracts. SBH-ASO's core contract with HCA allows SBH-ASO to retain 10% of all funds paid for administrative costs. During the period of time which SBH-ASO is administering COVID Enhanced Block Grant (2021-2023) and ARPA Block Grant funds (anticipated 2023-2025), SBH-ASO will have greater operational funding available.

Since this additional funding is time limited, staff is evaluating opportunities to invest in its infrastructure to increase efficiencies, rather than adding staff FTEs. Specific areas of focus include SBH-ASO's data system and utilization management technologies.

- **HB1477 (9-8-8) IMPLEMENTATION: CRIS COMMITTEE UPDATE**

In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 which changes the national suicide prevention hotline number and Veteran's crisis line number from 1-

800-273-8255, to 9-8-8. This change will go fully into effect on July 16, 2022. Legislation passed by Congress permits states to add a tax to telecom bills to pay for expected increase in call volume associated with the change to 9-8-8. 9-8-8 calls can only be routed to call centers accredited by the National Suicide Prevention Lifeline (NSPL).

In Washington, HB1477 (2021) was, in part, a legislative response to federal legislation. This allows anyone in Washington to utilize 9-8-8 when wishing to reach a suicide prevention line. HB1477 (2021) directs significant changes to and expansion of the behavioral health crisis response system. HB1477 established the Crisis Response Improvement Strategy (CRIS) Committee and CRIS Steering Committee. Two of the thirty-six CRIS Committee seats are held by BH-ASO Representatives.

The CRIS Committee and its sub-committees have been progressing quite slowly. The CRIS Committee first convened in September 2021. In December 2021, there was an "All-subcommittee Kick-off" and most subcommittees have not re-convened since this kickoff. There continue to be many questions related to the roll out of changes and the impact to the current crisis system.

In February 2022, the CRIS Steering Committee approved the formation of an Ad Hoc Workgroup to address the vision of this work. Salish is one of two BH-ASO representatives participating in this Ad-hoc Visioning Workgroup which convened for the first time on March 1, 2022.

This workgroup facilitated by Health Management Associates (HMA) was developed to assist in creating a vision statement for Crisis Response and Suicide Prevention System. Concern has been expressed by many, that a clear vision needs to be in place to be able to move the work of the CRIS committee and subcommittees forward. It is anticipated that the only change in July 2022 will be the addition of 9-8-8 as a contact number for the NSPL, and additional work towards implementation of statewide changes is pending.

Volunteers of America, Crisis Connections, and Frontier in Spokane are the three National Suicide Prevention Lifeline (NSPL) providers in Washington State. 9-8-8 response is divided by the three NSPL agencies, with Volunteers of America covering most of the state.

Update provided on the progress of the CRIS committee.

Discussion of work being done locally to align with the state-level work related to 9-8-8. Several meetings have been established related to crisis, law enforcement, and regional navigator programs and a LEAD-like coordination meeting across all three counties. SBH-ASO has been coordinating with crisis providers regularly.

HB1477 will remain a topic of discussion at future Executive Board meetings as the 9-8-8 rollout and crisis system redesign planning continues.

➢ **<u>LEGISLATIVE UPDATE</u>**

Staff will provide an update on the status of the following behavioral health related bills:

Related to Behavioral Health Workforce
- E2SSB 5884: Establishing Behavioral Health Support Specialists

Related to Law Enforcement
- SHB 1735: Modifying the Standard for Use of Force by Peace Officers

Related to Involuntary Treatment
- SHB 1773: Concerning Assisted Outpatient Treatment for Persons with

Behavioral Health Disorders 1735

Review of SHB 1735. Jurisdictions in the Salish region have expressed excitement about this legislation as a response to challenges experienced by Law Enforcement following HB 1310.

Review of SHB 1773, which expands who may file for Assisted Outpatient Treatment (AOT). Comment about how this bill addresses a huge gap locally regarding individuals who do not meet criteria or cannot be placed in treatment.

- **BHAB UPDATE**

Lois Hoell, Chair, will provide an update on behalf of the Advisory Board.

Lois Hoell was reelected as Chair of the Advisory Board. Sandy Goodwick was reelected as Vice-Chair. A lot of work has been spent reviewing RFPs. The Advisory Board is scheduled to meet on May 6th to review RFP applications and conduct interviews. The Advisory Board will provide recommendations to the Executive Board on May 27th.

PUBLIC COMMENT

G'Nell expressed sadness to see Martiann leave the SBH-ASO, noting that Martiann has provided immense help to Reflections with guidance on policies and procedures and practical use of providing services to their population. Reflections is very excited about information shared at today's meeting regarding Assisted Outpatient Treatment and is looking forward to learning more.

EXECUTIVE SESSION

Commissioner Brotherton commenced an Executive Session at 10:40 am. The Executive Session was concluded at 10:59 am.

GOOD OF THE ORDER

None.

ADJOURNMENT – Consensus for adjournment at 11am

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS
Commissioner Mark Ozias	Stephanie Lewis, SBH-ASO Administrator	Lois Hoell, SBHASO Advisory Board
Commissioner Greg Brotherton	Jolene Kron, SBH-ASO Deputy Admin/Clinical Director	Joe Roszak, KMHS
Commissioner Robert Gelder	Doug Washburn, Kitsap Human Services	Lori Fleming, Jeff Co. CHIP
Theresa Lehman, Tribal Representative	Melinda Garcia, SBH-ASO Staff	Becky Erickson, Mayor, City of Poulsbo
Celeste Schoenthaler, OCH Executive Director	Nicole Oberg, SBH-ASO Staff	Kimberly Hendrickson, City of Poulsbo

None Excused.	Glenn Lippman, SBH-ASO Medical Director	Kate Ingman, CHPW
		G'Nell Ashley, Reflections Counseling Group

NOTE: These meeting notes are not verbatim.

Schedule J, Youth Behavioral Health Navigator
Behavioral Health Administrative Service Organizations

1. PURPOSE

To develop a regional multidisciplinary team designed to improve access to and coordination of services for children and youth experiencing behavioral health crises. Youth boarding in emergency departments secondary to lack of placement are the priority focus of the multidisciplinary team.

2. TECHNICAL SUPPORT

a. Participate in technical support as scheduled.
b. Attend the monthly learning collaborative meetings as scheduled.

3. SCOPE

a. The contractor will identify and hire program staff including:

   i. Project Manager:
      - MSW or equivalent with at least five years' experience working in pediatric behavioral health.
      - Knowledge of community and regional resources, behavioral health funding, state law, and policy related to pediatric behavioral health.
      - Experience in group facilitation required.
      - Ability to generate public reports and communications required.
      - Strong documentation skills.
      - Familiarity with data collection and management preferred.

   ii. Care Coordinator:
      - BSW or equivalent required, MSW or equivalent, preferred with at least three years working in behavioral health or social services.
      - Experience with care coordination required.
      - Experience with advocacy and outreach preferred.

   iii. Navigator:
      - BSW or equivalent with three years' experience working in behavioral health or social services.
      - Strong communication and documentation skills required.
      - Knowledge of family systems preferred.

b. Develop Community Steering Committee:

   i. Convene regional providers with representation of significant partners, to include but not limited to:
      - child welfare,
      - schools,
      - emergency management services,
      - juvenile justice,
      - emergency departments,

- behavioral health providers,
- social support providers,
- community youth and family peer organizations,
- Black Indigenous People of Color and Tribal affiliated agencies,
- services, and community supports
- Managed Care Organizations care coordinators, and
- Development Disabilities Administration case managers

ii. Develop a working agreement that defines and describes the role of the Multidisciplinary Team (MDT) participants in:
- Developing a steering committee.
- Prioritizing the needs of youth with complex presentations.
- Increasing access to community resources in support of stabilization of the youth and family.
- Developing a mission, vision, and values for the MDT.

iii. Plan for incentivizing and engagement of steering committee members and MDT members.

iv. Develop/adopt regional release of information (ROI) that all treatment entities will accept.

v. Develop and implement non-disclosure/confidentiality form for partners who will be MDT members.

vi. Build or connect to community portal where community can request multi-disciplinary team convening.

c. Identify action strategies that are a regional priority.

d. Develop a regional crisis plan with the steering committee and MDT agencies/participants.

e. Identify a backbone organization and two-year action plan.

4. INDIVIDUALS SERVED

a. Children and youth experiencing behavioral health crises and their families and with priority given to youth boarding in emergency departments or other non-treatment facilities.

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION EXECUTIVE BOARD MEETING

Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

DATE: **Friday, September 16, 2022**

TIME: **9:00 AM – 11:00 AM**

LOCATION: **VIRTUAL ONLY:** **We will use the ZOOM virtual platform.**

Recommend participation by either computer or ZOOM app on your mobile phone. Please use this link to download ZOOM to your computer or phone: https://zoom.us/support/download.

LINK TO JOIN BY COMPUTER OR PHONE APP:

Join Zoom Meeting:
https://us06web.zoom.us/j/81473992443?pwd=ZHp2dnV3czBkYVJmU3MvVWdHYzBaQT09

Meeting ID: 814 7399 2443

Passcode: 079969

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

Dial by your location: 1-253-215-8782

Meeting ID: 814 7399 2443

Passcode: 079969

AGENDA

Salish Behavioral Health Administrative Services Organization – Executive Board

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of SBH-ASO Executive Board Minutes for July 15, 2022 (Attachment 5)
6. Action Items
   a. Advisory Board Recommendations Regarding Youth Mobile Crisis RFP
7. Informational Items
   a. Briefing on R.E.A.L. Program Subcontractor
   b. 9-8-8 and HB1477 Update
   c. SBH-ASO Staffing Update
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHAB	Behavioral Health Advisory Board
BH-ASO	Behavioral Health Administrative Services Organization
CAP	Corrective Action Plan
CMS	Center for Medicaid & Medicare Services (federal)
COVID-19	Coronavirus Disease 2019
CPC	Certified Peer Counselor
CRIS	Crisis Response Improvement Strategy
DBHR	Division of Behavioral Health & Recovery
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OST	Opiate Substitution Treatment
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PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
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P&P	Policies and Procedures
QUIC	Quality Improvement Committee
RCW	Revised Code Washington
R.E.A.L.	Recovery, Empowerment, Advocacy, Linkage
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SABG	Substance Abuse Block Grant
SAPT	Substance Abuse Prevention Treatment
SBH-ASO	Salish Behavioral Health Administrative Services Organization
SUD	Substance Use Disorder
TAM	Technical Assistance Monitoring
UM	Utilization Management
VOA	Volunteers of America
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Full listing of definitions and acronyms

Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

Friday, September 16, 2022

Action Items

A. ADVISORY BOARD RECOMMENDATIONS REGARDING YOUTH MOBILE CRISIS RFP

The Youth Mobile Crisis Team RFP was released July 8, 2022. This RFP was to provide a youth specific crisis team serving Kitsap County youth 24 hours per day, 7 days per week. The required model includes crisis response by a 2-person team. The RFP closed August 9, 2022. A single proposal was received.

The SBH-ASO Behavioral Health Advisory Board Review Committee reviewed the proposal August 23rd. The proposal was submitted by Kitsap Mental Health Services and met all requirements set forth in the RFP. The SBH-ASO BHAB Review Committee unanimously voted to forward the recommendation to contract in accordance with the submitted proposal.

