Salish Behavioral Health
Administrative Services Organization

Providing Behavioral Health Services in
Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION EXECUTIVE BOARD MEETING

DATE: **Friday, March 19, 2021**

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://zoom.us/j/96299445707?pwd=SklGdVN4d1dIV3R6MEo3eGJuRWoxdz09

Meeting ID: 962 9944 5707

Passcode: 996758

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

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

Meeting ID: 962 9944 5707

Passcode: 996758

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 January15, 2021 (Attachment 5)
6. Action Items
   a. Reappointment of Advisory Board Members
   b. Request for Proposal (RFP) for additional Block Grant Allocation
7. Informational Items
   a. United Health Care Contract Update
   b. MCO Reconciliation Update
   c. Legislative Update on “988” Bill (2SHB 1477 & SB 5209)
   d. Olympic Community of Health Behavioral Health Report Presentation (Attachment 7.d)
   e. Entrance of Community Health Plan of Washington (CHPW) on 7/1/21
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
CHPW	Community Health Plan of Washington
CMS	Center for Medicaid & Medicare Services (federal)
COVID-19	Coronavirus Disease 2019
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
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
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
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

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SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

March 19, 2021

Action Items

A. REAPPOINTMENT OF ADVISORY BOARD MEMBERS

On December 31, 2020, the terms for Jon Stroup and Janet Nickolaus expired.

- Jon Stroup was initially appointed to the BHO Advisory Board on January 1, 2016 and served to represent Kitsap County for the duration of the SBHO's operations. Mr. Stroup brings a wealth of knowledge and experience related to behavioral health services with a specific focus on youth and young adults. Mr. Stroup remains committed to serving his community and volunteered to continue serving on the SBH-ASO Advisory Board.

- Janet Nickolaus was also initially appointed to the BHO Advisory Board on January 1, 2016 and served to represent Clallam County for the duration of the SBHO's operations. Ms. Nickolaus is a retired Psychiatric ARNP, having worked for 28 years in various settings such as emergency rooms, jails and within the Veteran's Affairs system. Ms. Nickolaus remains committed to serving her community and volunteered to continue serving on the SBH-ASO Advisory Board.

The Advisory Board unanimously recommended that the Executive Board reappoint Jon Stroup and Janet Nickolaus for another 1-year term (1/1/21 – 12/31/21)

B. REQUEST FOR PROPOSAL (RFP) FOR ADDITIONAL BLOCK GRANT ALLOCATION

On January 6th, the Health Care Authority (HCA) convened a brief meeting with BH-ASOs to discuss the potential for additional Block Grant Funding, MHBG and SABG. This was a very preliminary conversation and did not include important details such as when the funds may be dispersed or the amount of funds. However, the HCA has asked BH-ASOs to beginning planning for how these funds could be quickly utilized to provide behavioral health treatment and treatment supports.

At this point, it has been suggested that if these funds are appropriated to the HCA, they could possibly be contracted to BH-ASOs as soon as this summer. It is also quite possible that it could take HCA until late fall of 2021 to execute contracts. HCA also indicated that the amount of funds could be as much as BH-ASOs standard annual allocation. This could be as much as 1 million dollars for SBH-ASO.

HCA reports awaiting an award from SAMHSA "any day". Upon receipt of the award letter, HCA has agreed to share funding and timeline details with BH-ASOs promptly. Staff anticipates needing to release an RFP to manage the subcontracting of these additional Block Grant Funds.

During the February 5th Advisory Board Meeting, this information was reviewed. Additionally, staff discussed the Needs Assessment and Community Priorities identified in 2020, as well as SBH-ASO service cuts over the past year. The Advisory Board agreed on RFP funding priorities and an RFP subcommittee was created. The Advisory Board unanimously agreed that the recommendations put forth by the RFP subcommittee would serve as the entire Board's recommendations.

The approved Block Grant funding priorities are:

- Facility-based Crisis Stabilization
- Withdrawal Management Services
- Mental Health Outpatient Treatment
- Substance Use Disorder Outpatient Treatment
- Behavioral Health Recovery Supports and Transportation
- Behavioral Health Training

Staff intends to release the RFP within 30 days of receiving sufficient information from the HCA. Staff is seeking Executive Board approval to initiate subcontracts based upon the Advisory Board RFP Subcommittee's recommendation.

Informational Items

A. UNITED HEALTH CARE CONTRACT UPDATE

At the January 15, 2021, Executive Board Meeting, staff presented a preliminary 6-month Medicaid budget. This was necessary due to protracted 2021 contract amendment negotiations with United Health Care (UHC). Throughout MCO negotiations, staff has requested the same compensation and terms from all IMC MCOs to equitably support the Regional Crisis System, Behavioral Health Ombuds, and Salish BH-ASO Administration expenses. Staff reached out to UHC Leadership in late January and ultimately HCA Leadership to assist with resolving a negotiating stalemate. On February 19th, UHC returned to virtual negotiating table and agreed to the terms that Salish initially requested in September 2020.

Upon completing negotiations with UHC, staff promptly began amending Medicaid Crisis Subcontracts to ensure the Regional Crisis System is adequately funded. All Medicaid Crisis Subcontracts, except, Volunteers of America's, will be amended retroactive to 10/1/20. VOA's amendment will be effective 1/1/21.

B. MCO RECONCILIATION UPDATE

After lengthy discussions, both UHC and Amerigroup have agreed to forgo semi-annual reconciliation for calendar year 2020, even though the term remains in Salish's contract. This commitment has been provided in writing from both MCOs. Salish has begun the process of semi-annual reconciliation with Molina for January-June 2020.

For 2021, both UHC and Amerigroup agreed to removing the term of semi-annual reconciliation from their contract with Salish. The term of reconciliation remains in Salish's contract with Molina. However, with now having details of Molina's methodology, Salish has sufficient information to maintain proper crisis system funding without concerns of later having to repay funds already paid out to crisis subcontractors.

C. LEGISLATIVE UPDATE ON "988" Bill (2SHB 1477 & SB 5209

In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 which changes the national suicide prevention hotline number and Veterans crisis line number from 1-800-273-8255, to 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 (NSPL).

In January 2021, BH-ASOs learned of a HB 1182 & SB 5209 which seek to outline a plan for Washington State to implement the 9-8-8 change. The House Bill has subsequently been renumbered and is 2SHB 1477. Staff will review the apparent goals that 2SHB 1477 seeks to achieve as well as concerns shared by all BH-ASOs related to the structure of the bill and its implementation.

D. OLYMPIC COMMUNITY OF HEALTH BEHAVIORAL HEALTH REPORT PRESENTATION

Last Fall, the OCH volunteered to take the lead on creating a regional behavioral health report. The report aimed to:

- Provide an overview of the makeup of the Olympic Region and unique factors impacting behavioral health.
- Offer a current snapshot of the Olympic Region's behavioral health prevalence.
- Outline current gaps and challenges faced by the Olympic Region.
- Describe actions the region has taken to support behavioral health needs and highlight creative approaches.
- Pinpoint specific opportunities and recommendations for future behavioral health support.

This report is a step towards better understanding the health of Clallam, Jefferson, and Kitsap Counties, and the sovereign Tribal nations within the region. Many collaborative and innovative projects are in the works across the region. There is much to gain from past and current successes, efforts, and partnerships. Supporting behavioral health needs is a large task to tackle, and together we can foster a region of healthy people and thriving communities.

Mel Melmed, Program Coordination with the Olympic Community of Health, will provide a brief presentation on the Behavioral Report which was released in February 2021.

E. ENTRANCE OF COMMUNITY HEALTH PLAN OF WASHINGTON (CHPW) ON 7/1/21

At the end of January, the HCA reached out to Salish Staff to share information about their Leadership's on-going conversations about allowing the Managed Care Organization, Community Health Plan of Washington (CHPW), to enter Salish region on 7/1/21. On January 29, 2021, Jason McGill, Assistant Director of HCA, attended the Salish IMC Leadership Forum to make this announcement and seek behavioral health provider feedback. On February 1, 2021, HCA initiated the readiness review process with CHPW for a 7/1/21 entrance into Salish Region. In February, Salish Staff began contract negotiations with CHPW and on March 3rd, CHPW and Salish agreed upon terms for a 7/1/21 contract, should CHPW be approved to enter the region.

CHPW Staff will join the Executive Board Meeting and provide an overview of Community Health Plan of Washington and their plan to return to Salish region for Apple Health Integrated Managed Care July 2021.

CHPW Attendees:

- Erin Hafer, VP Delivery & Health System Innovation and Community Partnerships
- Connie Mom-Chhing, Director of Integrated Managed Care
- Natalie Christopherson, Tribal Liaison

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

Friday, January 15, 2021
9:00 a.m. - 11:00 a.m.
VIRTUAL ONLY: ZOOM Virtual Platform

CALL TO ORDER – Commissioner Mark Ozias, Chair, called the meeting to order at 9:01 a.m.

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – .

- Commissioner Ozias offered tremendous gratitude to the generosity and flexibility from the Jamestown Tribe for sharing COVID-19 vaccinations.
- SBH-ASO Fiscal Analyst, Mavis Beach, will be retiring from SBH-ASO have 35 years of working within various Kitsap County Departments including the RSN, SBHO and now SBH_ASO. April 6, 2021 is the last in person workday.
- Thank you for the case example provided by Stephanie Lewis and Jolene Kron for the Ruckelshaus Facilitated Communications Workgroup.

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

APPROVAL of AGENDA – Commissioner Mark Ozias

Commissioner Greg Brotherton commented that the language in the SBH-ASO EB Packet references to the minutes as notes and inquired as to the change. Discussed that it was supposed to indicate minutes rather than notes.

MOTION: Request Approval of the Agenda. Commissioner Rob Gelder moved to approve the agenda as submitted. Commissioner Greg Brotherton seconded the motion. Motion carried unanimously.

APPROVAL of MINUTES –

MOTION: Tribal Representative Theresa Lehman moved to approve the meeting notes as submitted for the November 20, 2020 meeting. Commissioner Greg Brotherton seconded the motion. Motion carried unanimously.

ACTION ITEMS

- **ELECTION OF SBH-ASO EXECUTIVE BOARD CHAIR AND VICE-CHAIRS**

The SBH-ASO Interlocal Agreement dictates that, annually, the Board shall elect a Chair, Vice-Chair, a Second Vice-Chair and a Third Vice-Chair by majority vote. In 2020, Commissioner Ozias served as Chair, Commissioner Brotherton served as Vice-Chair, and Commissioner Gelder served as Second Vice-Chair. At the time of Officer Elections, there was not a sufficient number of voting Board Members to elect a Third Vice-Chair.

Staff respectfully requests that the Executive Board Elect Chair, Vice-Chair, Second-Vice Chair and Third-Vice Chair for 2021.

Commissioner Greg Brotherton nominated himself as Chair. Commissioner Robert Gelder nominated himself as Vice Chair. Tribal Representative Theresa Lehman nominated herself as Second-Vice Chair. Mark Ozias nominated himself as third-vice chair.

Commissioner Robert Gelder took a moment to appreciate the time and effort from Commissioner Ozias as being SBH-ASO Executive Board Chair for the last few years. Commissioner Greg Brotherton appreciated the example that Commissioner Mark Ozias has set as Chair of this board. Tribal Representative Theresa Lehman appreciated the time Commissioner Mark Ozias took to introduce her to this board and all of his effort.

Commissioner Mark Ozias expressed appreciation to Stephanie Lewis and acknowledged the SBH-ASO team.

Inquiry regarding the necessity for 3-vice chairs as there is no quorum and ability to vote if 1 member is not present. The interlocal agreement includes these requirements. The Interlocal Agreement will need to be updated later in 2021 and presents an opportunity to review and make changes to the requirement for 3-vice chairs for the SBH-ASO Executive Board.

- **MOTION: Commissioner Greg Brotherton moved to approve Election of SBH-ASO Executive Board Chair and Vice-Chairs. Commissioner Robert Gelder seconded the motion. Motion carried unanimously.**

- **2021 SBH-ASO BUDGET**

Due to significant delays in receiving both non-Medicaid (HCA) and Medicaid (MCOs) revenue contracts, a 2021 Budget could not be presented to the Executive Board prior to the January Meeting.

- *Calendar Year 2021 Non-Medicaid Budget*

  A summary of non-Medicaid revenues is attached for review. This includes revenue allocated within Salish's main contract with HCA. This attachment also reflects revenue from 2 additional HCA contracts, HARPs and Emergency COVID Grant, and revenue from a contract with Commerce for long-term housing subsidies.

  A summary of non-Medicaid expenditures is attached for review. The "comments" column identifies notable changes from the previous year's approved budget.
  Staff will provide additional details surrounding the proposed non-Medicaid budget and seeks the Board's approval.

  Reviewed 6.b.1 attachment, SBH-ASO Non-Medicaid Revenue – Calendar Year 2021.

  Board Inquired about the Long-term Civil Commitment line item and Staff indicated it is in reference to the court expenses for the long-term civil commitments. Behavioral Health Advisory Board is to support the activities of the BHAB, such as travel or attend trainings, for the calendar year. In addition, helps to pay for the support to the BHAB, such as SBH-ASO staff.

  Reviewed the 6.b.2 attachment, Summary of Non-Medicaid Expenditures – January 1 to December 31, 2021.