Staff seeks Executive Board Approval of the Advisory Board's recommendations to contract with Kitsap Mental Health for a Youth Mobile Crisis Team.

Informational Items

A. BRIEFING ON R.E.A.L PROGRAM SUBCONTRACTOR

Staff will brief the Board on concerns communicated by Executive Leadership at Discovery Behavioral Health regarding their R.E.A.L Program.

B. 9-8-8 AND HB1477 UPDATE

On July 16, 2022, Washington joined the rest of the United States in using the 988-dialing code — the new three-digit number for call, text, or chat that connects

people to the **existing** National Suicide Prevention Lifeline (NSPL). People can dial 988 if they are having thoughts of suicide, mental health or substance use crises, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support. Prior to July 2022, NSPL crisis centers were accessed by calling 1-800-273-TALK (8255). This number will remain active during the transition to 988.

The addition of the 988-dialing code to reach NSPL does not change the local protocols for accessing crisis resources.

Salish Regional Crisis Resources and Protocols that Remain Unchanged

- The addition of the 988 number does **not** impact the Salish Regional Crisis Line (SRCL) providing local crisis support and connection within the Salish region.

- Please continue to call the SRCL at 888-910-0416 to request local crisis support and connection with Mobile Crisis Outreach Teams across the Salish region.

- All community members including individuals, family members, community providers, first responders, law enforcement, hospitals, etc. continue to access crisis services through the Salish Regional Crisis Line. The Regional Toll-Free Crisis Line continues to function as triage, resource and referral, and dispatch of Mobile Crisis Outreach, including Designated Crisis Responders (DCRs).

Staff will share details regarding the local impact of these recent changes, as well as statewide conversations regarding crisis system reform.

C. SBH-ASO STAFFING UPDATE

Since the July Executive Board Meeting, SBH-ASO has the following staffing and recruitment updates.

New Hire

- SBH-ASO successfully recruited a new Fiscal Analyst. Matthew Carlin starts September 12th.

Recruitment

- Care Manager/R.E.A.L. Program Supervisor has been in active recruitment since June 16th.

- Youth Behavioral Health Program Supervisor began active recruitment on September 1st. This is a new position to oversee a new program.

- Assisted Outpatient Treatment Program Supervisor will begin recruitment in late September or early October. This is a new position that was directed by legislation and has corresponding funding from HCA to support it.

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

July 15, 2022
9:00 a.m. - 11:00 a.m.
VIRTUAL ONLY: ZOOM Virtual Platform

CALL TO ORDER – Commissioner Brotherton, Chair, called the meeting to order at 9:00 a.m.

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – None.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS – None.

APPROVAL of AGENDA –

MOTION: Commissioner Gelder moved to approve the agenda as submitted. Theresa Lehman seconded the motion. <u>Motion carried unanimously.</u>

APPROVAL of MINUTES –

MOTION: Theresa Lehmann moved to approve the meeting notes as submitted for the DATE meeting. Rob Gelder seconded the motion. <u>Motion carried unanimously.</u>

ACTION ITEMS

- **<u>SBH-ASO ADVISORY BOARD APPOINTMENT OF TRIBAL REPRESENTATIVE, STORMY HOWELL</u>**

On May 23, 2022, SBH-ASO received an application, from Stormy Howell, for appointment to the SBH-ASO Behavioral Health Advisory Board. Stormy has lived in Clallam County since 2006. She is employed by the Lower Elwha Klallam Tribe as a Treatment Program Manager. Stormy also currently serves on the Olympic Community of Health (OCH) Board of Directors.

The Advisory Board unanimously approved recommending Ms. Howell be appointed to the SBH-ASO Advisory Board, as a Tribal Representative, for a term of 2 years, 08/01/2022 - 07/31/2024.

Enthusiasm expressed for Stormy's willingness to volunteer on the SBH-ASO Advisory Board. Salish Staff noted that Stormy has been very engaged in SBH-ASO Integrated Providers meetings and is very informed about behavioral health across our region.

MOTION: Theresa Lehmann moved to approve the appointment of Stormy Howell to the SBH-ASO Advisory Board as a Tribal Representative. Rob Gelder seconded the motion. <u>Motion carried unanimously.</u>

INFORMATIONAL ITEMS

- **<u>YOUTH MOBILE CRISIS TEAM RFP UPDATE</u>**

As noted during the March Executive Board Meeting, SBH-ASO terminated its procurement of the Youth Mobile Crisis Outreach Team in late January following new information being shared by the

HCA on their development of a new program model.

SBH-ASO staff continued to seek additional programmatic and finance details from HCA to allow for procurement to resume. On June 23rd, HCA facilitated a meeting that addressed programmatic and finance concerns with BH-ASOs and MCOs. HCA informed BH-ASOs that many of the desired program elements were not actually included in the funding model for this new program. With this information, SBH-ASO staff was able to proceed with making necessary edits to the prior RFP and prepare its release for July 8th. Staff will share more information about the timeline for this new program.

Salish Staff presented a timeline of the procurement process for the Youth Mobile Crisis Team RFP. The proposal deadline is August 9th, 2022 at 3pm. Advisory Board RFP review committee recommendations will be presented to the Executive Board at the September 16th meeting.

Inquiry regarding the number of teams outlined in the RFP. Recent changes directed by the HCA require that 11 FTEs be dedicated to a team. The increase in dedicated FTEs requires that funding from the HCA for this program, along with some Medicaid funds, be allocated to a single team in Kitsap County. Salish Staff have raised concerns to the HCA regarding how the current approach will broaden the gap in resources between urban and rural communities in the Salish Region.

- **SBH-ASO STAFFING UPDATE**

Since the May Executive Board Meeting, SBH-ASO has experience some notable staffing changes.

- SBH-ASO successfully recruited a new Children's Care Manager, a position that was open following Martiann Lewis' departure. Amy Browning, Children's Care Manager, started on June 13th.
- Melinda Garcia, Care Manager and R.E.A.L. Program Administrator, resigned on June 13th. Her resignation was effective immediately.
- Melissa Russell, Fiscal Analyst, submitted her resignation. Her last day is July 15th.

Both Care Manager and Fiscal Analyst positions are posted for active recruitment. Jolene Kron, Deputy Administrator/Clinical Director, is assuming the responsibilities of the R.E.A.L. Program Administrator, and Stephanie Lewis, Administrator, is assuming the fiscal analyst responsibilities.

SBH-ASO will be conducting interviews at the end of July for both Care Manager and Fiscal Analyst positions.

Discussion regarding retention challenges. SBH-ASO has taken advantage of the resolution passed in April allowing for recruitment and retention incentives, noting that the resolution has helped ease some workforce challenges.

Gratitude expressed to Stephanie and Jolene for the additional work they have taken on.

- **BEHAVIORAL HEALTH ADVISORY BOARD UPDATE**

Stephanie Lewis provided an update on Advisory Board activities on behalf of Lois Hoell. The Advisory Board supported and provided feedback to formulate the Community Needs Survey released in May. In August, the Advisory Board will be discussing priorities for calendar years 2023 and 2024, informed by data collected from the Community Needs Survey. Those priorities

will be brought to the Executive Board in September.

PUBLIC COMMENT

- Helen Havens with SBH-ASO Advisory Board expressed gratitude to Stephanie and Jolene for their hard work amid staffing challenges.

GOOD OF THE ORDER

- Commissioner Gelder recommended holding an in-person Executive Board meeting in 2023. Discussion about planning a meeting to be held in an outdoor space, keeping in mind fluctuating COVID case rates and associated guidelines. Commissioner Brotherton will coordinate with Stephanie to create a plan to support an in-person meeting for board consideration.
- Recognition and gratitude expressed to Lori Fleming for her contributions to CHIP.

ADJOURNMENT – Consensus for adjournment at 10:27 a.m.

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS
Commissioner Greg Brotherton	Stephanie Lewis, SBH-ASO Administrator	Monica Bernard, Kitsap Mental Health Services
Commissioner Robert Gelder	Jolene Kron, SBH-ASO Deputy Admin/Clinical Director	Connie Mom-Ching, Community Health Plan of Washington
Theresa Lehman, Tribal Representative	Amy Browning, SBH-ASO Children's Care Manager	G'Nell Ashley, Reflections Counseling Services Group
Excused: Commissioner Mark Ozias	Nicole Oberg, SBH-ASO Program Specialist	Lori Fleming, Jeff Co. CHIP
		Helen Havens, SBH-ASO Advisory Board

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Providing Behavioral Health Services in
Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD MEETING

DATE: **Friday, July 15, 2022**

TIME: **9:00 AM – 11:00 AM**

LOCATION: **VIRTUAL ONLY:** **We will use the ZOOM virtual platform.**

Recommend participation by either computer or ZOOM app on your mobile phone. Please use this link to download ZOOM to your computer or phone: https://zoom.us/support/download.

LINK TO JOIN BY COMPUTER OR PHONE APP:

Join Zoom Meeting:
https://us06web.zoom.us/j/83717622551?pwd=YlpwQUsxVWJYYjJjR1BLOHBTVEJIUT09

Meeting ID: 837 1762 2551

Passcode: 467620

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

Dial by your location: 1-253-215-8782

Meeting ID: 837 1762 2551

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7. Informational Items
    a. Youth Mobile Crisis Team RFP Update
    b. SBH-ASO Staffing Update
    c. Behavioral Health Advisory Board (BHAB) Update
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Adjournment

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Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

Friday, July 15, 2022

Action Items

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C. BEHAVIORAL HEALTH ADVISORY BOARD UPDATE

Lois Hoell, Chair, will provide an update on the Advisory Board's activities.

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

May 27, 2022
9:00 a.m. - 11:00 a.m.
VIRTUAL ONLY: ZOOM Virtual Platform

CALL TO ORDER – Commissioner Greg Brotherton, Chair, called the meeting to order at 9:03 a.m.

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – None.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS –

Stephanie Lewis read written public comment submissions which related to Agenda Item 6.a.. Those comments are included at the end of the minutes.

APPROVAL of AGENDA – Commissioner Mark Ozias

> **MOTION: Commissioner Ozias moved to approve the agenda as presented. Tribal Representative Theresa Lehman seconded the motion. Motion carried unanimously.**

APPROVAL of MINUTES –

> **MOTION: Tribal Representative Theresa Lehman moved to approve the meeting notes as submitted for the March 18, 2022 meeting. Commissioner Gelder seconded the motion. Motion carried unanimously.**

ACTION ITEMS

- **ADVISORY BOARD RECOMMENDATIONS REGARDING R.E.A.L. PROGRAM RFP**

SBH-ASO named its Recovery Navigator Program the R.E.A.L Program. This program provides community-based teams to respond to referrals from law enforcement, first responders, and community members to support individuals with substance use or co-occurring needs. The priority population includes individuals who have had challenges being successful in traditional treatment settings and have had contact with the legal/justice system. This program is staffed by individuals with lived experience to engage individuals in need.

The RFP for Years 2 and 3 of R.E.A.L. Program funding was released on March 8th and closed on April 14, 2022. The R.E.A.L. Program RFP review was completed by the SBH-ASO Advisory Board Committee on May 6th.

Based upon available funding, population, and regional geography, the maximum number of R.E.A.L Teams per county was established as follows: Kitsap County (2), Jefferson (1) and Clallam (2).

The Committee reviewed eight proposals. All proposers attended interviews and were able to present their experience with peer programs and vision for this program to the Committee. There were two (2) proposals from Kitsap County, two (2) proposals from Jefferson County, and four (4)

proposals from Clallam County. After significant deliberation, the Committee was able to agree on recommendations to move forward.

The Committee recommends the following agencies for the contract period July 1, 2022 - June 30, 2024:

- Clallam County: Peninsula Behavioral Health and Reflections Counseling Services Group
- Jefferson County: Discovery Behavioral Health
- Kitsap County: Agape Unlimited and West Sound Treatment Services

Discussion of the RFP review process. Salish Staff noted that the RFP approval process for the R.E.A.L. Program is consistent with previous practices, with the following exceptions. The Advisory Board was involved in the development of the RFP prior to release, and the proposal review process included submitter interviews, which has not occurred previously. The Advisory Board review committee received all proposals via email and USPS for review before the review committee convened and conducted interviews. During the interview process, the same questions were asked of each presenting agency.

Anne Dean of the SBH-ASO Advisory Board provided comment regarding the RFP review process, noting that the board spent over four hours conducting interviews and discussing recommendations. All applications received were good to excellent. The recommendations for funding provided by the Advisory Board were challenging to formulate and the responsibility was not taken lightly. Anne urged residents in the region to apply to serve on the SBH-ASO Advisory Board to bring additional representation.

Inquiry about the criteria for consideration and whether any agencies were precluded based on data reporting requirements. Salish Staff responded that no agencies were excluded from consideration. The evaluation criteria as outlined in the RFP focused on program elements, fiscal proposal, and organization capacity.

Inquiry regarding whether there are tabulations available for Executive Board Review. Salish Staff will tabulate scores and provide this information. Salish Staff noted that each Advisory Board member conducted an independent review of the proposals, and interviews focused on two questions. The scores for each proposal were part of a more comprehensive, deliberative process and not the only element that influenced recommendations. Recommendations were made by consensus.

Inquiry regarding total funding amount and how five total awards was determined. Salish Staff determined that the funding for July 1, 2022 through June 2023 would be $1.9 million. This amount exceeds the amount of funding allocated for the first year, in part due to new contract requirements that require some level of service to be available 24/7. The HCA also requires a certain number of positions to exist on each team. Salish Staff evaluated how much minimum staffing would cost to fulfill this contract requirement and determined that $1.9 million could only support up to five teams.

Inquiry regarding the decision to contract for a two-year funding cycle for the R.E.A.L. Program. Salish Staff considered the amount of time and expense that goes into RFP and determined that a two-year cycle makes sense. Program stability was also strongly considered, acknowledging the challenge and cost associated with hiring and retention.

Inquiry about not selecting Believe in Recovery, noting that agency as an Indian health clinic. Question about whether Discovery Behavioral Health will be able to adequately serve the Native American population in Jefferson County. Salish Staff responded that Believe in Recovery was not identified as an

Indian Healthcare Provider or Tribal Clinic, and, noting that SBH-ASO is not aware of the cultural identity of the owner. SBH-ASO's expectation is that any Native American or American Indian Alaskan Native individual in the community can be served by any contracted agency and be provided with culturally inclusive services. Contracted agencies are expected to meet the needs of the individuals and communities they serve.

Helen Havens of the SBH-ASO Advisory Board commented that the RFP review process was very difficult and many of the presentations from new agencies were excellent. Helen noted that some programs were missing agency infrastructure that the Advisory Board looks for in their evaluation, including a lack of advisory group, lack of financial structure, or most of the work being done by a single person.

Salish Staff will provide agencies who were not approved for funding with direct feedback regarding the decision.

Appreciation and gratitude expressed to the Advisory Board for the work that went in to reviewing proposals and providing recommendations.

MOTION: Theresa Lehman moved to approve Advisory Board Committee Recommendations Regarding the R.E.A.L. Program RFP for the period of July 1, 2022 – June 30, 2024. Commissioner Gelder seconded the motion. Motion carried unanimously.

- **ADVISORY BOARD RECOMMENDATIONS REGARDING CO-RESPONDER RFP**

Behavioral Health Co-Responder funding provides for a single team, a licensed mental health professional paired with law enforcement officer or first responder (Fire/EMS), to respond to behavioral health emergencies within the community. The RFP released March 18th, closed April 21st, and provides for a single year of funding, July 1, 2022- June 30, 2023.

There was one response received. The Advisory Board Committee reviewed the proposal and recommended contracting with Poulsbo Fire Department.

Inquiry regarding rationale for only one year of funding. Salish Staff responded that this was an off-cycle addition to the SBH-ASO contract with the Health Care Authority. SBH-ASO initially prepared to release an RFP fall of 2021, but changes to the contract requirements from the HCA led SBH-ASO to pause release of the RFP and regroup.

Brief discussion of limited quantity and duration of funding.

MOTION: Commissioner Ozias moved to approve Advisory Board Recommendations Regarding the Co-Responder RFP for the period of July 1, 2022 to June 30, 2023. Commissioner Gelder seconded the motion. Motion carried unanimously.

INFORMATIONAL ITEMS

- **9-8-8 AND HB1477 UPDATE**

In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 which changes the National Suicide Prevention Lifeline (NSPL) hotline and Veteran's Crisis Line numbers from 800-numbers to the 3-digit number, 9-8-8. This national change will go fully into effect on July 16, 2022.

In 2021, the Washington State Legislature passed HB1477. In addition to Washingtonians being able to utilize the 3-digit number when wishing to reach the National Suicide Prevention Lifeline (NSPL), HB1477 directed significant changes to and expansion of the behavioral health crisis response system.

HB1477 established the Crisis Response Improvement Strategy (CRIS) Committee and CRIS Steering Committee. Staff will provide a high-level summary of the on-going work of the CRIS Committee related to Washington State Crisis System Redesign.

Salish Staff provided more information about the CRIS committee. The CRIS committee first convened in Summer 2021. Seven subcommittees were kicked off in December 2021. Following concerns about the vision of the CRIS committee, an ad-hoc visioning workgroup was formulated in February 2021. The visioning workgroup presented to the steering committee on May 20th. The only change in July 2022 is the creation of the 9-8-8 number. Additional stages of HB1477 are in review. Marketing for 9-8-8 has been minimal due to concerns that support processes have not yet been operationalized.

In Early May, Stephanie Lewis attended a trip to Arizona planned by legislators to learn about their crisis system. Staff noted that the landscape of the Washington State crisis system is extremely complex. This complexity is due in part to factors such as the Medicaid State Plan, Medicaid billing requirements, and Involuntary treatment laws and processes. It is critical that legislators and other state leaders that are guiding the crisis system redesign process understand how the complex factors are interrelated and shape crisis system operations. During the trip to Arizona, staff noted visitors interest with the ease of law enforcement drop off, without medical clearance, at crisis facilities. Staff also noted that the relationship between the State Medicaid Authority and crisis oversight agencies, like BH-ASOs, is very different in Arizona. This difference includes how Medicaid funds are directly paid from the State Medicaid Authority to crisis oversight entities, rather than through Managed Care Organizations. The involuntary treatment statute in Arizona is also very different than in Washington. The role of Designated Crisis Responder doesn't exist under Arizona's Involuntary Treatment Statute, which is called "Title 36." One concern that was noted by several visitors related to the higher reliance on law enforcement intervention to support crisis intervention, in Arizona, compared to Washington.

Jolene provided review of her involvement in the crisis system process mapping meetings. There has been some hesitancy to share information from the NSPL providers and regional crisis lines due to the complexity of answering crisis calls and the crisis system overall. No follow-up plan has been established, and the process mapping group is pending.

SBH-ASO remains involved in state-level conversations around HB1477 and changes to the crisis system. HB1477 will remain a standing item on the Executive Board agenda and will remain front and center.

- **<u>YOUTH MOBILE CRISIS TEAM RFP UPDATE</u>**

As noted during the March Executive Board Meeting, SBH-ASO terminated its procurement of the Youth Mobile Crisis Outreach Team in late January following new information being shared by the HCA on their development of a new program model.

SBH-ASO continues to collaborate with HCA regarding their development of the model for Youth Mobile Crisis Outreach Teams. Staff will update the Board on the nature of on-going conversations with HCA and anticipated timelines for releasing a revised RFP.

Inquiry regarding whether other BH-ASOs have expressed concerns or experienced roadblocks and whether such concerns have been discussed at the regional level. Salish Staff responded that other

ASOs had similar concerns regarding scope and how it fits into the current contract model. There has been some progress following conversations with HCA that have resulted in limited contract changes.

- **<u>NEW PROGRAMS UPDATE</u>**

<u>Expansion of Assisted Outpatient Treatment</u>

In 2022, the Legislature passed SHB1773 which directed the expansion of existing RCW regarding Assisted Outpatient Treatment. This bill also directed BH-ASOs to employ an "Assisted Outpatient Treatment Program Coordinator" to oversee system coordination. SBH-ASO's July 2022 Revenue Amendment with HCA will include additional funding to support the addition of this staff.

Discussion of expansion to existing RCW, including who may file assisted outpatient treatment, expansion of criteria for "in need of AOT", and length of outpatient treatment from 90 days to 18 months.

Question regarding the definition of Assisted Outpatient Treatment. AOT is treatment compelled by a court order.

<u>Youth Inpatient Navigator Team</u>

The Fiscal Year 2023 Budget, passed by the legislature, included funding to expand upon a pilot program called "Youth Inpatient Navigator" which currently has only been operating in one Regional Service Area.

The purpose of this new program is to develop a regional multidisciplinary team designed to improve access to and coordination of services for children and youth experiencing behavioral health crises. Youth boarding in emergency departments secondary to lack of placement are the priority focus of the multidisciplinary team.

The budget proviso directs that every Regional Service Area have a one of these multidisciplinary teams. The HCA outreached ASOs and requested that three (3) regions volunteer for the coming fiscal year, as this program will be phased in across the state over the next three fiscal years. SBH-ASO volunteered to join the first year of expansion as this would allow for increased influence on implementation and increased technical assistance. Draft contract language is attached. Staff is evaluating whether this program should be subcontracted or managed internally.

Inquiry regarding the scope of boarding in ERs in the Salish region. SBH-ASO does not get statistics on number of stays/days for youth in emergency rooms. We are aware of youth boarded 90 or more days in an emergency department. SBH-ASO does receive some feedback from emergency rooms at St. Michael Medical Center and St. Anthony Hospital. Typically, youth are there for a couple days awaiting placement. Clarification provided that this program does not add new resources, rather it engages a bigger team of professionals and community supports around youth.

Appreciation expressed for the ASO volunteering to be part of the first year for this program, acknowledging the SBH-ASO as leaders.

Funding added to July 2022 contract amendment.

- **<u>BEHAVIORAL HEALTH ADVISORY BOARD UPDATE</u>**

Lois Hoell, Chair, will provide an update on the Advisory Board's activities.

Jolene provided AB update on behalf of Lois Hoell. The Advisory Board has been performing a lot of work around RFPs, including increased involvement in development of the R.E.A.L. and Co-Responder Program RFPs. The Advisory board also provided review and feedback for the 2021 Regional Community Needs Survey. The survey will assist with development of priorities for 2023 and 2024.