  Discussed ITA bed numbers and costs. There is a reduction in beds due to the pandemic and increasing of safety and spacing of beds. March to September 2020 we noted a significant increase in individual detained and those individuals without Medicaid. If there

are not beds in Community Psychiatric Inpatient Hospitals or Evaluation and Treatment Centers, the hospitals utilize Single Bed Certifications incurs an expense and community hospitals are trying to manage this process.

MOTION: Tribal Representative Theresa Lehman moved to approve Calendar Year 2021 Non-Medicaid Budget. Commissioner Mark Ozias seconded the motion. Motion carried unanimously.

- *January – June 2021 Draft Medicaid Budget*

  Staff has included a draft Medicaid budget for the first 6 months of 2021. A draft budget is being proposed as negotiations with one MCO, United Healthcare, are still on-going. Therefore, Medicaid compensation for calendar year 2021 has not been finalized. Additionally, SBH-ASO only agreed to a 6-month contract extension with Molina.

  Staff will provide additional details surrounding the draft Medicaid budget. Staff seeks the Board's approval of this draft budget, and to allow for up to a 5% variance in revenue without additional action being required from this Board. Any variance within 5% will be brought forth to the Board as an informational item.

  Reviewed 6.b.3 attachment, Estimated** Medicaid Revenue: January – June 2021, and spoke to the reason why it is currently "estimated" as negotiations are currently outstanding with one of the Managed Care Organizations (MCO's).

  Discussion of waiting until negotiations have concluded and determined that the current budget estimations do support moving forward. With the approval of the draft Medicaid Budget , staff will then proceed with amending the Medicaid crisis contracts.

MOTION: Commissioner Mark Ozias moved to approve January – June 2021 Draft Medicaid Budget and include the 5% variance. Commissioner Robert Gelder seconded the motion. Motion carried unanimously.

➢ 2020/2021 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 8, 2020 and opportunity for subcontractor feedback was provided.

For the 2020/2021 Risk Assessment, the top 3 identified risks include:

- Implementation of Teleworking in response to COVID-19 safety guidance as there are increased risks related to privacy and security.
- Electronic Health Record/Data Platform changes create potential risk of data submission delays and can inhibit oversight.
- 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.

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

Clarification of reduced risk working remotely, specifically the VPN, and that Kitsap County IS Department is overseeing and notifying of any risks or recommendations.

Discussion of including within the Risk Assessment document, the risk of untimely response and coordination of (revenue) contracts, budgets and funding from some contracted providers.

MOTION: Commissioner Mark Ozias moved to approve 2020/2021 SBH-ASO Risk Assessment. Tribal Representative Theresa Lehman seconded the motion. Motion carried unanimously.

- **POLICES AND PROCEDURES FOR APPROVAL**

Changes in either July 1, 2020 or January 1, 2021 HCA/BHASO Contract, 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:

AD100 – Definitions

AD104 – Credentialing

CL203- Levels of Care

CL206- State Hospital Care Coordination

CL207- Jail Transition Services

CP304- Code of Conduct

CP304a- Code of Conduct Attestation

UM801- Utilization Management Requirements

UM804- Access to Withdrawal Management SUD Services

UM809- Access to Residential Substance Use Disorder Treatment Services

UM810- Criminal Justice Treatment Account (CJTA)

PS903a- Privacy and Security Policies Maintenance Plan

In an effort to develop a more sustainable workflow for updating Policies and Procedures, SBH-ASO Staff plan to reduce updates to its Policy and Procedure Manual to twice a year, January and July.

Noted on page 65, table missing the letter "I" in individuals.

MOTION: Commissioner Mark Ozias moved to approve Policies and Procedures for Approval with noted change. Tribal Representative Theresa Lehman seconded the motion. Motion carried unanimously.

INFORMATIONAL ITEMS

- **MCO RECONCILIATION**

During the September and November Executive Board Meeting, staff shared information regarding the challenges surrounding the MCO contract requirement of semi-annual reconciliation.

This process of MCO reconciliation involves the comparison each MCO's Medicaid Members' utilization of crisis services to the overall cost of SBH-ASO Crisis System. MCO's utilize this process to determine what they believe to be their portion of Crisis System financial responsibility. However, the utilization of crisis services, as a stand-alone measure, does not reflect that actual cost of the "Medicaid portion" of the crisis system. Through this reconciliation process, MCOs have recouped millions of Medicaid dollars from BH-ASOs and the crisis system in Washington State.

Up until July 1, 2020, HCA contracts with MCOs included the requirement for MCOs to engage BH-ASOs in semi-annual reconciliation. However, after several lengthy conversations between BH-ASO Leadership and HCA, the HCA agreed to remove this requirement from MCO's IMC contracts. However, this term remains in some contracts between the MCOs and SBH-ASO.

Since the November Executive Board Meeting, staff has obtained additional information from both MCOs and other BH-ASOs about the reconciliation process.

Other BH-ASOs have reported that Molina Healthcare is the only MCO reaching out to initiate reconciliation, not United Healthcare or Amerigroup. This has also been SBH-ASO's experience for its first semi-annual reconciliation. If Molina is the only MCO that follows through with reconciliation, the financial impact is 50% less impactful.

Additionally, Molina reported that any funds recouped from SBH-ASO must be redistributed to behavioral health providers within the Salish region that have sub-capitated contracts with Molina. If this is true, then these Medicaid funds are remaining within the region. If these recouped Medicaid funds are redistributed to local behavioral health providers, then the only financial loss to SBH-ASO is the small amount of administrative allowance that previously accompanied those Medicaid funds.

Staff will discuss this situation in greater detail. No action is required at this time as the decision about whether to participate in reconciliation for July-December 2020 does not need to be made until at least March 2021.

Lastly, with the Board's approval of the Medicaid Draft budget, staff intends to amend Medicaid Crisis Subcontracts to reduce the impact of reconciliation beginning 1/1/21.

Board Comment regarding a few Kitsap county providers signing contracts with CHPW. Staff noted no communication from HCA to support the introduction of another IMC MCO this year and will reach out to HCA to follow-up.

- **BEHAVIORAL HEALTH ADVISORY BOARD (BHAB) UPDATE**

In 2020, Advisory Board Meetings were held in February, June and October with the final meeting being held in December. Meetings are scheduled quarterly in 2021. A joint Advisory and Executive Board is proposed for the month of September 2021. The Advisory Board greatly appreciate the opportunity for a joint meeting in November 2019.

BHAB Chair, Lois Hoell or Staff will provide an update.

No SBH-ASO BHAB member was present. Stephanie provided the update. SBH-ASO BH AB discussed appreciation for a joint meeting in 2019. Suggested to ensure that there is a purpose and goal to that joint meeting.

PUBLIC COMMENT

- Celeste Schoenthaler shared three updates:
  - OCH in Salish region received a 245,000 donation that they have initially determined to use the money towards reducing Stigma. The donation is from the Cambia Health to help provide support specifically for rural mental health and substance disorder treatment: https://www.cambiahealth.com/news-and-stories/news-releases/cambia-health-solutions-commits-115-million-address-mental-health.
  - 1-Hope-Centered & Trauma Informed: Using Science to Improve Outcomes Training on February 9, 2021 via Zoom. Open to anyone in the Olympic Region, Trainings: https://www.olympicch.org/upcoming-events
  - Celeste participated in conversations this week with OCH and DOH that there is a movement to align communities based on health systems for COVID-19 response. There are some thoughts that there is more alignment between Kitsap and Mason, than with Clallam and Jefferson. Community comments have been to not include Mason due to their higher rates.
- Board discussion about the legislative proposal to regionalize of Public Health.
  - Lori Fleming was glad to hear the conversation regarding a coordinated and proactive approach to COVID-19.

GOOD OF THE ORDER

- None.

ADJOURNMENT – Consensus for adjournment at 10:46 a.m.

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS
Commissioner Mark Ozias	Stephanie Lewis, SBH-ASO Administrator	G'Nell Ashley, Reflections Administrator
Commissioner Greg Brotherton	Jolene Kron, SBH-ASO Deputy Admin/Clinical Director	Lori Fleming, Jeff Co. CHIP
Commissioner Robert Gelder	Doug Washburn, Kitsap County Department of Human Services Director	
Theresa Lehman, Tribal Representative	Ileea Clauson, SBH-ASO Staff	
Celeste Schoenthaler, OCH Executive Director	Martiann Lewis, SBH-ASO Staff	
None Excused.		

NOTE: These meeting notes are not verbatim.

THE OLYMPIC REGION

BEHAVIORAL HEALTH REPORT

CLALLAM | JEFFERSON | KITSAP

FEBRUARY 2021

Olympic COMMUNITY of HEALTH

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Acknowledgements

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***Celeste Schoenthaler,** Executive Director*

This report would not be possible without the input and support of regional partners. Olympic Community of Health expresses gratitude to the many who provided guidance and expertise throughout the report's research and creation process.

Contributors

***Andrew Lau**, Kitsap Public Health District*
***Bergen Starke**, Peninsula Community Health Services*
***G'Nell Ashley,** Reflections Counseling Services*
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Executive Summary

Behavioral health is an area of high importance and needed support in the Olympic region and across Washington State. Compared with other states, Washington State has a higher prevalence of behavioral health conditions and lower rates of access to care. The Olympic region faces many behavioral health challenges including barriers to transportation, broadband and technology, rural care, workforce, and access to recovery services. The region also has the benefit of caring, dedicated, and talented partners addressing both long-standing and current behavioral health needs.

This report is a step towards better understanding the health of Clallam, Jefferson, and Kitsap Counties, and the sovereign Tribal nations within the region. Many collaborative and innovative projects are in the works across the region. There is much to gain from past and current successes, efforts, and partnerships. Supporting behavioral health needs is a large task to tackle, and together we can foster a region of healthy people and thriving communities.

There are many opportunities for legislators, policy makers, health care providers, community-based organizations, social service agencies, Tribal health centers, and communities to prioritize behavioral health. Olympic Community of Health (OCH) proposes recommendations based off report findings and discussions with community and behavioral health partners. Recommendations include (*see all recommendations on page 23*):

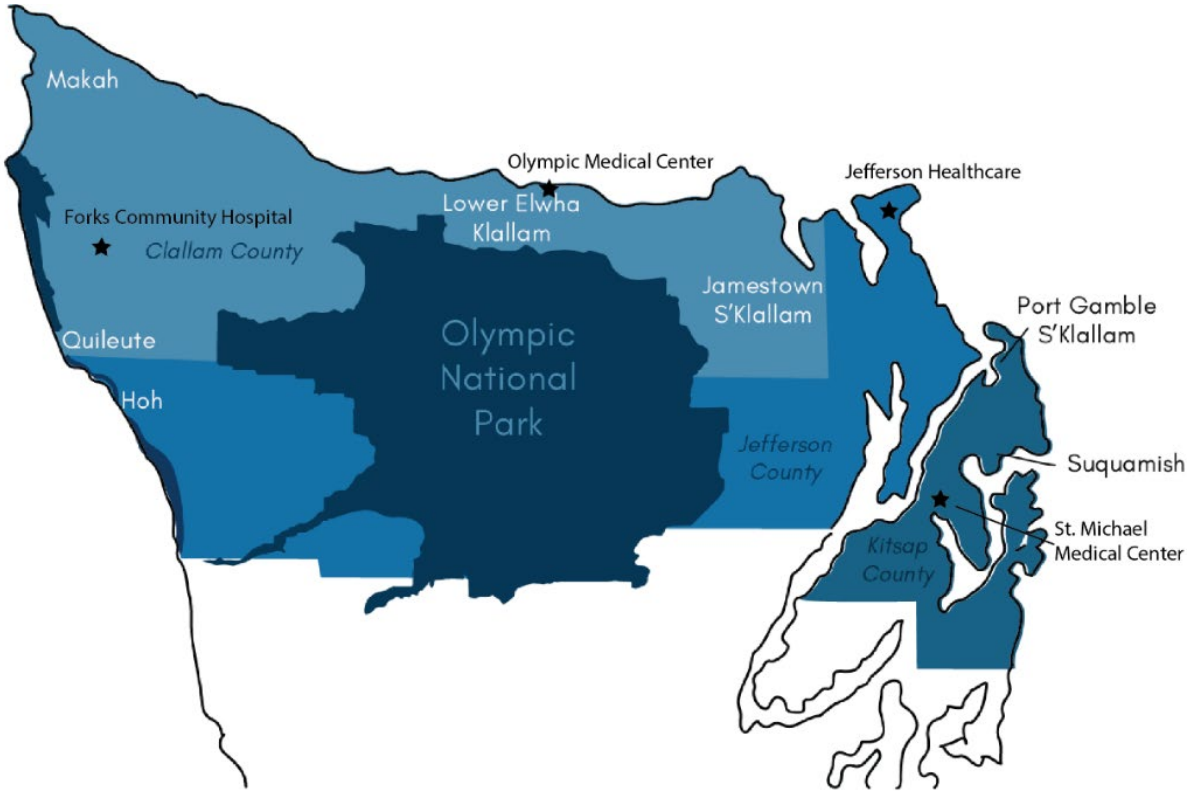
- Advocate for behavioral health reimbursement rates that are based on actual costs and salaries.
- Provide advocacy to increase salaries for behavioral health providers commensurate with their education, training, and the cost-saving benefit their services provide.
- Prioritize innovative and creative transportation solutions to improve access to care across the region.

This report aims to:

1. Provide an overview of the makeup of the Olympic region and unique factors impacting behavioral health.
2. Offer a current snapshot of the Olympic region's behavioral health prevalence.
3. Outline current gaps and challenges faced by the Olympic region.
4. Describe actions the region has taken to support behavioral health needs and highlight creative approaches.
5. Pinpoint specific opportunities and recommendations for future behavioral health support.

Introduction

OCH is an Accountable Community of Health (ACH) in Washington State that serves the Olympic region. OCH brings together partners from a variety of sectors and Tribes to tackle health issues no single sector or Tribe can tackle alone. ACHs are an integral part of the Washington's Medicaid transformation efforts, working to cost, experience, and quality of health care for community members enrolled in Medicaid (officially known as Apple Health in Washington State). Behavioral health is an area of high importance and needed support in the Olympic region. This report provides a summary of the current behavioral health challenges, successes, and opportunities within the Medicaid population of the Olympic region, in hopes that it will guide future decision making and regional next steps. OCH acknowledges that this is not a comprehensive report as it does not capture every aspect that impacts behavioral health in the Olympic region. This report is a step towards better understanding the health of the three-county region. Supporting behavioral health needs is a large task to tackle, and together we can foster a region of healthy people and thriving communities.



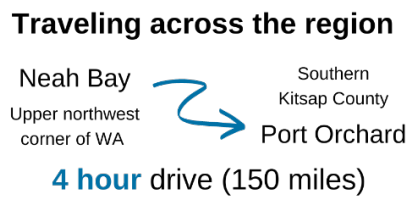
Overview: The Olympic Region

The Olympic region spans Clallam, Jefferson, and Kitsap Counties and includes the seven sovereign nations of the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, and Suquamish Tribes.

Clallam and Jefferson counties comprise the largely rural Olympic Peninsula. Port Angeles, the largest city and the seat of Clallam County, has a population of just over 20,000. Forks is the largest town and health care access point on the west end with a population of approximately 3,680 and one critical access hospital [1]. It is approximately a 1-hour journey by car to travel the 24 miles from the Hoh Reservation to the closest health care access point.

Port Townsend, with a population under 10,000, is the seat of Jefferson County [2]. It is the city and home to the only hospital in the county. It is approximately 38 miles and takes a little less than 1 hour to travel from Brinnon in

southern Jefferson County to Port Townsend. Public transportation is severely limited throughout most of the Olympic Peninsula and many locations are only accessible by use of private vehicle.



The Olympic Peninsula is home to the beautiful Olympic National Park. No through access is available in the National Park, elongating travel times around the region. Access from the Olympic Peninsula to Kitsap County is most commonly and conveniently made via the Hood Canal Floating Bridge, which closes daily due to leisure, commercial, and military marine traffic as well as unfavorable weather conditions.

Kitsap County is more suburban with a population of 272,200 and several city centers, in addition to the rural outreaches of Olalla, Seabeck, and Hansville. [3] Kitsap County's commuting population has steadily increased as access to Seattle becomes more convenient through a 30 minute fast-ferry ride. In recent years, public transportation has grown, including the use of some ride-share services. However, these options are still limited compared to larger cities and the most common and convenient transportation is use of private vehicle.

The Olympic region houses four hospitals, one each in Jefferson and Kitsap Counties, and two in Clallam County. Two of the hospitals, Forks Community Hospital (Clallam) and Jefferson Healthcare (Jefferson) are designated as critical access, a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS). It is designed to reduce the financial vulnerability of rural hospitals and improve access to health care by keeping essential services available in rural communities. [4] For severe acute health care services, travel out of the region is often necessary. It is common for individuals to be referred and receive specialty care in Kitsap, Pierce, and King Counties. The Olympic region also has two Federally Qualified Health Centers (FQHC), one in Port Angeles (North Olympic Healthcare Network) and the other (Peninsula Community Health Services) with locations in the major city centers of Kitsap County as well as mobile behavioral health clinic services.

Olympic Region Demographics

The Olympic region has a significantly older population when compared to the state average. This trend is important to note, as it effects region-wide service needs. Regionally, 25% of the population is enrolled in Medicare and approximately 20% are enrolled in Medicaid. [5]

Figure 1

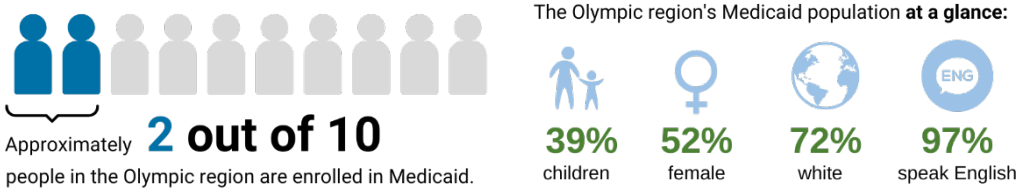


Figure 1 source: Washington Healthcare Authority (2020) [6]

Figure 2	Clallam	Jefferson	Kitsap	WA State
65+ years old	30.0%	38.0%	22.0%	16.0%
Median income	$49,913	$54,471	$71,610	$70,116
Education (four-year college graduation rate)	26.1%	41.8%	32.2%	35.5%

Figure 2 sources: U.S. Census Bureau (2020) [7] *and Washington State Office of Financial Management (2019)* [8]

Tribal Partners and Indian Health Care Providers

OCH is honored to partner with the seven sovereign Tribal nations in the Olympic region: Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, and Suquamish Tribes. Of the seven Tribes, six are Indian Health Care Providers (IHCPs). Each Tribe provides a range of services for their community including culturally relevant behavioral health prevention and wellness programs.

Travel can be a major obstacle for services not provided by the Tribes including urgent and critical care. It takes over an hour to travel from the Makah reservation to the nearest hospital in Forks and nearly two hours to reach Port Angeles for specialty referrals and Level III trauma care. It is common for Tribal members to travel to Bremerton and Seattle, four to five hours one-way by private vehicle from Quileute, Hoh, or Makah to access specialty care.

Military

The Olympic region has a robust military and substantial veteran presence. Kitsap County is home to the large Naval Base Kitsap, the host command for the Pacific Northwest Navy fleet, as well as the Puget Sound Naval Shipyard and Intermediate Maintenance Facility, the Pacific Northwest's largest Naval shore facility and one of Washington state's largest industrial installations. Jefferson county is home to Naval Magazine Indian Island, one of the largest munitions depots and ordnance storage sites. The Coast Guard has a presence in all three counties as well.

A large military presence is naturally reflected by a transient population, with frequent deployments and transfers. The military internally hosts comprehensive medical and social services, with most members and dependents receiving care at military facilities. However, emergency services are accessed through regional hospitals and emergency departments. Additionally, for a variety of reasons, some military members and dependents choose to seek health care and social services from community providers rather than military providers.

Veterans account for 16.8% of the total adult population in Kitsap County and for 15% and 15.7% in Clallam and Jefferson Counties, respectively. [9] Two Veterans Administration (VA) clinics serve eligible veterans in our region: the North Olympic Peninsula Community Based VA Clinic in Port Angeles (Clallam County) and the Silverdale VA Clinic (Kitsap County). Eligible veterans may apply with the VA to receive care from a local community provider who is part of the VA's network. [10]

Behavioral Health: A Current Snapshot

With the makeup of the Olympic region in mind, we can dive a bit deeper into the current behavioral health trends. Mental health and substance use disorders (SUDs) are collectively referred to as behavioral health disorders.

Adults with behavioral health disorders are less likely to care for their chronic medical conditions and more likely to experience worse outcomes of co-occurring chronic diseases compared with patients without behavioral health disorders. [11] They are also more likely to have frequent emergency department (ED) visits.

Nationally, use of the ED for mental health visits has been increasing. A report by the Agency for Healthcare Research and Quality found that the number of ED visits related to behavioral health disorders increased more than 44 percent between 2006 and 2014, with suicidal ideation visits growing by nearly 415 percent. [12] Similarly, behavioral health is among the top reasons for hospital inpatient stays among adults 18-44 years of age. [13]

Meeting community behavioral health needs is a long-standing priority for the Olympic region. Behavioral health progress is evident in myriad creative strategies that have been implemented in the Olympic region, including:

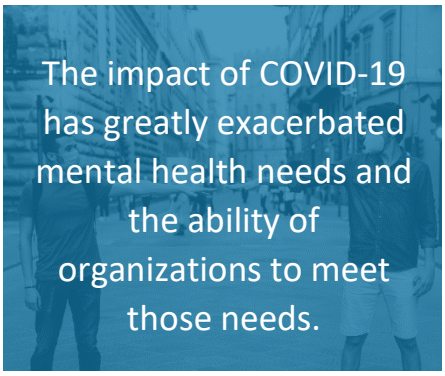
- **Kitsap**
  Peninsula Community Health Services' community health workers are innovatively partnering with local organizations including the county jail, Salvation Army, and WorkSource to better understand and provide for community needs.
- **Clallam**
  The Port Angeles Fire Department implemented a community-paramedicine program which partners with agencies including Peninsula Behavioral Health and Olympic Peninsula Community Clinic ("the free clinic") to connect clients who are frequent emergency department users with the services they need. The result is a 50% reduction in emergency department visits among individuals assisted by the community paramedic.
- **Jefferson**
  The Sheriff's department has secured funding to hire a navigator who will assist individuals with unmet behavioral health needs to access services and care.
- **Community-based interventions** to support well-being and prevent behavioral health problems are evident in the work of Kitsap Strong and the Clallam Resiliency Project. These non-profits work towards upstream solutions, providing education on N.E.A.R. Science (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience) and trauma-informed practices for health care providers, schools, faith-based organizations, and other community groups.

A current behavioral health focus is integration of services. Integration can be achieved through a variety of approaches. One approach is to increase the range of services a practice offers. For instance, for primary care practices to onboard behavioral health staff, and vice-versa. Another effective option is to create closer collaboration and referral networks between and among organizations. Examples of strategies to achieve integration of services includes hiring clinical social workers to facilitate care connection for complex medical patients, creating multiagency care coordination teams such as Clallam Care Connection (see page 23), and using telehealth services to provide psychiatric evaluations, behavioral health therapy, and medication management. Behavioral health practices face unique challenges when it comes to integrating physical health, largely due to reimbursement barriers.

Across the region, behavioral health and physical health providers have made substantial progress in collaborating. Notably, the Three-county Coordinated Opioid Response Project (3CCORP) provides collaboration opportunities for behavioral health and physical health partners to align strategies and goals around opioid use disorder.

COVID-19

The impact of COVID-19 has greatly exacerbated mental health needs and the ability of organizations to meet those needs. [14] Behavioral health providers described losing clients during the rapid closing of services in March 2020 as Washington's "Stay Home, Stay Healthy" COVID-19 order was instituted. Inpatient and outpatient practices abruptly limited or halted in-person treatment while scrambling to implement distancing and sanitation protocols and to develop telehealth capacity including securing equipment, writing telehealth policies, and teaching staff and clients how to use the equipment and digital platforms (such as Zoom and Doxy.me). At practices which continued seeing patients in person, employees navigated fear of COVID-19 exposure as they initiated new safety protocols such as wearing a mask and other personal



protective equipment (PPE), all while responding to personal and family needs as schools and workplaces were closed. [15] Initially, Medicaid and Medicare reimbursement restrictions on telehealth and audio-only telehealth prevented behavioral health providers from being able to use remote modalities while staying financially afloat. Reimbursement policy changes at the federal and state level enabled behavioral health practices to provide remote services for their clients during the pandemic. [16]

While some behavioral health clients successfully transitioned to remote care, not all clients are able to access remote services due to technological capacity, such as limited broadband access, and personal comfort level using digital platforms such as Zoom. Washington State Health Care Authority supported access to telehealth by providing Zoom licenses for behavioral health providers and loaning cell phones and laptops to Medicaid clients. They also worked with managed care organizations (MCOs) to ensure rapid resolution of denied telehealth payments as new billing codes were implemented. These actions were a lifeline for cash-strapped behavioral health providers and their clients.

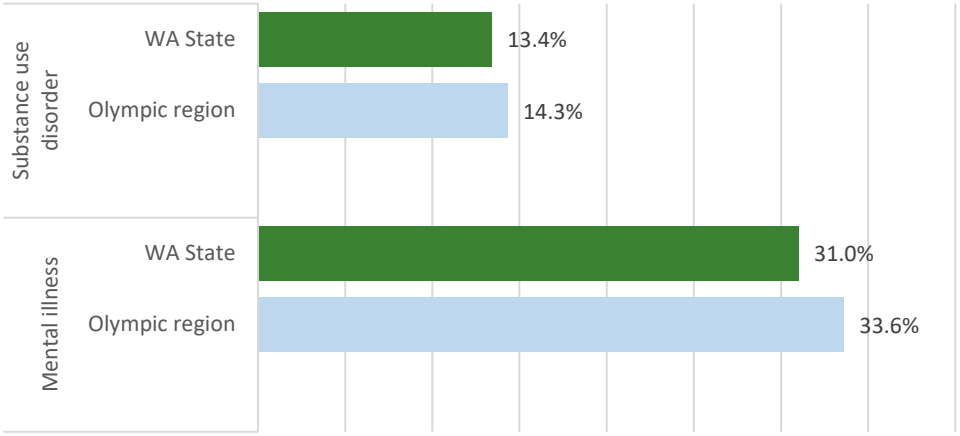
Prevalence of Behavioral Health Conditions

The prevalence of behavioral health conditions in the three-county region is defined as the proportion of the Olympic region's population who experiences behavioral health conditions in a given time period (including both mental health conditions and substance-use disorder). By diving into the prevalence of adult mental health, youth mental health, emergency utilization, self-inflicted harm, and treatment penetration, a broader picture of the regional behavioral health needs emerges.