One application was received from a regional tribal entity that will be up for review at the June 3, 2022 Advisory Board meeting.

Salish Staff urged the board and call attendees to complete and share the 2021 Regional Community Needs Survey. A link to the survey was provided in chat.

PUBLIC COMMENT

Jenny Oppelt expressed gratitude for the valuable information shared today and asked about the qualifications for serving on the SBH-ASO Advisory Board.

General qualifications include an interest in behavioral health (professional or lived experience), and two positive references. The only exclusionary criteria is that an Advisory Board member cannot be employed by any of the agencies we have contracts with nor can they sit on an advisory or executive board for any of the agencies that we fund.

A link to the application was shared in the chat.

GOOD OF THE ORDER

- None.

ADJOURNMENT – Consensus for adjournment at 10:56 a.m.

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS
Commissioner Mark Ozias	Stephanie Lewis, SBH-ASO Administrator	Anne Dean, SBH-ASO Advisory Board
Commissioner Greg Brotherton	Jolene Kron, SBH-ASO Deputy Admin/Clinical Director	Helen Havens, SBH-ASO Advisory Board
Commissioner Robert Gelder	Glenn Lippman, SBH-ASO Medical Director	Joe Roszak, KMHS
Theresa Lehman, Tribal Representative	Doug Washburn, Kitsap County Human Services	Lori Fleming, Jeff Co. CHIP
None Excused.	Sonya Miles, Kitsap County Human Services	Gabbie Caudill, Believe in Recovery
	Nicole Oberg, SBH-ASO Staff	Beth Morrison, West Sound Treatment Center
		Britania Ison, West Sound Treatment Center
		Kate Ingman, Community Health Plan of Washington

		Jenny Oppelt, Clallam County Health and Human Services

NOTE: These meeting notes are not verbatim.

Public Comments Submitted for the May 27, 2022 Salish Behavioral Health Administrative Services Organization Executive Board Meeting

Public Comment #1

I am deeply saddened that existing harm reduction outreach programs in our communities were not given the opportunity to apply for the REAL funding in the first place. Programs like ReDisCovery and Believe in Recovery were already out providing field based referral and diversion services. Why were they not even allowed to apply for the initial funding? The programs that were recommended to be awarded this time were the programs that were initially funded. Rather than funding programs that previously existed, and providing the momentum to keep those existing programs going, your recommendations were to keep the momentum going with new programs. I implore you to reconsider funding the existing recovery navigator programs in our region. Thank you

Public Comment #2

The REAL program calls for inclusivity of the BIPOC community, and yet, you pass up on a well known business in Port Townsend owned by a Native American woman. This woman has gone above and beyond to help our struggling community members, on her own dime, never judging or forcing anyone to be sober. I have seen this woman out with cops doing community outreach in the various homeless camps, at the food banks, going to court for people, really advocating for harm reduction. This woman was out there for our community when everyone else closed their doors. That woman shows up when called, whether its 2pm or 2am. That woman stood in the rain and snow handing out narcan after a drug related death. That woman owns Believe in Recovery. Just because an agency exists, doesn't mean it is reliable or cares about the community. However, Believe in Recovery does. I beg you to look at the programs you are funding and reconsider funding reliable community programs.

Public Comment #3

I am speaking up on behalf of our community members struggling with things like addiction, homelessness, and mental health. Our community needs to have REAL teams that care about the person and not the dollar. Programs like OPCC's Rediscovery should be funded to continue this work. They were existing before this grant opportunity became available, and they were not even able to apply for initial funding because they didn't have a ASO contract. They were already doing the work. It's my understanding that a similar outreach recovery navigator program already existed in Jefferson County as well. Why are they also not being funded? Why are we funding new programs instead of supporting the existing programs?

Public Comment #4

I urge you to reconsider following the advisory boards recommendation for the REAL funding. There are existing programs in our community, Jefferson County and Clallam County both had existing recovery navigator community outreach programs. These programs genuinely care about the individuals they are serving. These programs also genuinely care about their staff members. OPCC and Believe In Recovery have both built their programs up to be reliable within the Recovery community. These programs both go above and beyond helping our struggling community members. These programs have both done this with little to no recognition, And sometimes little to no compensation. We should be supporting our local agencies that are actually serving the struggling people we have.

Public Comment #5

I am Employed by one of the real teams. I have gone forward to the advisory board with my complaint, and received no help. Please reconsider funding the existing programs, because especially the one I am working for, is not run well. We are not allowed to really help the people that we are supposed to be helping. There are other agencies that can provide better services for people. Our biggest barrier is the agency that we work for. we will not be successful in this program if we remain where we are. Please reconsider.

Public Comment #6

As someone in very early recovery, again, I just want everyone to know that i am being forced to deal with an agency that has kicked me and numerous others while we were already down. dbh treated me horribly. and now i have to use them if i want "real team" help... Where is my choice? I speak for the rest of Jefferson counties homeless and drug users. we demand a choice in where we can get services. every other county has a choice. we dont. you force us to use the place that has treated us like we were "less than" while we suffered. this happened before when only safe harbor could take state insurance because of the bho. we finally got a choice when believe in recovery was allowed to take our insurance. i beg you not to go backwards. why not fund both programs so we have our choice back? you could easily split the money in jefferson county between both places. believe in recovery staff stood by me for 18 months while i struggled to get back on track. they never judged me. just supported me. please, i beg you. youre dooming us all by only funding one place. Thank you, Jenny

Public Comment #7

I would like the executive board to see and consider a tabulation and submission summary for each proposal submitted before awarding contracts. I believe the R.E.A.L. team funding should be transparent. I know that several submissions for this funding opportunity were programs that previously existed within our communities before this funding came. The initial round of funding for this program went to existing BHO contracts due to the "short turn around time" that was supposedly required. However, these new programs did not roll out quickly. There was ample time to consider funding the existing programs in our communities. However, they were denied the opportunity. It is my understanding that at least one agency was nearing the end of the contracting process during that time, and was still not eligible to apply. Our communities have grown attached to the existing community outreach programs and are now being forced into working with other agencies as the smaller ones get stepped on. I believe these funds would best be awarded to the programs that can provide the best services, and I don't think that is what is happening here today. When participants complain of programs, its one thing. But when collectively all staff of certain existing R.E.A.L teams are asking to go with other agencies, we should listen. I urge the executive board to reconsider the programs they are awarding.

Thank you, Steve

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION EXECUTIVE BOARD MEETING

Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

DATE: **Friday, December 9, 2022**

TIME: **9:00 AM – 11:00 AM**

LOCATION: **Port Blakely Conference Room, Kitsap County Administration Building**
619 Division Ave, Port Orchard, WA 98366

LINK TO JOIN BY COMPUTER OR PHONE APP:

Please use this link to download ZOOM to your computer or phone: https://zoom.us/support/download.

Join Zoom Meeting:
https://us06web.zoom.us/j/86425667740?pwd=OVZ0T1ZYcWJQKzJUOGV3NU5lZUNCdz09

Meeting ID: 864 2566 7740

Passcode: 079992

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

Dial by your location: 1-253-215-8782

Meeting ID: 864 2566 7740

Passcode: 079992

AGENDA

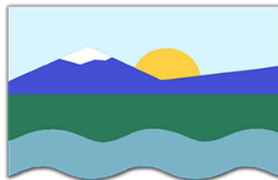
Salish Behavioral Health Administrative Services Organization – Executive Board

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of SBH-ASO Executive Board Minutes for September 16, 2022 (Attachment 5)
6. Action Items
   a. Approval of Amended Advisory Board By-Laws (Attachment 6.a)
   b. Reappointment of Helen Havens to Advisory Board
   c. Approval of Calendar Year 2023 SBH-ASO Budget (Attachments 6.c.1, 6.c.2, and 6.c.3)
   d. Approval of Interlocal Agreement for Opioid Settlement Funds (Attachment 6.d)
7. Informational Items
   a. 2023 SBH-ASO Executive Board Meetings
   b. SBH-ASO Staffing Update and Organizational Chart (Attachment 7.b)
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHAB	Behavioral Health Advisory Board
BH-ASO	Behavioral Health Administrative Services Organization
CAP	Corrective Action Plan
CMS	Center for Medicaid & Medicare Services (federal)
COVID-19	Coronavirus Disease 2019
CPC	Certified Peer Counselor
CRIS	Crisis Response Improvement Strategy
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DCR	Designated Crisis Responder
DDA	Developmental Disabilities Administration
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
FIMC	Full Integration of Medicaid Services
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
MAT	Medical Assisted Treatment
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OPT	Opiate Treatment Program
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QUIC	Quality Improvement Committee
RCW	Revised Code Washington
R.E.A.L.	Recovery, Empowerment, Advocacy, Linkage
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SABG	Substance Abuse Block Grant
SAPT	Substance Abuse Prevention Treatment
SBH-ASO	Salish Behavioral Health Administrative Services Organization
SUD	Substance Use Disorder
TAM	Technical Assistance Monitoring
UM	Utilization Management
VOA	Volunteers of America
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Full listing of definitions and acronyms



Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

Friday, December 9, 2022

Action Items

A. APPROVAL OF AMENDED ADVISORY BOARD BY-LAWS

Staff is seeking the Executive Board's approval of the attached amended Advisory Board By-Laws. The Advisory Board reviewed the proposed revisions and recommended that the Executive Board approve the changes. The proposed changes can be found in the "Membership Appointment" section of the By-laws, bottom of page 1, Section 3.a.(2).

With the Executive Board's approval, the underlined sentence below would be added to the Advisory Board By-laws, effective immediately.

> To ensure continuity, the initial Advisory Board will be made up of six members appointed for one-year terms; three members will serve two-year terms and two members will serve three-year terms. Subsequent terms for reappointment shall be three-year terms. Individuals appointed to fill vacancies shall serve the remainder of the term.

B. REAPPOINTMENT OF HELEN HAVENS TO ADVISORY BOARD

Helen Havens' current term on the Salish BH-ASO Advisory Board expired November 30, 2022. She has expressed interest in continuing to serve and the Advisory Board unanimously recommended that the Executive Board re-appoint her to serve another term. Helen also currently serves on Kitsap County's "Mental Health, Chemical Dependency and therapeutic Court Community Advisory Board" as an SBH-ASO Representative. Staff requests that the Executive Board reappoint Helen Havens to the SBH-ASO Advisory Board. If the requested action related to amending the Advisory By-Laws is approved, then the term for Helen Havens' reappointment would be December 1, 2022 – November 30, 2025.

C. APPROVAL OF CALENDAR YEAR 2023 SBH-ASO BUDGET

Non-Medicaid Budget

A summary of anticipated calendar year 2023 non-Medicaid revenue is attached for the Board's review. This includes estimated American Rescue Plan Act (ARPA) Block Grant Funds which HCA has communicated will be allocated to BH-ASOs in July 2023. Thirty percent of estimated ARPA Block Grant revenue has been included in the 2023 budget, with the remaining 70% for inclusion in the 2024 budget.

A summary of anticipated calendar year 2023 non-Medicaid expenditures is attached for the Board's review. Staff will review these documents in detail.

Medicaid Budget

A summary of anticipated calendar year 2023 Medicaid Revenue and Expenditures is attached for the Board's review. Staff will review this document in detail.