Compared with other states, Washington State has a higher prevalence of behavioral health conditions and lower rates of access to care, ranking 37th (out of 51 states) for adults and 35th for youth in 2021. [17] The 2021 rankings reflect substantial improvement over 2020 when Washington State ranked 45th (out of 51) for adults and 43rd for youth on higher prevalence and lower rate of access. [18]

The prevalence of mental illness and substance use disorder among Medicaid enrolled adults between the ages of 18 and 64 in the Olympic region is higher than the statewide prevalence (Figure 3).

Figure 3: Prevalence of any mental illness and substance use disorder among adults 18-64 years of age and older on Medicaid (2019)

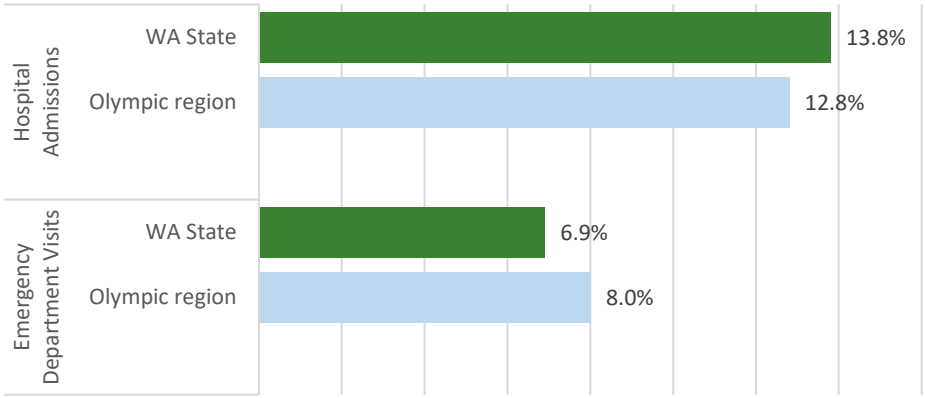


Source: Washington State Healthcare Authority (2020) [19]

Emergency Department and Hospital Inpatient Behavioral Health Needs

In 2019, Medicaid enrollees within the Olympic region demonstrated a lower percentage of hospital inpatient admissions among behavioral health related diagnoses compared to Washington state, accounting for 13.8% of hospital admissions in the region. In contrast, Medicaid enrollees in the Olympic region utilized the emergency department for behavioral health related needs at a higher rate compared to Washington State (Figure 4).

Figure 4: Medicaid enrollee ED utilization with behavioral health diagnosis, all ages (2019)



Source: Washington State Healthcare Authority (2020) [20]

Suicide and Self-Inflicted Injury

In 2020, the Olympic region experienced 735 emergency department (ED) visits related to suicide and self-inflicted injury. Kitsap County accounted for 70% of those visits (Figure 5), followed by Clallam County with 23%, and Jefferson County with 7%. Clallam County experienced the highest incidence rate of suicide and self-inflicted injury visits to the emergency department in the region with 221 visits per 100,000 residents (Figure 6) in 2020. These visits included any individual that presented in an ED in the Olympic region for suicide and self-inflicted injury regardless of insurance status and geographic area of residence.

Figure 5: Percentage of ED visits by County for suicide or self-inflicted injury in the Olympic region (2020)

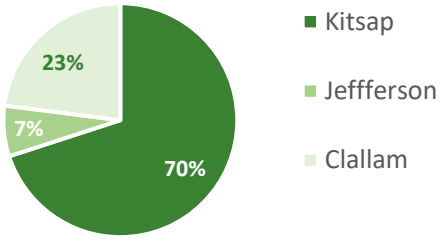
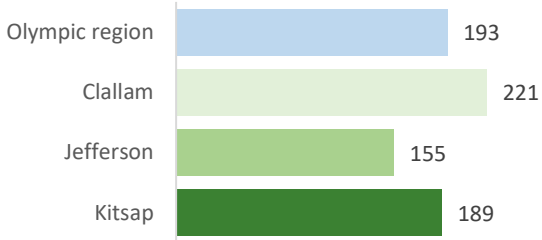


Figure 6: Incidence Rate of Suicide and Self-Inflicted Injury Visits to the Emergency Department per 100,000 Residents by County (2020)



Figures 5 and 6 source: National Syndromic Surveillance Program *(2020)* [21]

By Age

Of ED visits related to suicide and self-inflicted injuries across the three-county region, 51% were under the age of 29. The average rate across all age groups during this time period was 193 visits per 100,000 residents in 2020. The rate of visits for children under the age of nine were suppressed due to small numbers. Rates for individuals between 10 and 29 years of age were over two times the average rate across all age groups (Figure 7).

By Gender

In the Olympic region, females accounted for 53% of ED visits related to suicide and self-inflicted injuries, while males accounted for 47%. Females visited the ED at a rate higher than average for the region at 206 visits per 100,000. (Figure 8*)*.

Figure 7: Incidence rate of suicide and self-inflicted ED visits per 100,000 by age group in the Olympic region (2020)

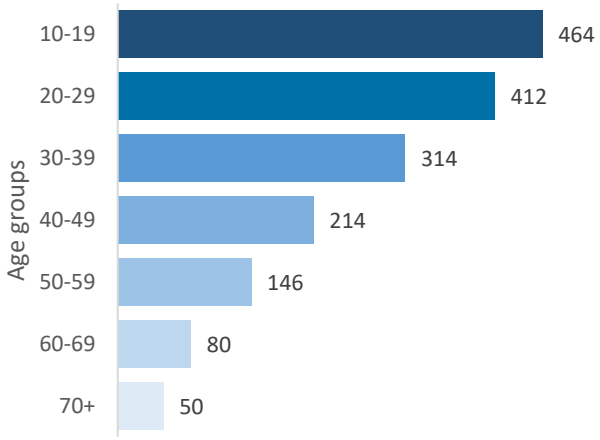
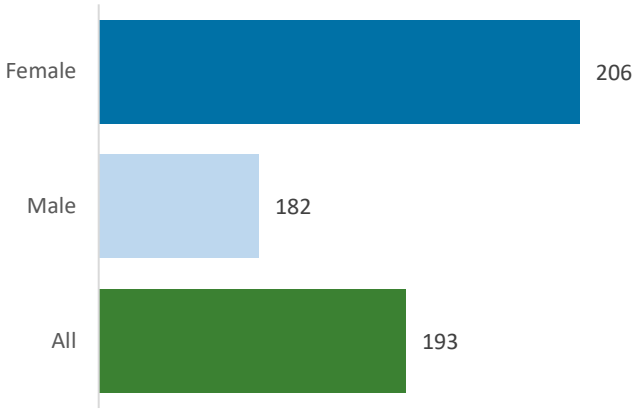


Figure 8: Incidence Rate of Suicide and Self-Inflicted injury ED visits per 100,000 by Gender in the Olympic Region (2020)



Note: Rate for ages 0-9 suppressed due to low number of visits

Figures 7 and 8 source: National Syndromic Surveillance Program *(2020)* [22]

Behavioral Health Treatment

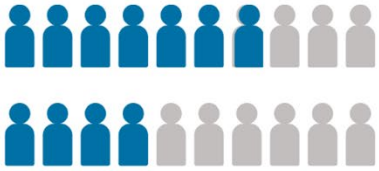
Mental Health Treatment Penetration

Approximately **1 in 2** adults on Medicaid (in the Olympic region) received the **mental health care** they needed.

In the Olympic region, only 53% of adult Medicaid enrollees (age 18-64) and 66% of youth Medicaid enrollees (age 6-17) with a mental health service need identified within the past two years received at least one qualifying service during 2019. While these numbers are not substantially different than the state's mental health treatment penetration rate, there is room for improvement. [23]

Approximately **7 out of 10** **youth** on Medicaid (in the Olympic region) received the **mental health care** they needed.

Approximately **4 out of 10** **youth** on Medicaid (in the Olympic region) received the **SUD treatment** they needed.



Substance Use Disorder (SUD) Treatment Penetration

In the Olympic region, 46% of adult Medicaid enrollees (age 18-64) with a SUD treatment need identified within the past two years received at least one qualifying service during 2019. Among youth Medicaid beneficiaries (age 12-17), 35% received at least one qualifying treatment. SUD treatment penetration among adults varies by county. Clallam County has strongest treatment penetration at 46%, followed by Jefferson County at 35% and Kitsap County at 31% [24]

Opioid Use Disorder (OUD) Treatment Penetration

Approximately **1 in 2** adults on Medicaid (in the Olympic region) received the **OUD treatment** they needed.

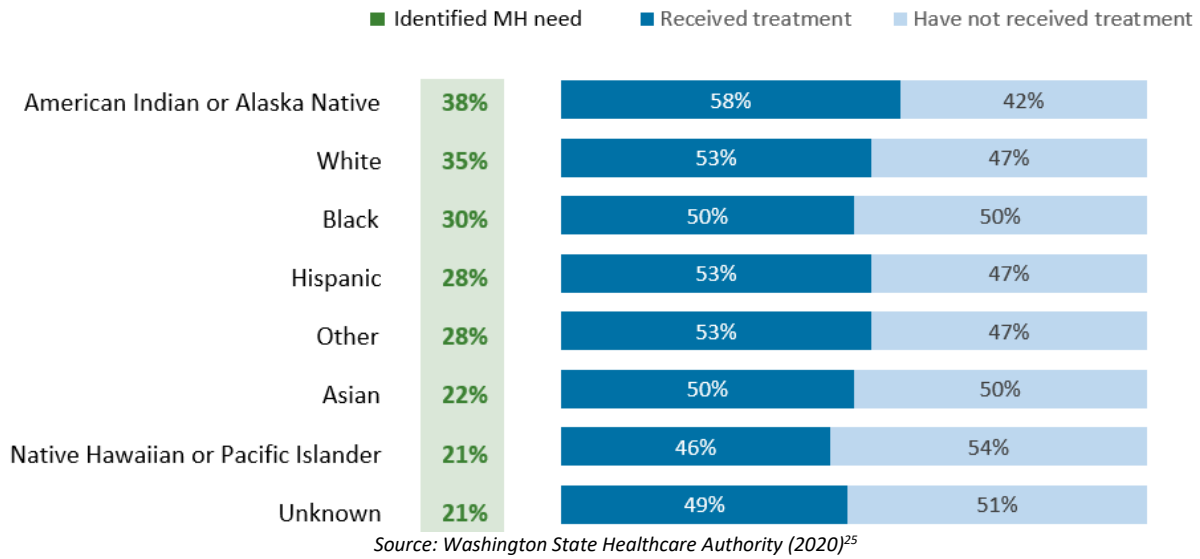
In the Olympic region, 52.7% of adult Medicaid enrollees (18-64) with an OUD treatment need identified within the past two years received medication-assisted treatment (MAT) or medication-only treatment for opioid use disorder during 2019. This compares with state OUD treatment penetration rate of 58.6%. This reflects an improvement over time from 34.8% measured in 2017. [25]

Behavioral Health Need and Rate of Treatment by Race & Ethnicity

Behavioral health needs vary by race and ethnicity in the Olympic region. Among Medicaid enrollees (ages 18-64), 38% of American Indian/Alaska Native (AI/AN) have an identified mental health need compared with 21% of Native Hawaiian or Pacific Islander. Treatment rate disparities exist between races and ethnicities for those with an identified mental health need. Among those identified as having a mental health need, 46% of Native Hawaiian or Pacific Islander Medicaid enrollees have received treatment compared to 58% of AI/AN Medicaid enrollees. Medicaid enrollees who are Asian, Black, 'Unknown' race, or Native Hawaiian and Pacific Islander are less likely to receive needed behavioral treatment than AI/AN, Other, White, and Hispanic. Overall, less than 53% of those identified with a mental health need have received treatment (Figure 9).

The Olympic region has improved opioid use disorder treatment penetration from 34.8% in 2017 to 52.7% in 2019.

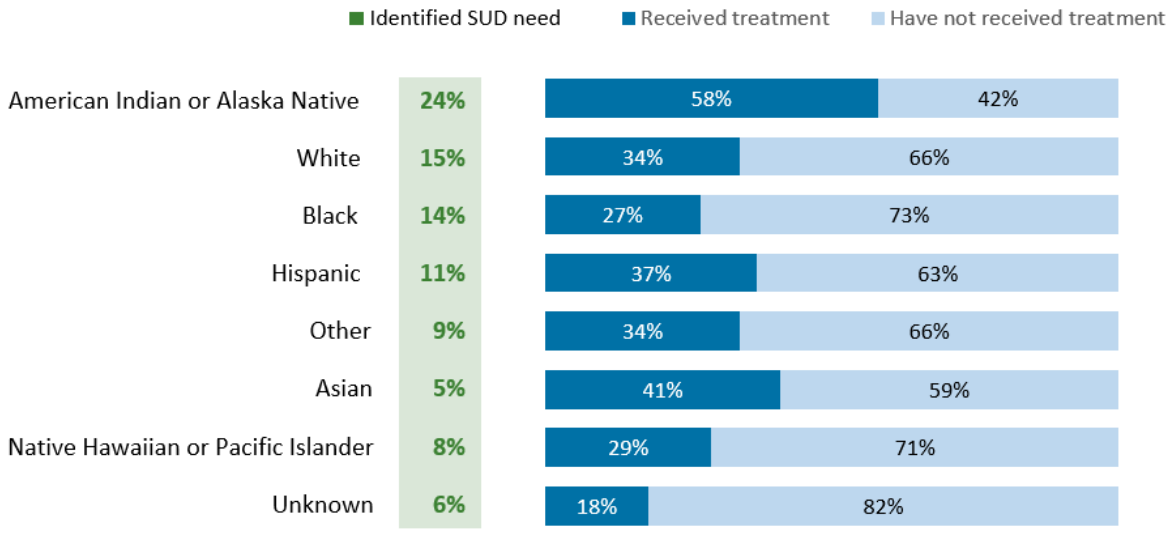
Figure 9: Identified mental health (MH) need and treatment rate among Olympic region adult Medicaid enrollees, by race/ethnicity (2019)



Source: Washington State Healthcare Authority (2020)[25]

Substance use need among adult Medicaid enrollees (ages 18-64) varies by race and ethnicity as well. As shown in Figure 10, AI/AN experience the highest rate of identified substance use need at 24% of Medicaid enrollees. The AI/AN population in the Olympic region also experiences the highest rate of treatment at 58%. Across all races, 36% of Medicaid enrollees with an identified substance use disorder treatment need in the Olympic region are receiving treatment.

Figure 10: Identified substance use disorder (SUD) need and treatment rate among Olympic region adult Medicaid enrollees, by race/ethnicity (2019)



Source: Washington State Healthcare Authority (2020) [26]

Behavioral Health Workforce

Improving behavioral health care services depends in part on ensuring that people have access to a behavioral health provider. Each county in the Olympic region is designated as a Mental Health Professional Shortage Area. [27] Shortages are calculated as the number of psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, advanced practice nurses specializing in mental health care as well as providers that treat alcohol and other drug abuse per 100,000 population. Most of Washington State is experiencing mental health professional shortages. Overall, the I-5 corridor is more successful in recruiting and retaining mental health professionals than the more rural counties as shown in Figure 11.

Figure 11: Mental health professional shortage areas by county (2020)

	# Mental Health Providers	Ratio to Population
WA State		270:1
Clallam County	256	300:1
Jefferson County	128	250:1
Kitsap County	887	300:1

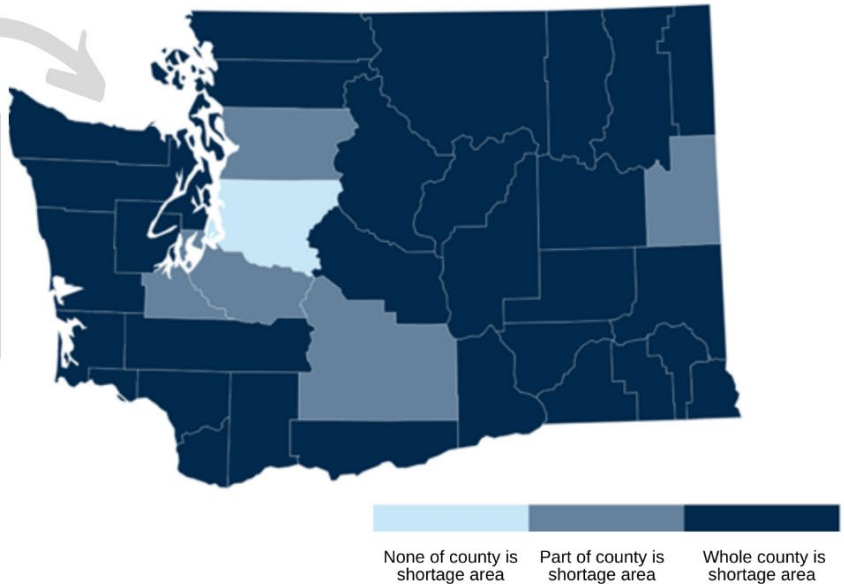


Figure 11 sources:
County Health Rankings & Roadmaps (2020) [28] and Rural Health Information Hub (2020) [29]

In 2017, Washington State conducted a Behavioral Workforce Assessment. The Assessment identified twenty-four categories of occupations credentialed for providing behavioral health services in Washington. The assessment identified that the Olympic region has an aging workforce. The mean age of practitioners is greater than 50 years of age. [30] The implications of this trend will be felt by the region in the coming years, as practitioners retire.

Salary

According to local behavioral health care professionals, Wendy Sisk (Peninsula Behavioral Health) and Jim Novelli (Discovery Behavioral Healthcare), salary wages for local behavioral health staff positions have not historically been shared due to competition for hiring (personal communications, January, 2021). This is slowly changing as agencies begin posting salary ranges for the current openings listed on their websites.

National data show that salaries vary, with licensed clinical and medical providers such as psychiatrists and psychiatric nurse practitioners receiving salaries that are significantly higher than salaries for non-licensed behavioral health workers. A national average for substance use, behavioral disorder, and mental health counselor salary is $52,000.

Source: U.S. Bureau of Labor Statistics (2020) [31]

Local behavioral health agencies that were willing to share staff salary ranges for this report indicated that salaries in the Olympic region trend lower, especially among the community mental health agencies which primarily serve Medicaid enrollees. Jim Novelli, Executive Director for Discovery Behavioral Healthcare explains,

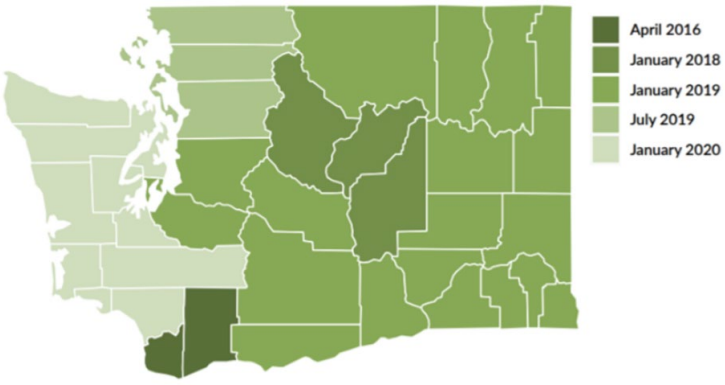
> *"It's a historical issue with community mental health, the rate of pay is significantly lower than those offered by a FQHC or hospital setting due to Medicaid rates being lower than other reimbursement forms. The proposed upcoming Medicaid rate increase of 4.5% isn't sufficient to reach parity with other payers. As a primary Medicaid provider our first priority is Medicaid clients. We don't turn them away or limit the number of Medicaid clients like other places may do. We also struggle to serve Medicare because only licensed clinical social workers are eligible to bill Medicare. We are unable to match salaries offered by hospital systems or other healthcare clinics."* (personal communication, January 14, 2021).

An additional, ongoing challenge to workforce recruitment is the shortage of affordable housing for potential hires wishing to move into the region poses. In Kitsap, average rental rates have increased by 60% over the past ten years, with a 2019 vacancy rate of 4%, lower than a "healthy" vacancy rate of 6 - 8%. [32] Looking at fair market value for rentals, each county in the region rates as "very high" compared to the national average and more expensive than most of the state of Washington. [33]

Integrated Managed Care

Mandated by the state, integrated managed care (IMC) aims to coordinate physical health, mental health, and substance use disorder treatment services to help provide "whole-person" care under one health plan. Most Medicaid clients have managed care, which means Washington State Medicaid pays health plans (Managed Care Organizations) a monthly premium for preventive, primary, specialty, and other health services coverage. Some Medicaid clients remain on a fee-for-service (FFS) arrangement, including many Tribal members.

Figure 13: IMC regions by implementation date



Source: Center for Health Systems Effectiveness (2020) [34]

Transitioning to Integrated Managed Care in the Olympic Region

The Olympic region fully transitioned to IMC on January 1, 2020 (Figure 13). The transition to IMC impacted all behavioral health providers in the region as well as physical health providers in Clallam County, the only county in Washington State that did not previously have managed care for physical health. While the region had ample notice regarding the transition, no funds were allocated to support system improvements such as electronic health record (EHR) changes, technical assistance to providers to understand the changes, and community education. Providers spent many hours and financial resources preparing for and implementing the transition.

The unforeseen COVID-19 pandemic collided with the region's transition to IMC and augmented the IMC transition challenges for providers and clients:

- ***Provider payments –*** Many behavioral health providers experienced unwarranted claim denials and rejections due to new billing codes.
- ***Reduced funding for non-Medicaid services*** – Services for individuals who are uninsured and underinsured decreased dramatically in 2020 causing some to turn to emergency departments for care and many to go without needed behavioral health care entirely.
- ***Launch of telehealth services*** – While the launch of telehealth services is greatly needed, especially in a rural area like the Olympic region, it was not planned for. The region lacks widespread broadband internet access, and many behavioral health clients do not have access to cell phones or computers.

The Olympic region's transition to Integrated Managed Care collided with the COVID-19 pandemic, causing a range of additional challenges and burdens for providers and clients.

Role of the Behavioral Health Administrative Service Organization

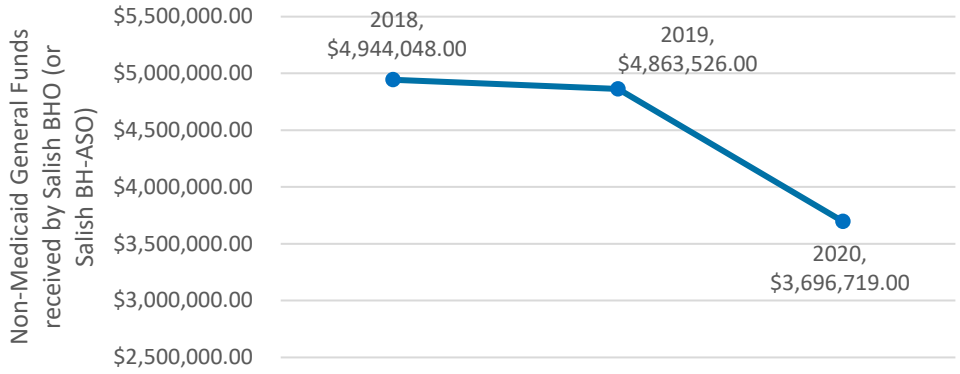
Prior to the launch of IMC in 2020, Medicaid enrollees' low intensity mental health service benefits were managed by Washington State Medicaid MCOs. Low intensity mental health services are defined as services provided by primary care offices and by private practitioners and therapists. Higher intensity mental health services and all substance use treatment were behavioral health benefits managed by regional Behavioral Health Organizations (BHOs). [35]

With the transition to IMC, the role of the BHO dissolved. The responsibility for behavioral health benefits management, low to high intensity services, was transitioned to Medicaid MCOs. Under IMC, MCOs manage both physical and behavioral health benefits, referred to as whole-person care, for Medicaid Managed Care enrollees. The MCOs currently providing managed care benefits in the Salish region are: Amerigroup Washington, Molina Healthcare of Washington, and UnitedHealthcare Community Plan. [36]

Another system change that was implemented in January 2020 was the creation of a Behavioral Health Administrative Services Organization (BH-ASO). In the Olympic region, this is the Salish BH-ASO (SBH-ASO). The SBH-ASO is responsible for managing the Regional Crisis System for all individuals regardless of funding or insurance status. The SBH-ASO contracts with a network of local behavioral health agencies who are licensed to provide 24/7 crisis services. Crisis services include toll-free crisis line services, mobile crisis outreach, and involuntary treatment investigations. The SBH-ASO is also responsible for the cost of involuntary treatment (psychiatric inpatient and secure withdrawal management) for individuals without Medicaid or other resources.

If financial resources remain after providing for the Regional Crisis System and involuntary treatment, the SBH-ASO may also provide for limited non-crisis behavioral health services for non-Medicaid individuals, such as outpatient treatment. However, with the reduction in non-Medicaid funding that occurred with the transition to IMC, very limited funding is available to provide for non-crisis services to non-Medicaid individuals. Overall, non-Medicaid funding from the state's General Fund has decreased from 2018 through 2020 (Figure 14).