D. APPROVAL OF INTERLOCAL AGREEMENT FOR OPIOID SETTLEMENT FUNDS

The attached Interlocal Agreement has been signed by Clallam, Jefferson and Kitsap Counties. The last action required to fully execute the ILA is signature of the SBH-ASO Chair, on behalf of the organization. Staff will provide an update on the information available about the release of these settlement funds.

Informational Items

A. 2023 SBH-ASO EXECUTIVE BOARD MEETINGS

Staff is planning for 2023 Executive Board Meetings to be held in a hybrid format. Staff will provide an update on information gathered regarding options for physical meeting location.

SBH-ASO Executive Board Meetings in calendar year 2023 are tentatively planned for the 3rd Friday of the month from 9am-11am in the months of January, March, May, July and September. The last meeting in 2023, will be scheduled on either December 8th or 15th, depending upon Board preference.

Once this plan is confirmed by the Board, staff will send out calendar invitations to secure the dates.

B. SBH-ASO STAFFING UPDATE AND ORGANIZATIONAL CHART

Since the September Executive Board Meeting, SBH-ASO has the following staffing and recruitment updates.

New Hire

- SBH-ASO successfully recruited a supervisor for the new Youth Behavioral Health Navigator Program. Bryan Gross started on November 21st.

Recruitment

- Care Manager/R.E.A.L. Program Supervisor has been in active recruitment since June 16th. Staff revisited minimum qualifications in October and removed the requirement for licensure.
- Two Youth Behavioral Health Navigator Program Coordinators began recruitment on November 18th. These are bachelors level positions that will report to our newly hired program supervisor.
- Crisis Programs Supervisor will begin recruitment in the first week of January. The Crisis Programs Supervisor will also manage the expansion of Assisted Outpatient Treatment, which was legislatively directed earlier this year.

An updated organizational chart has been included for the Board's reference.

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

September 16, 2022
9:00 a.m. - 11:00 a.m.
VIRTUAL ONLY: ZOOM Virtual Platform

CALL TO ORDER – Commissioner Greg Brotherton, Chair, called the meeting to order at 9:00 a.m.

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – None.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS – None.

APPROVAL of AGENDA –

MOTION: Commissioner Gelder moved to approve the agenda as submitted. Commissioner Ozias seconded the motion. <u>Motion carried unanimously.</u>

APPROVAL of MINUTES –

MOTION: Commissioner Gelder moved to approve the meeting notes as submitted for the July 15, 2022 meeting. Tribal Representative Theresa Lehmann seconded the motion. <u>Motion carried unanimously.</u>

ACTION ITEMS

- **<u>ADVISORY BOARD RECOMMENDATIONS REGARDING YOUTH MOBILE CRISIS RFP</u>**

The Youth Mobile Crisis Team RFP was released July 8, 2022. This RFP was to provide a youth specific crisis team serving Kitsap County youth 24 hours per day, 7 days per week. The required model includes crisis response by a 2-person team. The RFP closed August 9, 2022. A single proposal was received.

The SBH-ASO Behavioral Health Advisory Board Review Committee reviewed the proposal August 23rd. The proposal was submitted by Kitsap Mental Health Services and met all requirements set forth in the RFP. The SBH-ASO BHAB Review Committee unanimously voted to forward the recommendation to contract in accordance with the submitted proposal.

Staff seeks Executive Board Approval of the Advisory Board's recommendations to contract with Kitsap Mental Health for a Youth Mobile Crisis Team.

MOTION: Tribal Representative Theresa Lehmann moved to approve Advisory Board recommendations regarding Youth Mobile Crisis RFP. Commissioner Ozias seconded the motion. <u>Motion carried unanimously.</u>

INFORMATIONAL ITEMS

- **<u>BRIEFING ON R.E.A.L PROGRAM SUBCONTRACTOR</u>**

Staff will brief the Board on concerns communicated by Executive Leadership at Discovery

Behavioral Health regarding their R.E.A.L Program.

SBH-ASO Staff provided an overview of an incident involving a R.E.A.L. Program employee at Discovery Behavioral Health as follows:

- *DBH R.E.A.L. Project Manager held and dispensed fentanyl to a long-time friend with the intention of assisting the individual with detox.*
- *R.E.A.L. Program subordinate staff became aware of the situation and reported the situation to leadership.*
- *The Project Manager's employment was terminated immediately and DBH Leadership reported the situation to the Department of Health and SBH-ASO.*

An investigation was performed by SBH-ASO which determined that DBH Leadership responded in a timely manner to address the situation and made appropriate reports.

Discussion regarding an email sent by community member Lisa C on August 17, 2022 to Salish Staff and multiple community entities. This email outlined specific concerns regarding DBH's R.E.A.L. staff conduct. DBH Executive Director and SBH-ASO Administrator have reached out to Lisa regarding her concerns.

Inquiry about implementing future safeguards as well as any impact on current R.E.A.L. program operations resulting from this incident. The R.E.A.L. team at DBH has experienced minimal disruption and continues to provide services efficiently. An existing R.E.A.L. staff member has stepped into the role of Project Manager and is doing well.

Lisa C provided public comment regarding the situation at DBH and her August 17, 2022 email. She expressed dissatisfaction with the response from DBH leadership following her email. She advocated for a full investigation of the situation, expressing concern that more than one family may have been impacted by the staff member's conduct.

SBH-ASO Leadership will outreach to Lisa C again and offer another opportunity for a meeting where she can share her concerns.

➢ 9-8-8 AND HB1477 UPDATE

On July 16, 2022, Washington joined the rest of the United States in using the 988-dialing code — the new three-digit number for call, text, or chat that connects people to the **existing** National Suicide Prevention Lifeline (NSPL). People can dial 988 if they are having thoughts of suicide, mental health or substance use crises, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support. Prior to July 2022, NSPL crisis centers were accessed by calling 1-800-273-TALK (8255). This number will remain active during the transition to 988.

The addition of the 988-dialing code to reach NSPL does not change the local protocols for accessing crisis resources.

Salish Regional Crisis Resources and Protocols that Remain Unchanged

- The addition of the 988 number does **not** impact the Salish Regional Crisis Line (SRCL) providing local crisis support and connection within the Salish region.

- Please continue to call the SRCL at 888-910-0416 to request local crisis support and connection with Mobile Crisis Outreach Teams across the Salish region.

- All community members including individuals, family members, community providers, first responders, law enforcement, hospitals, etc. continue to access crisis services through the Salish Regional Crisis Line. The Regional Toll-Free Crisis Line continues to function as triage, resource and referral, and dispatch of Mobile Crisis Outreach, including Designated Crisis Responders (DCRs).

Staff will share details regarding the local impact of these recent changes, as well as statewide conversations regarding crisis system reform.

Discussion about the marketing language used for 9-8-8 and potentially adding to confusion in the region. SBH-ASO is striving to leverage as many communication opportunities as possible to remind community members and agencies that the process for accessing local resources, including Mobile Crisis Outreach Teams (MCOTs), has not changed.

Inquiry about the experience of other BH-ASOs in the state regarding confusion related to 9-8-8. Other regions have expressed similar challenges, though SBH-ASO's use of VOA as their regional crisis hotline subcontractor adds a layer of complexity since VOA is also the largest 9-8-8 hub in the state.

Discussion regarding the importance of warm handoffs between 9-8-8 and regional crisis lines to ensure individuals promptly connect with local resources. Currently, individuals calling the National Suicide Prevention Lifeline (NSPL) are connected to a regional line based on the area code of their phone number, which often does not reflect their actual location. This is an issue nationally which has not yet been resolved. Discussion about the use of geolocation as a potential solution has been met with concern.

HB1477 legislation states that the long-term objective is for 9-8-8 to dispatch resources directly. This is not currently the case. Communication of these future goals may have also caused confusion in thinking they already are in place.

Dr. Lippman outlined additional challenges with the shift to 9-8-8. NSPL data for August indicates that only 84% of calls are answered, which is much lower than the Salish regional line requirement of 95%. Additionally, 9-8-8 routes calls not only by area code but also wait time, which results in callers being routed to regional lines far outside the area in which they reside.

VOA's statistics for the Salish Regional Crisis Line in August are excellent, showing that they have succeeded in balancing their regional crisis line responsibilities as well as 9-8-8.

Discussion of the path forward to resolving the challenges currently experienced with the rollout of 9-8-8. Salish Staff stressed the importance of all parties communicating and being on the same page.

SBH-ASO Staff provided information about the structure and objectives of the CRIS Committee and CRIS Steering Committee. The CRIS Steering Committee is comprised of representatives from the House and Senate, Governor's office, Department of Health, Healthcare Authority, and individuals with lived experience. The Steering Committee guides the work of the CRIS Committee. The CRIS Committee, along with its nine subcommittees, are tasked with making recommendations related to implementation of an integrated behavioral health crisis and suicide prevention system. The CRIS committee process has been moving very slowly, resulting in some workflows outside of the committee process.

Behavioral Health System elements currently evaluated for redesign include expansion of 23-hour observation units, expansion of crisis triage/stabilization facilities, and expanding the number and

structure of Mobile Crisis Outreach Teams in each region, including designated Youth Mobile Crisis Outreach Teams. Additionally, ongoing planning regarding interoperability of 9-8-8, 911, and regional crisis lines, ensuring that dispatch of any type of resources is streamlined.

The second CRIS Committee progress report – along with preliminary recommendations regarding crisis call center hubs and final recommendations related to funding of crisis response services are due to legislature 01/01/23.

The ASO Administrators group reached out to the HCA to request a meeting for HCA to describe their vision for the future state of the crisis system. ASO Administrators have also invited HCA leadership and program staff to next week's Administrators meeting to talk about roles and responsibilities between 9-8-8 and regional crisis lines.

Inquiry regarding the veterans' use of the 9-8-8 and whether they will be routed to their designated veteran's crisis line. Salish Staff responded that veterans call 9-8-8 they are presented with a menu option to be connected to the Veterans crisis line.

VOA was also awarded the contract for a tribal 9-8-8 hub in Washington State, which has not yet been established.

Discussion of the volume of calls to 9-8-8 versus the SRCL following implementation of 9-8-8. Salish has not experienced a drop in calls to the SRCL. Other regions have experienced a drop in calls to their regional crisis line number and an increase in calls to 9-8-8.

➢ **SBH-ASO STAFFING UPDATE**

Since the July Executive Board Meeting, SBH-ASO has the following staffing and recruitment updates.

New Hire

- SBH-ASO successfully recruited a new Fiscal Analyst. Matthew Carlin starts September 12th.

Recruitment

- Care Manager/R.E.A.L. Program Supervisor has been in active recruitment since June 16th.
- Youth Behavioral Health Program Supervisor began active recruitment on September 1st. This is a new position to oversee a new program.
- Assisted Outpatient Treatment Program Supervisor will begin recruitment in late September or early October. This is a new position that was directed by legislation and has corresponding funding from HCA to support it.

Recruitment of a Youth Behavioral Health Program Supervisor follows legislation directing a Youth Behavioral Health Navigator Program be operational within each region of the state. This expansion will occur in phases over the next three years. SBH-ASO volunteered to be in the first year of expansion. The Youth Behavioral Health Navigator Program will be comprised of a three-person team, include two Program Coordinators. Recruitment will occur following hire of the Program Supervisor.