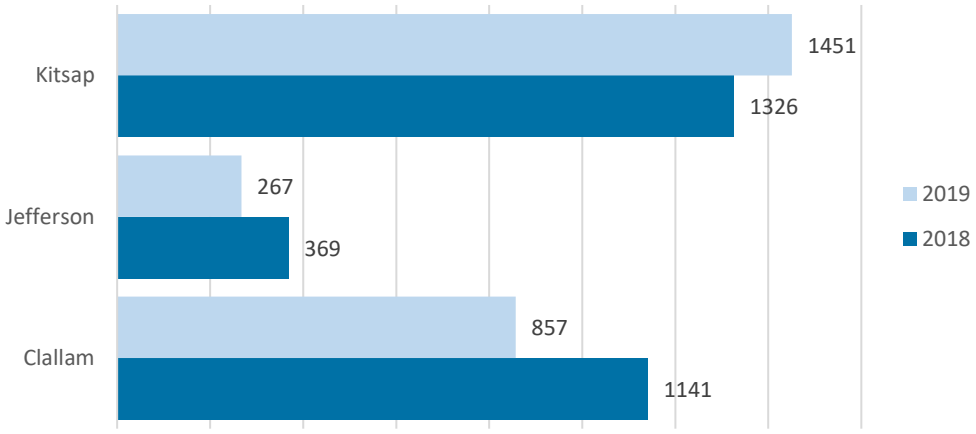
Figure 14: Non-Medicaid General Funds received in 2018-2020



Source: Salish Behavioral Health Administrative Services Organization (2020) [37]

The SBH-ASO provides for behavioral health crisis services to everyone within the region, regardless of insurance coverage. During 2018 and 2019, the most recent years for which data is available, the SBHO's Crisis Provider Network provided a total of 4,845 and 4,594 crisis services, respectively. [38] These services are broken down by county in Figure 15.

Figure 15: Crisis Services provided by Salish Behavioral Health Organization by County in 2018-2019

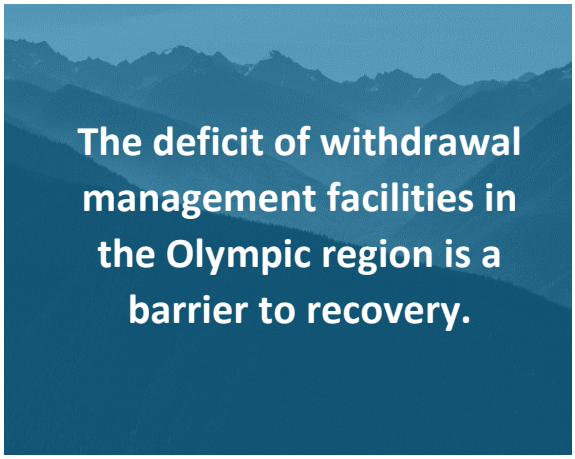


Source: Salish Behavioral Health Administrative Services Organization (2020)

Gaps & Challenges

There are many opportunities for improvement in prevention, treatment, and access to behavioral health care in the Olympic region. Here we focus on areas that have been raised by partners across our region.

Substance Use Withdrawal Management Facilities



Medically supported withdrawal management is often recommended for individuals with severe addiction who are at risk of seizures, respiratory failure, or other fatal side effects caused by acute withdrawal. Medical withdrawal management provides inpatient care so that the individual may be continuously monitored and supported by medical professionals. There are currently **zero medically assisted withdrawal management facilities** operating in Olympic region**.** Individuals requiring medically assisted withdrawal management services are referred to high-demand facilities in Tacoma, Chehalis, Lacey, Seattle, and other distant locations. Even when a referral is secured and a bed space is available, lack of transportation to these locations is a barrier to accessing care.

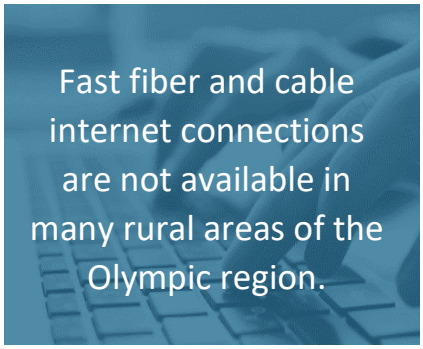
Residential withdrawal management (formerly known as "subacute detoxification") provides short-term non-medical inpatient support services for clients experiencing mild to moderate withdrawal symptoms. It is designed to monitor vitals, provide medication reminders, and support the client through the withdrawal process. To be accepted for this service, individuals must meet agency-established limits based upon screening tools that determine if an individual is not at medical risk and is past the worst symptoms of withdrawal (Figure 16). [39]

Figure 16: Residential withdrawal management facilities currently operating in the Olympic region

Kitsap County	Kitsap Recovery Center	**6 male & 3 female beds**
Kitsap County	Olalla Recovery Centers	**2 male & 1 female beds**
Jefferson County	N/A	**0 beds**
Clallam County	N/A - *Specialty Services closed their withdrawal management unit in March 2020*	**0 beds**

Broadband Internet Access

Limited access to broadband internet is a barrier to utilizing telehealth and telemedicine diagnosis and treatment services. Broadband internet, as defined by the Federal Communications Commission (FCC), has speeds of at least 25 megabytes per second (Mbps) download and at least 3 Mbps upload. [40] Limited access is also a barrier for youth and adults struggling to keep up with remote school and work requirements.



Broadband internet access varies geographically with lower access in rural and remote geographic areas; 3% of Kitsap residents do not have access to broadband compared with 15% and 17% in Clallam and Jefferson, respectively. [41] Fast fiber and cable internet connections are not available in many rural areas of the Olympic region. Current options in these areas include using phone lines (which can be slow and ineffective for the live audio and visual streaming required by telemedicine) and satellite connections (which are expensive). In Forks, there are three providers offering residential internet service, of which only one offers wired connection (DSL via phone lines). In comparison, residents of Bremerton may select from five residential internet providers, four of which offer wired connections (high-speed fiber and cable). [42]

Rates and Policies

Access to behavioral health care is impacted by reimbursement rates and policies. Here we describe two examples that have negatively impacted access to health care services: Medicare restrictions on SUD inpatient treatment and low or no reimbursement rates for telehealth.

Medicare coverage of SUD inpatient treatment is subject to restrictions which make it difficult for clients to access services. Medicare reimbursement for inpatient treatment is limited to hospital-based treatment facilities. There are no such facilities in the Olympic region and there is a high demand for openings in out-of-region hospital-based treatment facilities. Previously, the BHO provided funding to support inpatient treatment for Medicare clients at non-hospital facilities; that assistance has diminished with the decreased funding now provided to the BH-ASO (personal communication, Three-county Coordinated Opioid Response Project Treatment workgroup, January 20, 2021).

Before COVID-19, FQHCs and Rural Health Centers (RHCs) were not permitted to bill Medicare as a distant site for telehealth. While it is temporarily permitted, under the COVID-19 CARES Act, it “unfortunately still reimburses relatively poorly,” at about 30% of what would be reimbursed by Medicare for an in-person visit (M. Maxwell, personal communication, March 21, 2020). For other non-FQHC/RHC health care practices, telehealth was permitted prior to COVID-19 and billed at a lower rate than in-person care.

Early in the pandemic, Governor Inslee’s Proclamation 20-29 recognized the importance of telehealth options and specifically authorized such visits to be reimbursed at the same payment as an in-person encounter. Unlike the situation with Medicare, this removed any financial penalty barriers to providing telehealth services for Medicaid clients. Similarly, the Governor mandated that, during the pandemic, the commercial insurance plans must reimburse telehealth at the same rate they would reimburse a face-to-face visit. [43] These allowances are characterized as temporary for the duration of the pandemic emergency. Should encounter-parity be removed post-pandemic, there will once again be a barrier to providing telehealth.

Privacy Regulations: HIPAA and 42 CFR Part 2

In 1975 Congress passed legislation known as 42 CFR Part 2 which guarantees the confidentiality of information for individuals seeking treatment or with a diagnosis of substance use disorder at a federally assisted program. The statute requires that a patient must give specific written consent before information related to their SUD diagnosis or treatment plan is shared with non-addiction providers. The intent behind the law was to safeguard alcohol and drug patient information from use by law enforcement as well as to prevent housing and employment discrimination. [44]

No other chronic or acute diagnosis has the same shroud of protection as substance use disorder. Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which permits disclosure of client records without consent for the purpose of case management and care coordination. The only mental health record disclosure given special attention under HIPAA are psychotherapy notes which are recorded separately and are not included in the medical record. [45]

Because 42 CFR Part 2 requires an individual's consent for almost every instance of disclosure, it is an obstacle to timely sharing of information and blocks providers from easily and effectively coordinating care. The result is a fragmented system of care which frustrates efforts to integrate behavioral and physical health for individuals experiencing SUD, with potential for duplication and gaps in care which increase possibility for patient harm. [46] An additional unintended consequence of 42 CFR Part is that behavioral health providers face additional barriers to participating in electronic health information exchanges. [47]

Recovery Housing

Recovery houses are safe, healthy, substance-free living environments that support individuals who are in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. [48] There currently is no state or local data source identifying existing recovery residences in Washington State.

In 2019 Washington State HB1529 legislated a registry of certified recovery housing be established and maintained. As part of that process, OCH's Three-county Coordinated Opioid Response Project (3CCORP) treatment workgroup began collaborating with the Fletcher Group and surveyed the region to identify existing recovery housing. Initial findings from the regional survey indicate that the vast majority of recovery housing available in the Olympic region are peer-run Oxford Houses [49]. Regionally, Oxford Houses accommodate seven to ten individuals with better access to housing for men than for women and families available. Access to recovery housing in the Olympic region varies by county, with 9 Oxford Houses (75 beds) in Clallam County, 26 (224 beds) in Kitsap County, and none in Jefferson County. [50]

1/10th Citizens Advisory Committees

The Hargrove bill was passed by the Washington State legislature in 2005. It allows counties to pass a 1/10 (one tenth) of 1% sales tax for mental health, substance use treatment and to support court treatment programs. The bill was passed in recognition that behavioral health needs exceeded available funding. Each county administers their own 1/10th of 1% dollars. [51] Jefferson County Commissioner Brotherton reported that many 2020 applicants returned with funding requests in 2021. The county allocated $493,123 to 15 programs including transitional housing projects by Olympic Community Action Programs (OlyCAP) and Discovery Behavioral Healthcare and therapeutic housing support by Jefferson County's Juvenile & Family Court (personal communication, January 14, 2021).

Determinants of Health

It is estimated that about 20% of what creates health is related to access and quality of health care, including behavioral health care. The remaining 80% is shaped by the conditions in which people are born, live, grow, work, and age. These conditions shape health in a way that is beyond the reach of the health system and are referred to as the determinants of health (DoH). DoH can shape a person's health positively or negatively. Addressing social needs is an upstream solution that may prevent behavioral health needs before they begin.

Figure 17: Determinants of Health

Economic Stability	Education	Social and community context	Neighborhood and physical environment	Health and health care
Employment	Early childhood education & development	Civic participation	Violence and safety	Access and coverage to health care
Income	Education level	Discrimination	Housing quality	Quality of care
Debt	High school graduation	Incarceration	Transportation	Provider cultural competency
Food security	Language and literacy	Social cohesion	Walkability and parks	Health literacy
Housing	Vocational training	Support systems	Environmental pollutants	
		Stress	Air and water quality	

Figure 17 source: Olympic Community of Health (2020)[50]

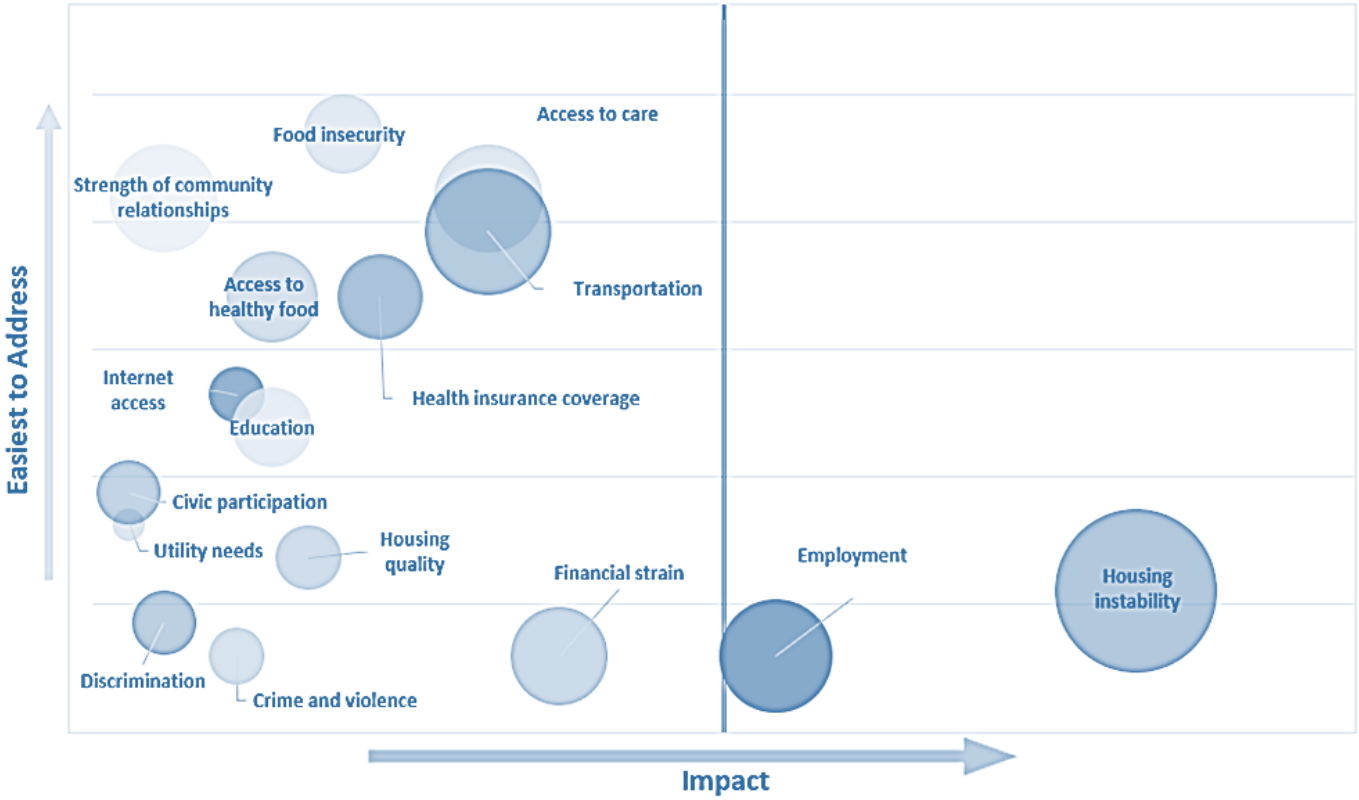
The COVID-19 pandemic is exacerbating social risk factors for millions, including loss of employment, subsequent health coverage loss, worsening food insecurity, and increasing housing instability. Many marginalized communities have been impacted disproportionately.