Inquiry regarding SBH-ASO's recruitment experience amidst employee market changes over the past couple months. Previously SBH-ASO experienced a broad pool of applicants competing for available positions, which has not been the case over the last 12 months. There many more positions for an individual to choose from within the field of behavioral health. Recruiting for clinical positions is particularly challenging due to a smaller applicant pool.

Request for an overview of staffing and/or organization chart at a future meeting. SBH-ASO Staff will include this in the December meeting.

Discussion regarding the evolving state of behavioral health service delivery and programming, including recent increases in state funding, legislative requirements for new programs, and overall workforce challenges.

Dr. Lippman noted SBH-ASO's exceptional performance on a recent state-level audit, including compliments from the State on how well SBH-ASO has done in meeting their contract requirements to provide appropriate quality and quantity of care to the community they serve.

PUBLIC COMMENT

- Commissioner Brotherton read written public comment submission by Lisa C related to Agenda Item 6.a. Those comments are included at the end of the minutes.
- Jim Novelli of DBH read a letter sent by the mother of the individual involved in the incident regarding distribution of Fentanyl by the former R.E.A.L. Program Manager.
- Gratitude expressed to DBH and SBH-ASO for their prompt and professional investigation of the incident.

GOOD OF THE ORDER

- Plan to revisit virtual-only format for the December Executive Board meeting. Commissioner Brotherton and Stephanie Lewis will discuss options for doing a hybrid meeting.
- Commissioner Brotherton requested a briefing on the resolution of a recent opioid lawsuit at the December meeting.

ADJOURNMENT – Consensus for adjournment at 10:16 a.m.

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS
Commissioner Mark Ozias	Stephanie Lewis, SBH-ASO Administrator	Jim Novelli, Executive Director, DBH
Commissioner Greg Brotherton	Jolene Kron, SBH-ASO Deputy Admin/Clinical Director	Kate Ingman, CHPW
Commissioner Robert Gelder	Doug Washburn, Kitsap Human Services	Lori Fleming, Board Member, DBH
Theresa Lehman, Tribal Representative	Dr. Glenn Lippman, SBH-ASO Medical Director	Lisa Thomas, University of Washington
Celeste Schoenthaler, OCH Executive Director	Ileea Clauson, SBH-ASO Staff	Jenny Oppelt, Clallam Co. Health and Human Services

None Excused.	Nicole Oberg, SBH-ASO Staff	Mackenzie Dobson, Kitsap Community Resources
		Gabbie Caudill, Believe in Recovery
		Lisa C

NOTE: These meeting notes are not verbatim.

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION ADVISORY BOARD

BYLAWS

1. NAME

Salish Behavioral Heath Administrative Services Organization (SBHASO) Advisory Board (hereinafter Advisory Board).

2. PURPOSE

The purpose of the Salish Behavioral Health Administrative Services Organization Advisory Board is to advise the Salish Behavioral Health Administrative Services Organization Executive Board on the planning and delivery of behavioral health services in Clallam, Jefferson and Kitsap Counties by the authority granted to BH-ASOs in RCW 71.24 and under the terms of the Salish BH-ASO Interlocal Agreement.

The purpose of the Advisory Board is to:

* a. Review and make recommendations to the Executive Board regarding the Behavioral Health Plans developed by Salish Behavioral Health Administrative Services Organization Administrative Entity.

b. Review and make recommendations to the Executive Board regarding contracts and subcontracts that implement the services under Salish Behavioral Health Administrative Services Organization plans.

c. Participate in the Request for Proposal (RFP) processes that implement services within the Salish Behavioral Health Administrative Services Organization.

d. Review programs through monitoring reports, audit reports, and on-site visits as appropriate.

* Required role by RCW

3. MEMBERSHIP

a. Appointment

(1) The Advisory Board shall be comprised of eleven members, appointed by the Salish BHASO Executive Board and who serve at the pleasure of the Executive Board.

(2) To ensure continuity, the initial Advisory Board will be made up of six members appointed for one-year terms; three members will serve two-year terms and two members will serve three-year terms. Subsequent terms for reappointment shall be three-year terms. Individuals appointed to fill vacancies shall serve the remainder of the term.

b. Representation

The Advisory Board shall be comprised of a maximum of eleven members, with three individuals representing each participating county, and two at-large Tribal representatives. At least 51% of the membership will be made up of consumers or parents or legal guardians of individuals with lived experience with a behavioral health disorder.

4. TERMINATION

c. Resignation

Any Advisory Board member may resign by submitting written notice to the Salish Behavioral Health Administrative Services Organization Administrator.

d. Removal

Appointments to the Board may be terminated at any time by action of the Executive Board.

The Advisory Board can remove a member by majority vote of the total membership, provided that fifteen days notice of the pending action has been provided to the Advisory Board.

A member may be removed from the Advisory Board if absent from three consecutively scheduled meetings without good cause. Good cause shall be determined by the chairperson

5. ATTENDANCE

All members are expected to attend regularly scheduled meetings. More than three unexcused absences by any member during any twelve-month period may result in removal of the member by the SBHASO Executive Board. A member's absence is unexcused if the member fails to notify the SBHASO administrator in advance of a regular meeting that the member will not attend.

6. MEETINGS

a. Public Meetings Law

All meetings will be open to the public and all persons will be permitted to attend meetings of the Advisory Board. Open public meetings and open public attendance is not required at meetings when less than a quorum is present.

b. Regular Meetings

The Advisory Board shall meet at intervals established by the SBHASO Administrator or their designee. Administrative support including crafting agendas, preparing materials, arranging speakers and presentations, and

forwarding recommendations will be provided by the SBHASO staff. Regular meetings may be canceled or changed to another specific place, date and time provided that notice of the change is delivered by mail, fax, or electronic mail and posted on the SBHASO Website.

c. Notice

The Kitsap County Human Services Department will provide notice of regular meetings to Advisory Board members, interested persons, news media that have requested notice, and the general public. Notice shall include the time and place for holding regular meetings. The notice will also include a list of the primary subjects anticipated to be considered at the meeting. Distribution of meeting notices will be in a manner which maximizes the potential of the public to be aware of the proceedings and to participate.

d. Special Meetings

Special meetings may be called by the Chair with notice to all members and the general public not less than 24 hours prior to the time of the special meeting. A special meeting should be called only if necessary, to conduct business that cannot wait until the next regularly scheduled meeting. The notice will be provided as soon as possible to encourage public participation.

e. Meeting Location

Advisory Board meetings are generally held at the same location and time unless otherwise notified.

f. Quorum

A quorum shall consist of a total of not less than 50% of the membership, provided there is representation from each county.

g. Voting

Voting shall be restricted to Advisory Board members only, and each Board member shall have one vote. The chair shall vote when a tie results. Except, the chair may vote in elections. All decisions of the Advisory Board shall be made by no less than a majority vote of a quorum at a meeting where a quorum is present.

h. Minutes

The minutes of all regular and special meetings shall be recorded by administrative staff. Minutes will include time and date, meeting length, members present, motions and motion makers, recommendations and due date, if applicable. Draft minutes will be distributed to the membership not less than five days prior to the next regular monthly meeting for comment and correction, and will be formally approved at the next regular monthly meeting and submitted for posting on the Kitsap County website.

i. Agendas

Items may be placed on a meeting agenda by any member or by BHASO staff. The Chair and staff will coordinate preparation of the meeting agendas. The agenda will be distributed to members at least five days prior to a regular meeting.

j. Parliamentary Procedures

When not consistent with the provisions in these bylaws, Roberts Rules of Order will govern parliamentary procedure at regular and special meetings.

k. Decorum and Control

In the event any meeting is interrupted by an individual or individuals so as to render the orderly conduct of the meeting unfeasible and order cannot be restored by the removal of the person or persons who are interrupting the meeting, the Chair may order the meeting room cleared and continue in session or may adjourn the meeting and reconvene at another location selected by the majority vote of the members. In such a session, final disposition may only be taken on matters appearing on the agenda. The Chair may readmit an individual or individuals not responsible for disturbing the orderly conduct of the meeting.

7. OFFICERS

a. Chair and Vice Chair

The chairperson and vice chairperson shall be elected by a majority vote for a one-year term, beginning on January 1 and ending on December 31 of the calendar year following election.

b. Process

The Chair shall appoint a three-member Nominating Committee. Elections shall be held at the first regular meeting of the fourth calendar quarter from a slate presented by the Nominating Committee and nominations from the floor. Nominees must be active members who have consented to serve. All elections shall be by secret ballot unless dispensed with by a majority vote of the members present.

c. Chair Responsibilities

The Chair will lead and guide the conduct of public meetings. The Chair is the official representative of the Advisory Board and shall follow the Public Communications Guidelines established in the Kitsap County Advisory Group Handbook when acting as the official spokesperson to the media. The Chair will be the main contact between the Advisory Board and SBHASO staff.

d. Vice Chair

The Vice Chair shall assume the responsibility and authority of the chairperson in his/her absence.

e. Chair Pro Tempore

In the absence of the Chair and Vice Chair, a Chair pro tempore shall be elected by a majority of the members present to preside for that meeting only.

f. Vacancies or Removal of Officers

The SBHASO Executive Board may remove an officer when it determines that it is in the interest of the Advisory Board or the SBHASO. If the Chair position is vacated, the Vice Chair will assume the Chair's position. If the Vice Chair is vacated, members will elect a replacement.

8. SPECIAL COMMITTEES

Such committees shall be established by the Advisory Board as are necessary to effectively conduct business. The Chair of the Board shall appoint members to and designate the chair of the standing and temporary committees.

9. CONFLICTS OF INTEREST

a. Declaration

Members are expected to declare a conflict of interest prior to consideration of any matter causing a potential or actual conflict.

b. Conflict of Interest

No Advisory Board member shall engage in any activity, including participation in the selection, award, or administration of a sub-grant or contract supported by the SBHASO revenue contracts if a conflict of interest, real or apparent, exists.

c. If a board member (or the board member's partner, or any member to the board member's family) has, or acquires, employment, or a financial interest in, an organization with an SBHASO grant or subcontract, the board member is disqualified, and must resign from the board.

10. REPRESENTATION

A member may speak for the board only when he/she represents positions officially adopted by the body.

11. COMPENSATION

Members of the Board shall serve without compensation. Reimbursement for expenses incurred while conducting official Advisory Board business may be provided for with the approval of the Director of the Kitsap County Human Services Department.

12. STAFFING

The Kitsap County Human Services Department shall have the responsibility to provide professional, technical and clerical staff as necessary, to support the activities of the Board.

13. AMENDMENT OF BYLAWS

These bylaws may be amended by a two-thirds majority vote of the members present at any regular or special meeting insofar as such amendments do not conflict with pertinent laws, regulations, ordinances, or resolutions of the Salish Behavioral Health Administrative Services Organization, state or federal governments. Proposed amendments to be in the hands of members at least ten days prior to the meeting at which the amendment is to be voted on. Any recommendations agreed upon by vote shall be forwarded to the SBHASO Executive Board for its approval.

14. ADOPTION

These bylaws and any amendments hereto, shall become effective only upon approval of the Salish Behavioral Health Administrative Services Organization Executive Board.