Figure 18 provides a visual of the Olympic region's priorities regarding determinants of health as determined by a regional survey conducted by OCH in May, 2020. Housing instability and employment were identified as social risk factors that would have both great impact and benefit from a regional response.

OCH is committed to addressing local determinants of health by taking the following next steps:

- Complete a full inventory of regional determinants of health work with a goal of maximizing current resources and work, increasing collaboration, and identifying funding gaps.
- Host a region-wide housing summit including a full data overview, highlighting successes, promising models, and providing space for collaborative problem solving.
- Encourage current Medicaid Transformation Project partners to advance community-clinical linkages, strengthening relationships across organizations, Tribes, and communities.
- Identify and coordinate funding opportunities to support local efforts addressing determinants of health.

Figure 18: Determinants of health priorities regarding ease, potential impact, and benefit from regional response (circle size).



Source: Olympic Community of Health (2020) [52]

Olympic Region Creativity & Successes

Local Approaches

The Olympic region has many communities, organizations, and Tribes working together to support the behavioral health needs across the region. OCH has seen many successes related to improving individual and population health across the region. Below are just a few examples of innovative projects by OCH partners.

Resiliency and Trauma-Informed Care Related Projects

Becoming a trauma-informed organization | Olympic Area Agency on Aging's (O3A)
O3A's Program Manager is a certified trauma-informed care trainer and is equipped with the experience and tools necessary to lead trauma-informed care workshops for all O3A branches. During COVID-19, O3A adapted their trauma-informed care training to a digital platform, allowing them to cater the training to a remote workforce and engage more staff than initially planned.

Resilience video project | Clallam Resilience Project
Clallam Resilience Project's Take Care and Be Well Tiny Video Series is a collection of short videos (2-5 min) highlighting resilience centered skills. The videos feature representatives from Jefferson County Health Department, Quillayute Valley School District, United Way of Clallam County, First Step Family Support Center, Nurturing Families LLC, Olympic

Community of Health, Clallam County Commissioner, Clallam County Health and Human Services, and more.

Tribal wellness kits | The Quileute Tribe
The Quileute Tribe provides monthly wellness kits to every household in the reservation. The kits have had an incredible impact on the community, providing opportunities for creative expression, safe community connections, and raising awareness of local services available through the Quileute Health Center.

Substance-Use Disorder/ Opioid-Use Disorder Related Projects

Syringe exchange | Peninsula Community Health Services (PCHS)
PCHS is now providing syringe exchange at five of their pharmacies. Kitsap Public Health District is partnering with PCHS to transition the public health district's syringe exchange services to a network of fixed-location health care facilities while the health district continues to provide a mobile syringe exchange program in rural areas of Kitsap County. PCHS provides medication assisted treatment and this change will increase linkage between needle exchange and treatment services.

Community paramedicine program | Port Angeles Fire Department
Port Angeles Fire Department hired a community paramedic who works with the Port Angeles Police Department social worker to remove barriers to recovery. The community paramedic and social worker remove barriers by identifying high risk individuals, coordinating care, providing transportation, and conducting outreach with the homeless community via homeless shelters and visits to homeless camps. In just six months, the Community Paramedicine program saw a 50% decrease in EMS calls and transports to the Emergency Room after initial contact with the Community Paramedic. The concept of community paramedicine has spread, Jefferson Police Department is in process of creating policies and procedures to support a social worker.

Community Health Improvement Program (CHIP) | Jefferson County
Jefferson County CHIP works to strengthen and expand Substance Use Disorder and Opioid Use Disorder prevention, treatment and recovery services. They conducted a needs assessment addressing the treatment and recovery needs of Jefferson County and developed a strategic, workforce, and sustainability plan.

Telehealth Related Projects

MAT telehealth | Port Gamble S'Klallam Health Clinic
Port Gamble S'Klallam Health Clinic initiated telehealth services allowing counselors and MAT providers to provide individual and group services via telehealth. Telehealth has been implemented across primary care and behavioral health services.

Virtual dialectical behavior therapy | Kitsap Mental Health Services
Kitsap Mental Health Services implemented virtual Dialectical Behavior Therapy (DBT) within the Child and Family Department. The program has since seen a 100% participation rate.

Community Connect pilot clinic | Jamestown Family Health Clinic
Integration of virtual/telehealth visits and patient scheduling via a patient portal

(MyChart). Jamestown Family Health Clinic was the Community Connect pilot clinic for the implementation and testing of the integrated telemedicine using Zoom with MyChart. This allows a more efficient and functional telemedicine experience for the patient. Medical Laboratory Technicians and Licensed Clinical Social Worker were trained to provide audio/video as well as telephone only visits.

OCH Solutions

In addition to supporting partner projects and initiatives (such as the ones listed above), OCH is committed to leading creative approaches addressing regional health priorities. The examples below outline a few areas that OCH will be taking lead on over the next year.

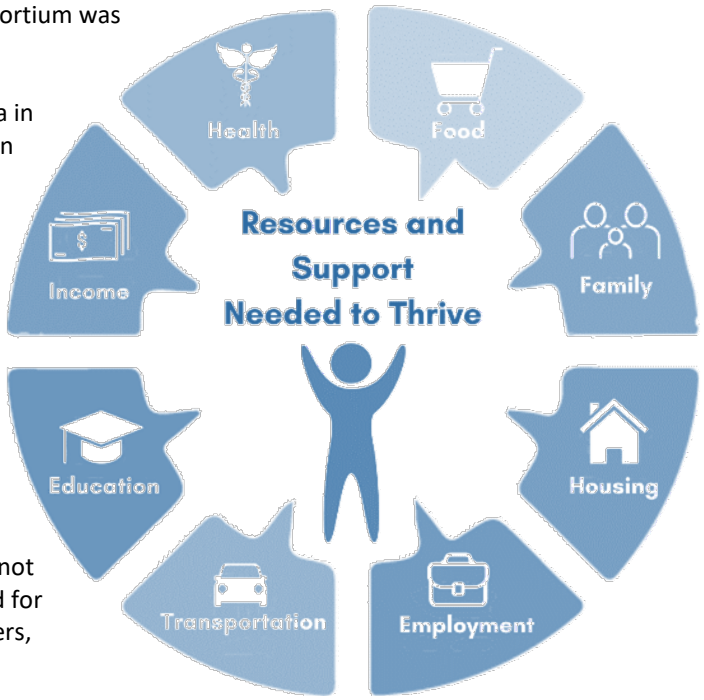
Addressing Stigma

Stigma is defined as "a mark of disgrace associated with a person, a personal quality, or a personal circumstance." [53] Stigma can be a barrier to seeking behavioral health services. It can also be a barrier to reaching out to friends or employers for help as stigma contributes to alienation from others who do not understand the disease or how to help. [54] The American Society of Addiction Medicine webpage reports:

> *"Unfortunately, because of the legal and social ramifications associated with addiction, patients are often reluctant to tell their doctor that they may have addiction or consent to the disclosure of information about their addiction treatment. This is an unfortunate aspect of the stigma that surrounds this disease, and it exacerbates the addiction treatment gap that exists in this country."* [55]

OCH and its partners are committed to addressing stigma in the Olympic region in 2021. The Steering Committee of Three-county Coordinated Opioid Response Project (3CCORP) prioritized stigma as an intervention focus area. OCH was awarded $245,000 by Cambia Health Solutions and directed those funds be used to implement a multi-prong approach to combat behavioral health stigma in our region, especially stigma related to substance use disorder.

At the local level, the Jefferson County Behavioral Health Consortium was awarded $1,000,000 Rural Communities Opioid Response – Implementation (RCORP-I) by Health Resources and Services Administration (HRSA) with an objective to address SUD stigma in Jefferson & Clallam counties in partnership with the Jamestown S'Klallam Tribe. [56]



Clallam Care Connection (3C)

Fragmented care occurs when health care providers and other organizations do not effectively work well together. Providers describe working in silos with systems that are not set-up to support collaborative multidisciplinary coordinated care for high-risk Individuals such as those with serious mental health and/or substance use disorders. This challenge is not unique to the Olympic region, a recent study by Health Affairs reported that, "Compared to physicians in other countries, substantial proportions of U.S. physicians did not routinely receive timely notification or the information needed for managing ongoing care from specialists, after-hours care centers,

emergency departments, or hospitals". [57] One of the most effective methods of improving client outcomes while decreasing costs is care coordination.

Clallam Care Connection (3C) is a pilot project that provides coordinated care to improve the health status of individuals with complex, chronic conditions to deliver a seamless experience of care that is person-centered, cost-effective, addresses social determinants of health, and results in improved health and wellness. Connecting weekly, providers from health, social service and community organizations are breaking the silos and moving towards whole-person care. 3C focuses on serving members of the community who are at risk for or experiencing: debilitating mental health and substance use disorder, repeat 911/emergency department use, risk of suicide, transition out of inpatient services or jail/prison; disjointed or discontinuous care.

3C is in its start-up phase with four organizations currently participating: North Olympic Healthcare Network (NOHN), the Port Angeles Fire Department, Peninsula Behavioral Health, and REdisCOVERY (a team of navigators who work closely with the Port Angeles Police Department to respond to mental health crises in the field). The benefits are already apparent with increased appointment and medication adherence among 3C clients and unnecessary 911 and ED visits prevented. Additionally, 3C team members have the benefit of closed-loop referrals (meaning that the outcome of a referral is known). In the future, 3C will use a shared digital information exchange platform if one becomes available and if the parties agree to pay and participate in its use.

Opportunities & Recommendations

There are many opportunities for legislators, policy makers, health care providers, community-based organizations, social service agencies, Tribal health centers, and communities to prioritize behavioral health. OCH's regional partners recommend the following:

Workforce

- Provide advocacy to increase salaries for behavioral health providers commensurate with their education, training, and the cost-saving benefit their services provide.
- Conduct a behavioral health workforce study to ascertain current strengths and opportunities to address workforce staffing shortages.
- Advocate for behavioral health reimbursement rates that are based on actual costs and salaries, not on past and current rates which have not kept up with cost of living and education.
- Improve access to housing. Ensure that housing (rental and home ownership) is affordable over time for occupancy by local employees and residents.

Determinants of Health

- Prioritize innovative and creative housing and transportation solutions to improve access to care across the region.
- Strengthen partnerships between community-based organizations and clinical providers to address social needs.
- Sustainable funding to address determinants of health.

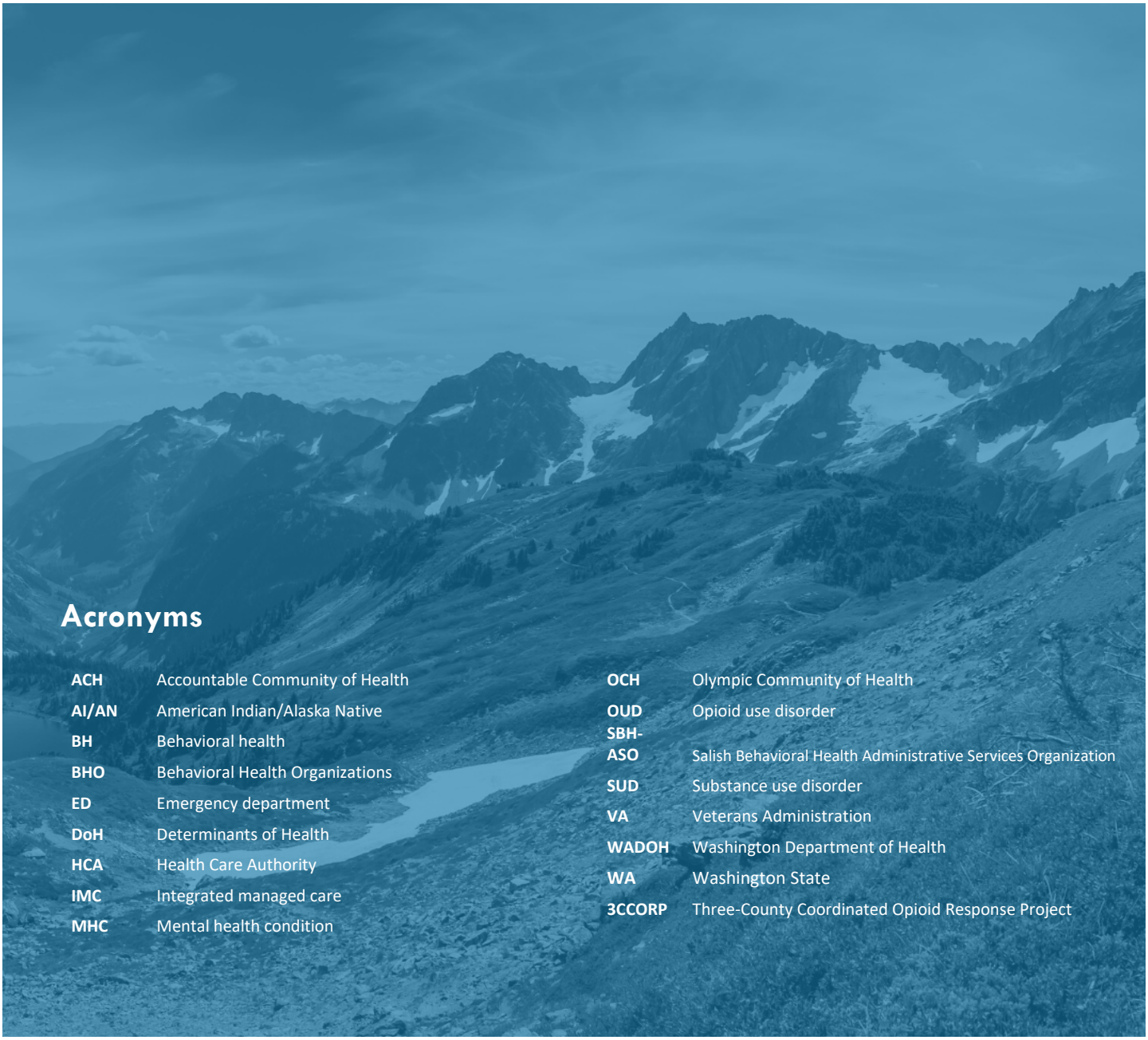
Services

- Address the need for additional withdrawal management and stabilization services in the Olympic region and across the state.
- Implement guidance that improves data sharing and communication between clinical and community partners.
- Increase mental health and substance use disorder services; expand eligibility for existing services and increase the number and type of services.

- Increase funding to the Behavioral Health Administrative Service Organizations to funding levels of 2018 and 2019. This will improve access to non-crisis services, such as outpatient treatment, among non-Medicaid individuals.

Technology & Whole Person Care

- Establish guidance to streamline and support implementation of HIE in our region and state. Enhance referral systems and processes to better connect clients to existing community resources.
- Address perceived barriers to coordination and integration of care, including health information exchanges (HIE) among behavioral health providers regionally and statewide. Provide training on complying with confidentiality regulations such as 42CFR Part 2 while using HIE.
- Continue to support COVID-19 recovery and resources including cell phones and laptop distribution programs for Medicaid clients to ensure continued access to services and treatment.



Acronyms

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
BH	Behavioral health
BHO	Behavioral Health Organizations
ED	Emergency department
DoH	Determinants of Health
HCA	Health Care Authority
IMC	Integrated managed care
MHC	Mental health condition
OCH	Olympic Community of Health
OUD	Opioid use disorder
SBH-ASO	Salish Behavioral Health Administrative Services Organization
SUD	Substance use disorder
VA	Veterans Administration
WADOH	Washington Department of Health
WA	Washington State
3CCORP	Three-County Coordinated Opioid Response Project

References

[1] Washington State Office of Financial Management, Forecasting Division, single year intercensal estimates 2001-2009; 2011–2019, Community Health Assessment Tool (CHAT), February 2020. Web Accessed 11/19/2020.

[2] Ibid.

[3] Ibid.

[4] Rural Health Information Hub. (2021). *Critical access hospitals (CAH).* https://www.ruralhealthinfo.org/topics/critical-access-hospitals

[5] Centers for Medicare and Medicaid Services. (2020). *Yearly aged and disabled enrollment counts by state and county. Enrollment dashboard data file_01_21_2021*. Web Accessed 1/25/2021. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard

[6] Washington State Health Care Authority (2020). Healthier Washington Dashboard. *Medicaid Population Explorer*. Web accessed 1/6/2021

[7] U.S. Census Bureau. (2020). *2014-2018 American Community Survey 5-year Public Use Microdata Samples*. Web Accessed 11/19/2020.

[8] Washington State Office of Financial Management, Forecasting Division, single year intercensal estimates 2001-2019, Community Health Assessment Tool (CHAT).

[9] Live Stories (2021). *Veterans Demographics and Statistics for Kitsap, Jefferson, and Clallam Counties*. Accessed 2/10/21. https://www.livestories.com/statistics/washington/kitsap-county-veteran-demographics

[10] U.S. Department for Veterans Affairs. (2021). *Community Care: Veterans Overview*. Accessed 2/10/21. https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp

[11] Agency for Healthcare Research & Quality (2018). *Chartbook on care coordination: Preventable emergency department visits*. https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html

[12] Agency for Healthcare Research & Quality (2017). *Trends in emergency department visits 2006-2014*. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf

[13] Agency for Healthcare Research & Quality (2020). HCUP Fast Stats - Most Common Diagnoses for Inpatient Stays. https://www.hcup-us.ahrq.gov/faststats/NationalDiagnosesServlet?year1=2017&characteristic1=22&included1=0&year2=&characteristic2=0&included2=1&expansionInfoState=hide&dataTablesState=hide&definitionsState=hide&exportState=hide

[14] Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel. L., Muñana, C., & Chidambaram, P. (2021, August 21). *The Implications of COVID-19 for Mental Health and Substance Use*. Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[15] Olympic Community of Health. (2020). *Behavioral Health Collaboration Call* June 26, 2020. https://www.olympicch.org/post/covid-19-collaboration-calls-6-26-20

[16] Health & Human Services. (2020). Billing for telehealth during COVID-19. https://telehealth.hhs.gov/providers/billing-and-reimbursement/

[17] Mental Health America. (2021). *2021: The State of Mental Health in America.* https://www.mhanational.org/issues/2021/mental-health-america-prevalence-data#three

[18] Mental Health America. (2021). *2020: The State of Mental Health in America*. https://mhanational.org/issues/2020/ranking-states

[19] Washington State Health Care Authority (2020). Derived from Healthier Washington Measures Dashboard. Web Accessed 11/25/2020.

[20] Washington State Health Care Authority (2020). Derived from Healthier Washington Measures Dashboard. Web Accessed 11/25/2020. https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboards

[21] Centers for Disease Control and Prevention, National Syndromic Surveillance Program, Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), accessed 10/30/2020; Washington Office of Financial Management, Population Estimates, 2018, 2019, 2020.

[22] Centers for Disease Control and Prevention, National Syndromic Surveillance Program, Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), accessed 10/30/2020; Washington Office of Financial Management, Population Estimates, 2018, 2019, 2020.

[23] Washington State Health Care Authority (2020). Healthier Washington Dashboard. Measure Explorer. Retrieved January 6, 2021, from https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/MeasureExplorer?%3AisGuestRedirectFromVi3999zportal=y&%3Aembed=y

[24] Washington State Health Care Authority (2020). *Healthier Washington Dashboard. Measure Maps*. Retrieved January 6, 2021 from https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/MeasureMaps?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

[25] Washington State Health Care Authority (2020). *Statewide Trends*. Retrieved December 29, 2020 from https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/Trends?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

[26] Washington State Health Care Authority (2020). Derived from Healthier Washington Measures Dashboard. Web Accessed 11/25/2020. https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboards

[27] Washington Department of Health (2020). *2020 Health Professional Shortage Areas (HPSA) List*. https://www.doh.wa.gov/Portals/1/Documents/2900/689141.pdf

[28] County Health Rankings & Roadmaps (2021). *Washington 2020 Mental Health Providers*. https://www.countyhealthrankings.org/app/washington/2020/measure/factors/62/data

[29] Rural Health Information Hub. (2020). *Health Professional Shortage Areas: Mental Health, by County, 2020 - Washington*. https://www.ruralhealthinfo.org/charts/7?state=WA

[30] Gattman, N.E., McCarty, R.L., Balassa, A., & Skillman, S.M. (2017). *Washington State Behavioral Health Workforce Assessment.* Washington Workforce Training and Education Coordinating Board. P15. https://www.wtb.wa.gov/wp-content/uploads/2019/05/WA-Behavioral-Health-Workforce-Assessment-2016-17.pdf

[31] U.S. Bureau of Labor Statistics. (2020). *Occupational Employment and Wages, May 2019 21-1018 Substance Abuse, Behavioral Disorder, and Mental Health Counselors.* https://www.bls.gov/oes/current/oes211018.htm

[32] Kitsap Sun (2019). *Across the west sound, rent continues to climb*. https://www.kitsapsun.com/story/news/2020/02/19/rent-continues-climb-across-west-sound/4809221002/

[33] RentData.org. (2021). *Washington fair market rent for 2020*. Accessed January 20, 2021. https://www.rentdata.org/states/washington/2020

[34] The Center for Health Systems Effectiveness at Oregon Health & Science University. (2020). *Medicaid Transformation Project Evaluation Interim Report (December 13, 2020)*. https://www.hca.wa.gov/assets/program/mtp-interim-report.pdf

[35] Washington State Department of Health and Social Services. *Medicaid-Funded Behavioral Health Treatment Guide for Individuals and Families.* https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO/BH_Info_Clients.pdf

[36] Washington State Health Care Authority (2021). *Apple Health managed care Service area map - January 2021.* https://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf

[37] Salish Behavioral Health Administrative Services Organization. (2020).

[38] Ibid.

[39] National Institute on Drug Abuse (2020). *Clinical Opiate Withdrawal Scale*. https://www.drugabuse.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

[40] Federal Communications Commission (2020). *2020 Broadband Deployment Report*. https://docs.fcc.gov/public/attachments/FCC-20-50A1.pdf

[41] Broadband Now (2020). *Broadband Service in Washington*. https://broadbandnow.com/Washington
[42] Ibid.
[43] Office of the Governor (2020). *Proclamation by the Governor amending Proclamation 20-05: 20-29 Telemedicine*. March 25, 2020. https://www.governor.wa.gov/sites/default/files/proclamations/20-29%20Coronovirus%20OIC%20%28tmp%29.pdf
[44] Wakeman, S.E., and Friedmann, P. Health Affairs. (2017*). Outdated privacy law limits effective substance use disorder treatment: The case against 42 CFR Part 2*. https://www.healthaffairs.org/do/10.1377/hblog20170301.058969/full/
[45] Holland & Heart Health Law Blog (January 29, 2020). *HIPAA, Psychotherapy Notes, and Other Mental Health Records*. https://www.jdsupra.com/legalnews/hipaa-psychotherapy-notes-and-other-42359/
[46] The Association for Community Affiliated Plans (ACAP). 2016. *The Impact of 42 CFR Part 2 on care coordination by health plans for members with substance use disorders*. https://www.opioidlibrary.org/wp-content/uploads/2019/08/Impact42CFR_ACAP.pdf
[47] Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Frequently Asked Questions Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE).* Accessed 2/12/21. https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf
[48] Substance Abuse And Mental Health Services Administration. *Recovery housing: Best practices and suggested guidelines*. https://www.samhsa.gov/sites/default/files/housing-best-practices-100819.pdf
[49] Three-county Coordinated Opioid Response Project (3CCORP). (2020*). September 16, 2020 Treatment Workgroup Minutes*. https://2f7b4411-f7f6-4d37-bfcb-6d23ced1c9b7.filesusr.com/ugd/ea40b8_8a2c33ae711d4dcbbcd09e523da5a724.pdf
[50] Oxford Vacancies. Retrieved December 24, 2020. https://www.oxfordvacancies.com/
[51] Washington State Legislature (2021). *RCW 82.14.460. Sales and use tax for chemical dependency or mental health treatment services or therapeutic* courts. https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460
[52] Olympic Community of Health. (2020). *Advancing and Transforming the Social Determinants of Health in the Olympic Region*. https://www.olympicch.org/sdoh-report
[53] Oxford Dictionary of Psychology (3rd ed.) Oxford University Press. Online edition (2014). https://www.oxfordreference.com/view/10.1093/acref/9780199534067.001.0001/acref-9780199534067-e-9263
[54] Mayo Clinic Staff. (2018). *Mental Illness: Overcoming the stigma of mental illness*. https://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477
[53] American Society of Addiction Medicine. (2021). *Confidentiality*. https://www.asam.org/advocacy/practice-resources/confidentiality-(42-cfr-part-2)
[54] Olympic Community of Health (2021). *Three-county Coordinated Opioid Response Project (3CCORP) Treatment Workgroup Meeting Packet* (November 18, 2020). https://2f7b4411-f7f6-4d37-bfcb-6d23ced1c9b7.filesusr.com/ugd/ea40b8_5f3c0610b2cd47f0a9afd713a5e7aa29.pdf
[55] Health Affairs. (2019). *Primary Care Physicians' Role In Coordinating Medical And Health-Related Social Needs In Eleven Countries*. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01088?journalCode=hlthaff