SBH-ASO Non-Medicaid Revenue - Calendar Year 2023	
State (GFS)	$5,212,700.00
PACT	$189,450.00
Assisted Outpatient Treatment (AOT)	$61,764.00
Jail Services	$111,816.00
5480 ITA Non-Medicaid	$163,260.00
Detention Decision Review	$27,492.00
Crisis Triage/Stabilization	$446,004.00
Long-term Civil Commitment (court costs)	$18,746.00
Trueblood Misdemeanor Diversion	$131,280.00
Designated Marijuana Account (DMA/DCA)	$226,560.00
CJTA	$693,556.00
Secure Detox	$101,592.00
Behavioral Health Advisory Board	$39,996.00
E&T Discharge Planners	$107,294.00
Behavioral Health Enhancement Funds	$224,904.00
SB 5092 Youth Mobile Crisis Team	$599,828.00
New Journeys	$51,166.00
Blake Recovery Navigator Program	$1,239,833.00
Youth Behavioral Health Navigator Program	$422,984.00
SB 5476 Blake Recovery Navigator Program Administrator	$140,000.00
SB 5073 Conditional Release/Less Restrictive Alternative Monitoring (CR/LRA)	$40,000.00
Assisted Outpatient Treatment (AOT) Administrator	$140,000.00
Governor's Housing Funds	$50,000.00
Mental Health Block Grant (MHBG)	$329,354.00
Peer Bridger (MHBG)	$160,000.00
FYSPRT	$75,000.00
Substance Abuse Block Grant (SABG)	$1,209,622.00
MHBG COVID Crisis Services	$17,000.00
MHBG COVID Services non-Medicaid Individuals	$199,133.00
MHBG COVID Peer Bridger Participant Funds	$4,925.00
MHBG COVID Certified Peer Counselor Addition to Crisis Teams	$102,843.00
MHBG COVID Peer Transition from Incarceration	$49,000.00
SABG COVID Peer Transition from Incarceration	$49,000.00
SABG COVID Services non-Medicaid Individuals	$289,498.00
Block Grant Co-Responder	$100,000.00
ARPA SABG*	$214,799.00
ARPA MHBG*	$192,753.00
HCA HARPS	$790,440.00
Commerce Community Behavioral Helath Housing	$643,827.00
Total Non-Medicaid Revenue	**$14,867,419**

* Estimated

Summary of Non-Medicaid Expenditures - January 1 - December 31, 2023	
Crisis Line	$218,280.00
Crisis Response/Mobile Outreach	$2,181,558.00
Certified Peer Counselor Crisis Team Expansion	$166,476.00
Youth Mobile Crisis Outreach Team	$599,828.00
Next Day Appointments	$162,337.00
Total Crisis	**$3,328,479.00**
Involuntary (ITA) Psychiatric Inpatient	$1,412,000.00
ITA Secure Withdrawal Management and Stabilization	$101,592.00
ITA Court Costs	$350,000.00
LRA/CR Outpatient Monitoring and Treatment	$111,764.00
Total Involuntary	**$1,975,356.00**
Facility-based Crisis Stabilization	$50,000.00
SUD Residential Treatment	$116,560.00
SUD Withdrawal Management	$4,000.00
Total Residential Treatment	**$170,560.00**
PPW Childcare	$200,000.00
PPW Housing Support	$60,000.00
PACT	$189,450.00
New Journeys Program	$51,166.00
Recovery Navigator (REAL) Program	$1,909,833.00
Co-Responder Program (RFP)	$90,000.00
CJTA Services and Supports	$693,556.00
E&T Discharge Planners	$107,294.00
Peer Bridger and PB Participant Funds	$164,925.00
Behavioral Helath Enhancement Payments	$224,904.00
Jail Services and Jail Peer Transition Pilot	$257,816.00
Behavioral Health Advisory Board	$39,996.00
Community Education/Training	$84,133.00
FYSPRT Program	$75,000.00
Transportation	$100,000.00
Interpreter Services	$3,000.00
SABG RFP Awards (Outpatient, Residential and Recovery Supports)	$381,297.00
MHBG RFP Awards (Outpatient, Residential and Recovery Supports)	$72,783.00
Address Gaps Not met by ARPA RFP Submissions	$420,620.00
Difficult to Discharge/Hisk Risk Individual Supports	$300,000.00
SBH-ASO Housing Program (Subsidies and Services)	$1,400,324
Youth Behavioral Health Navigator Program	$422,984.00
SB 5476 Recovery Navigator Administrator	$140,000.00
Assisted Outpatient Treatment Program Administrator	$140,000.00
Total Special Programs, Provisos and Recovery Supports	**$7,529,081.00**
BH-ASO Administration	**$1,863,943.00**
Total Expenditures	**$14,867,419.00**

Medicaid Budget: January - December 2023	
Revenue*	
MCO Revenue (Amerigroup, CHPW, Coordinated Care, Molina, United Healthcare)	$ 4,230,107
Total Medicaid Revenue	**$ 4,230,107**
Medicaid Expenditures	
Crisis Services	
Regional Crisis Line	$ 282,801
Crisis Response Teams/Mobile Crisis Outreach	$ 3,595,427
Other Medicaid Expenses	
BH-ASO Administration	$ 351,879
Total Medicaid Expenses	**$ 4,230,107**

** Revenue is estimated as SBH-ASO is paid on a per member per month (PMPM) baisis by each MCO. As Medicaid Membership fluctuates, so does Salish's Medicaid Revenue.*

INTERLOCAL AGREEMENT BETWEEN CLALLAM COUNTY JEFFERSON COUNTY KITSAP COUNTY AND SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

This Agreement is made between Clallam County, Jefferson County, and Kitsap County, on the one hand, and Salish Behavioral Health Administrative Services Organization (SBH-ASO), through Kitsap County, its administrative entity, on the other, (collectively "Parties") for the purpose of administering monetary amounts allocated to the counties of Clallam, Jefferson, and Kitsap resulting from settlements with and/or litigation against opioid pharmaceutical supply chain participants. The Parties to this Agreement mutually agree to the terms contained herein.

RECITALS

A. Clallam, Jefferson, and Kitsap counties are Participating Counties in the National Prescription Opiate Litigation, United States District Court for the Northern District of Ohio, Case No. 1:17-md-02804-DAP.

B. Clallam, Jefferson, and Kitsap counties are also Participating Local Governments to the One Washington Memorandum of Understanding Between Washington Municipalities (One WA MOU), a copy of which is attached hereto as Attachment A and fully incorporated herein.

C. Clallam, Jefferson, and Kitsap counties are also Participants to the Allocation Agreement Covering the Allocation of Funds Paid by the Settling Opioid Distributors in Washington State, a copy of which is attached hereto as Attachment B and fully incorporated herein (Allocation Agreement).

D. Clallam, Jefferson, and Kitsap counties anticipate receipt of other funds resulting from settlements with and/or litigation against opioid pharmaceutical supply chain participants.

E. Funds allocated to Clallam, Jefferson, and Kitsap counties pursuant to the One WA MOU and the Allocation Agreement shall be collectively referred to herein as "Opioid Funds."

F. Clallam, Jefferson, and Kitsap counties and the Jamestown S'Klallam Tribe are parties to an interlocal agreement (KC-279-19, as it may be amended or superseded from time to time) establishing the SBH-ASO. The SBH-ASO administers behavioral health services and programs under chapters 71.24 and 71.05 RCW within the Olympic Community of Health Region regional service area established under RCW 74.09.870.

G. Clallam, Jefferson, and Kitsap counties seek to designate SBH-ASO as the Olympic Opioid Abatement Council pursuant to Section C.4.h of the One WA MOU and

pursuant to Section 15 of the Allocation Agreement for the purposes of receiving, managing, distributing, and administering Opioid Funds allocated to Clallam, Jefferson, and Kitsap counties consistent with the Approved Purposes set forth in the One WA MOU and consistent with the purposes set forth in Section 8 of the Allocation Agreement.

H. SBH-ASO's Tribal members are subject to separate agreements concerning Opioid Funds, are not subject to the One WA MOU or the Allocation Agreement described herein, and thus it is unnecessary to join SBH-ASO's Tribal members as parties to this Agreement.

I. This Agreement is made pursuant to the Interlocal Cooperation Act, Chapter 39.34 RCW.

J. This Agreement does not contemplate a joint budget.

K. This Agreement does not contemplate the joint acquisition of property by the parties. At termination, each party will remain the sole owner of its own property.

AGREEMENT

1. The foregoing Recitals A through H are true and correct and are incorporated herein by reference as if fully set forth herein.

2. Clallam, Jefferson, and Kitsap counties hereby designate SBH-ASO as the Olympic Opioid Abatement Council pursuant to Section C.4.h of the One WA MOU and pursuant to Section 15 of the Allocation Agreement to oversee allocation, distribution, expenditures, and dispute resolution of Opioid Funds allocated to Clallam, Jefferson, and Kitsap counties consistent with the Approved Purposes set forth in the One WA MOU and Allocation Agreement and consistent with the purposes set forth in Section 8 of the Allocation Agreement (collectively "Approved Purposes").

3. Clallam, Jefferson, and Kitsap counties shall pay over to SBH-ASO those Opioid Funds distributed to Clallam, Jefferson, and Kitsap counties or authorize that Opioid Funds allocated to Clallam, Jefferson, and Kitsap County be paid over directly to SBH-ASO.

4. SBH-ASO shall maintain Opioid Funds in a separate fund and Opioid Funds shall not be comingled with other funds received by SBH-ASO from HCA or other sources.

5. Ten percent (10%) of Opioid Funds received by SBH-ASO will be reserved, on an annual basis, for administrative costs related to managing, distributing, and administering Opioid Funds consistent with Approved Purposes. SBH-ASO will provide an annual accounting for actual costs and any reserved funds that exceed actual costs will be reallocated to Approved Purposes.

6. Opioid Funds will be subject to mechanisms for auditing and reporting to provide public accountability and transparency. All records related to the receipt and expenditure of

Opioid Funds shall be maintained for no less than five (5) years and such records shall be available for review by the Parties to this Agreement, government oversight authorities, and the public. Each party shall be responsible for its own compliance with the Washington Public Records Act, chapter 42.56 RCW (as may be amended). This Agreement, once executed, will be a "public record" subject to production to a third party if it is requested under the chapter 42.56 RCW.

7. SBH-ASO will be responsible for the following actions with respect to Opioid Funds:

a. Overseeing distribution of Opioid Funds to programs and services within the Olympic Community of Health Region regional service area for Approved Purposes.

b. Preparing annual expenditure reports for compliance with Approved Purposes.

c. Reporting and making publicly available all decisions on Opioid Fund allocation applications, distributions, and expenditures by SBH-ASO.

d. Developing and maintaining a centralized public dashboard or other repository for the publication of expenditure data for expenditures of Opioid Funds by SBH-ASO, which it shall update at least annually.

e. If necessary, require and collect additional outcome-related data to evaluate the use of Opioid Funds.

f. Hearing complaints by Clallam, Jefferson, and/or Kitsap Counties regarding alleged failure to (1) use Opioid Funds for Approved Purposes or (2) comply with reporting requirements.

8. If any Party to this Agreement believes another Party violated the terms of this Agreement, the WA One MOU, and/or the Allocation Agreement, the aggrieved Party may seek judicial enforcement of the terms of this Agreement, the WA One MOU, and/or the Allocation Agreement. The Parties hereby stipulate that venue of any action shall be Thurston County Superior Court in accordance with RCW 4.12.080. Prior to filing any such action, the alleging Party shall first provide the alleged offending Party notice of the alleged violation(s) and a reasonable opportunity to cure the alleged violation(s). In such an enforcement action, any alleging Party or alleged offending Party may be represented by their respective public entity in accordance with Washington law.

9. Nothing in this MOU shall be interpreted to waive the right of any Party to seek judicial relief for conduct occurring outside the scope of this Agreement that violates any Washington law. In such an action, the alleged offending Party may be represented by their respective public entities in accordance with Washington law. In the event of a conflict, any Party may seek outside representation to defend itself against such an action.

10. This Agreement is subject to the terms and conditions of the Parties' interlocal

agreement establishing the SBH-ASO (KC-279-19, as it may be amended or superseded from time to time), except that in the event of an inconsistency between this Agreement and the Parties' interlocal agreement establishing the SBH-ASO, unless otherwise provided, the inconsistency is resolved by giving precedence in the following order:

a. Applicable Federal and Washington State Statutes and Regulations.
b. All terms and conditions in this Agreement, including the One WA MOU and the Allocation Agreement.
c. The Parties' interlocal agreement establishing the SBH-ASO (KC-279-19, as it may be amended or superseded from time to time).
d. Any other material incorporated herein by written reference.

11. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. The Parties agree not to deny the legal effect or enforceability of this Agreement solely because it is in electronic form or because an electronic record was used in its formation. The Parties agree not to object to the admissibility of this Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the grounds that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

12. This Agreement shall take effect upon the date of its full execution and shall expire on the date that the Interlocal Agreement establishing the SBH-ASO expires (KC-279-19, as it may be amended or superseded from time to time).

13. Each Party represents that all procedures necessary to authorize such Party's execution of this Agreement have been performed and that the person signing for such Party has been authorized to execute this Agreement.

14. Once fully executed, this Agreement shall by filed by Kitsap County with the Kitsap County Auditor.

15. The parties shall keep and maintain all records required by law in connection with the performance of this Agreement.

16. The parties signed this Agreement in the State of Washington. The laws of the United States and the State of Washington govern this Agreement, as if applied to transactions agreed upon and to be performed wholly within the State of Washington. No Party shall argue or assert that any state law other than Washington law applies to the governance or construction of this Agreement.

17. This agreement may be amended to address distribution of additional funds received from settlements with and/or litigation against opioid pharmaceutical supply chain participants.

Approved this 25 day of October, 2022

CLALLAM COUNTY BOARD OF COMMISSIONERS

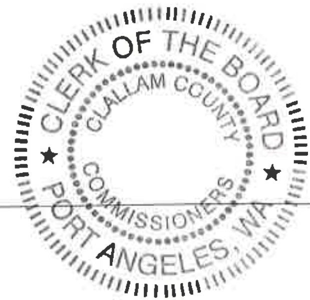
Mark Ozias, Chair

Randy Johnson, Commissioner

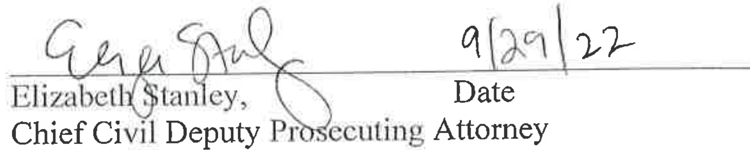
Bill Peach, Commissioner

Attest:

Loni Gores, Clerk of the Board



Approved as to form only:

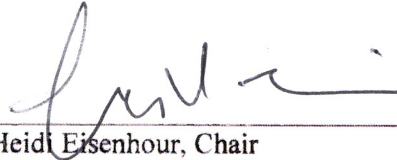


9/29/22

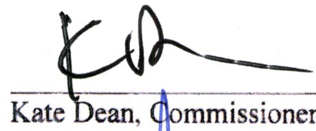
Elizabeth Stanley, Date
Chief Civil Deputy Prosecuting Attorney

Approved this 10th day of October, 2022

JEFFERSON COUNTY BOARD OF COMMISSIONERS

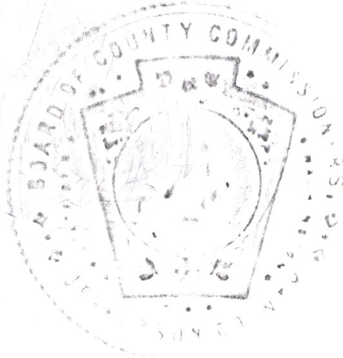


Heidi Eisenhour, Chair



Kate Dean, Commissioner

Greg Brotherton, Commissioner



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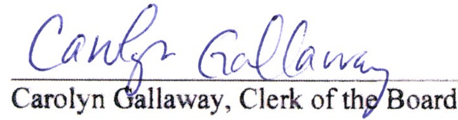
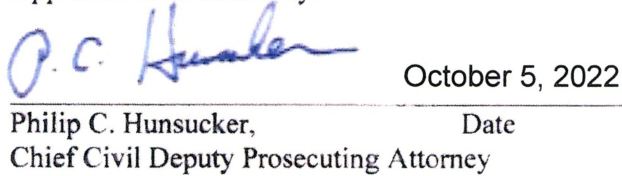


Carolyn Gallaway, Clerk of the Board

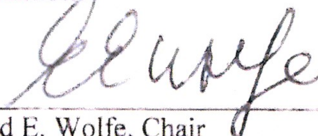
Approved as to form only:



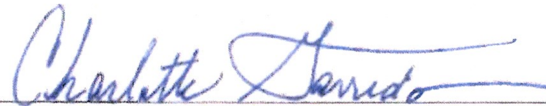
October 5, 2022

Philip C. Hunsucker, Date
Chief Civil Deputy Prosecuting Attorney

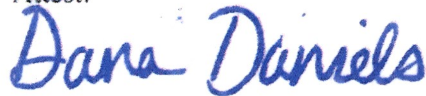
Approved this 5 day of October, 2022



KITSAP COUNTY BOARD OF COMMISSIONERS, in its capacities as the governing body of Kitsap County and as the administrative entity for the Salish Behavioral Health Organization



Edward E. Wolfe, Chair



Charlotte Garrido, Commissioner

NOT PRESENT

Rob Gelder, Commissioner

Attest:

Dana Daniels

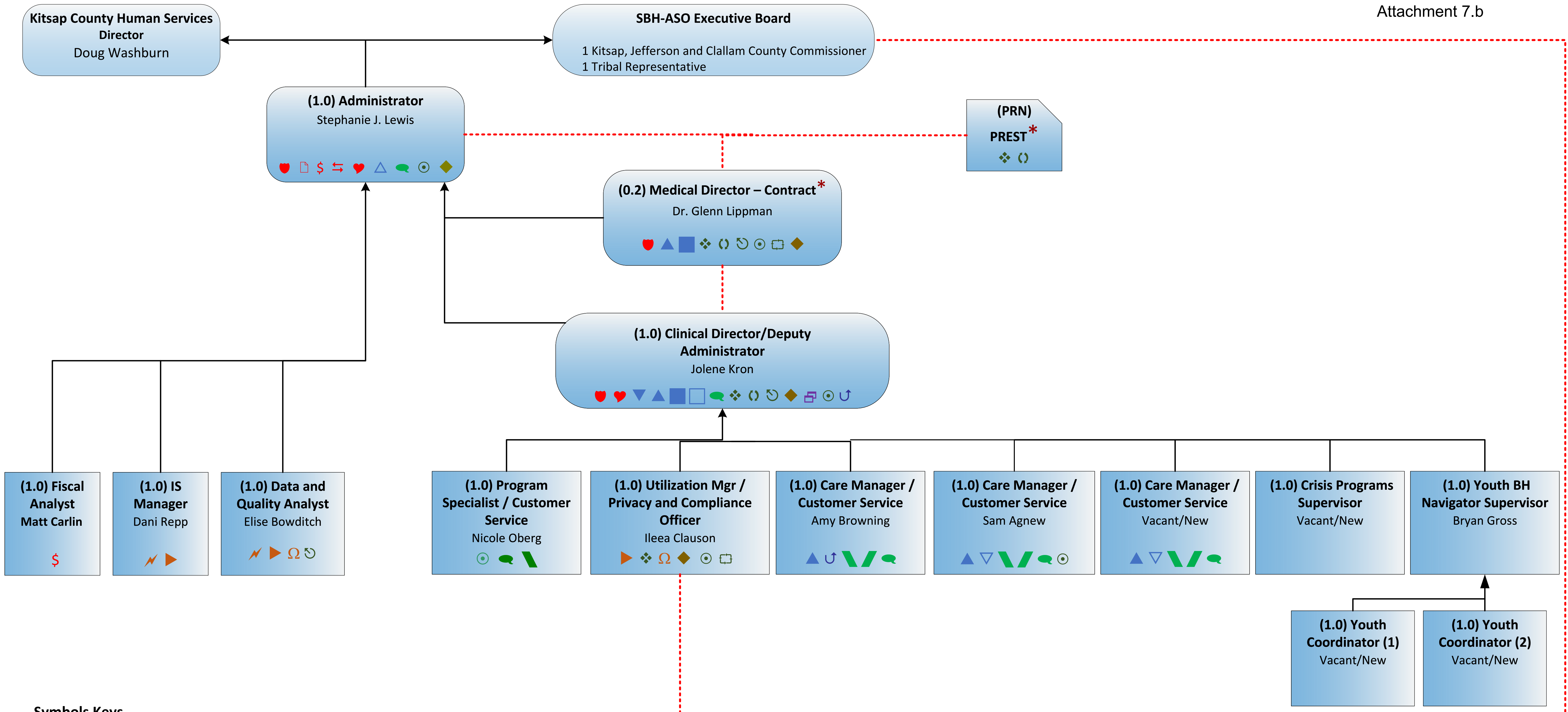
Dana Daniels, Clerk of the Board

Approved this ___ day of ______________, 2022

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE ORGANIZATION

____
Greg Brotherton, Chair

SBH-ASO Organization Chart *11/29/2022*



Symbols Keys

Additional Details: *——— Solid lines indicate direct supervision - - - - - Red lines indicate direct communication channels | Administrative services are the responsibility of all employed staff.*

⬣	Leadership Team	▼	Clinical Director	▍	General information, referral, and overall customer service	❖	Utilization Management	Ω	Data Analytics	◆	Staff and Provider Training
🗋	Network Development and Contracting	▲	Care Management/Care Coordination	▍	Specific information, referral, and customer service on BH clinical services	()	Grievance and Appeal	⚡	Information Services	🗗	Federal Block Grant Reporting
$	Financial Planning, Analytics and Reporting	■	Crisis response system, including oversight of VOA	💬	Member Services	↻	Quality Management	▶	Claims, Encounters and Supplemental Data Processing	*	Contractor
⇆	Government and Community Liaison	□	Crisis Triage Administration			⦿	Credentialing				
♥	Provider Relations	△	Child Specialist			⛶	Program Integrity; Fraud and Abuse				
		▽	Addiction Specialist								
		↺	Tribal Liaison								