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 18, 2022**

TIME: **9:00 AM – 11:00 AM**

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

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

LINK TO JOIN BY COMPUTER OR PHONE APP:

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

Meeting ID: 896 5965 8569

Passcode: 715701

USE PHONE NUMBER and MEETING ID TO JOIN BY PHONE:

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

Meeting ID: 896 5965 8569

Passcode: 715701

AGENDA

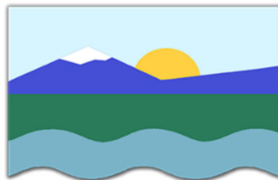
Salish Behavioral Health Administrative Services Organization – Executive Board

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

ACRONYMS

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

Full listing of definitions and acronyms



Providing Behavioral Health Services in Clallam, Jefferson and Kitsap Counties

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

EXECUTIVE BOARD MEETING

Friday, March 18, 2022

Action Items

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

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

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

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

Informational Items

A. UPDATE ON STATUS OF RFPS

Youth Mobile Crisis Team

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

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

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

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

Behavioral Health Co-Responder

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

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

B. BRIEFING FROM COMMISSIONER OZIAS ON RUCKELSHAUS WORKGROUP

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

C. SBH-ASO STAFFING UPDATE

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

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

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

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

D. EVALUATING SBH-ASO INFRASTRUCTURE IMPROVEMENTS

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

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

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

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

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

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

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

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

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

F. <u>LEGISLATIVE UPDATE</u>

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

Related to Behavioral Health Workforce

- E2SSB 5884: Establishing Behavioral Health Support Specialists

Related to Law Enforcement

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

Related to Involuntary Treatment

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

G. <u>BHAB UPDATE</u>

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

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION
EXECUTIVE BOARD

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

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

INTRODUCTIONS – Self introductions were conducted.

ANNOUNCEMENTS – None.

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

APPROVAL of AGENDA – Commissioner Brotherton

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

APPROVAL of MINUTES –

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

ACTION ITEMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reviewed Risk Assessment ranking at the top of document.

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

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

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

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

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

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

INFORMATIONAL ITEMS

- **OLYMPIC COMMUNITY OF HEALTH UPDATE**

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

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

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

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

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

- **SBH-ASO ADVISORY BOARD UPDATE**

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

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

PUBLIC COMMENT

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

GOOD OF THE ORDER

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

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

ATTENDANCE

BOARD MEMBERS	STAFF	GUESTS

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

NOTE: These meeting notes are not verbatim.

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

SALISH BH-ASO POLICIES AND PROCEDURES

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

Effective Date: 1/1/2020

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

Reviewed Date: 5/2/2019

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

PURPOSE

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

POLICY

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Crisis System General Requirements

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

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

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

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

2. Crisis Services shall be delivered as follows:

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

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

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

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

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

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

Crisis System Staffing Requirements

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

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

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

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

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

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

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

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

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

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

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

Crisis System Operational Requirements

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

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

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

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

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

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

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

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

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

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

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

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

Integrated Crisis System:

1. Crisis services reflect the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mobile Outreach Services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Care Coordination Post Crisis

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

Ancillary Requirements of the SBH-ASO Crisis System

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

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

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

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

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

   QACC will monitor outcomes from those recommendations.

SALISH BH-ASO POLICIES AND PROCEDURES

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

POLICY

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c) Engage the treatment team in care planning

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

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

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

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

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

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

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

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

MONITORING

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

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: INVOLUNTARY TREATMENT ACT SERVICES	**Policy Number:** CL202
Effective Date: 1/1/2020	
Revision Dates: 11/2/2021	
Reviewed Date: 4/16/2019; 2/3/2021	
Executive Board Approval Dates: 5/17/2019	

PURPOSE

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

DEFINITIONS

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

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

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

POLICY

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

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

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SALISH BH-ASO POLICIES AND PROCEDURES

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

Effective Date: 1/1/2020

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

Reviewed Date: 10/8/2019

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

PURPOSE

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

POLICY

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

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

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

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

   2. Adverse authorization decisions involving an expedited authorization

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

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

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

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

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

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

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

1. Authorization reviews shall be conducted by state licensed Behavioral

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

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

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

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

PROCEDURE

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

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

Level 3 Services

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

Inpatient Psychiatric Hospitalization and Secure Withdrawal Management and Stabilization Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

include impulsive, aggressive, or abusive behaviors)

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

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

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

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

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

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

4.1. Involuntary Treatment Act Detention Notification Protocol

4.1.1. Prospective Authorization is not required for ITA detentions.

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

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

4.2. Post Service Certification Requests

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Level 2 Services

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

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

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

Level 3.1 – Clinically Managed, Low Intensity Residential Services

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

Level 3.5 – Clinically Managed, Medium Intensity Residential Services

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

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

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

2.1. Need for SUD services is established,

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

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

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

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

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

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

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

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

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

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

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

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

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

supervisor;

5.2. Or if consent for treatment is withdrawn;

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

Mental Health Residential Treatment Services – *within available resources*

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

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

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

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

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

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

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

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

Level 1 Services

Outpatient behavioral health services.

Mental Health Outpatient Services – *within available resources*

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

medical necessity, financial eligibility, and within available resources.

Mental Health Outpatient – Standard – *within available resources*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental Health Outpatient - PACT– *within available resources*

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

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

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

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

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

AND PACT criteria listed below:

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

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

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

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

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

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

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

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

6. ***Discharge.*** Discharge from care is based upon one or more of the following:

6.1. Treatment goals have been met and the individual does not require a continuation of services within the current, or another, category of care to maintain the gains or prevent deterioration.

6.2. The individual's needs can be met via other resources within their support system (e.g., Primary Care Provider (PCP), support groups, etc.).

6.3. The individual is not participating in treatment and does not meet criteria for involuntary treatment.

6.4. The individual (or the legal guardian) requests that services be discontinued.

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

6.6. Loss of eligibility or lack of available resources.

Psychological Assessment/Testing

Medical necessity criteria for Psychological Assessment/Testing:

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

The psychological testing outcome could not otherwise be ascertained during:

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

All of the following criteria must be met:

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

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

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

Psychological testing is not covered for the following:

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

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

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

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

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

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

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

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

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

Outpatient Standard Level of Care.

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

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

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

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

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

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

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

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

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

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

Substance Use Disorder Outpatient – Opiate Treatment Program – *within available resources*

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

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

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

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

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

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

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

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

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

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

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

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

Level 0 Services

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

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

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

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

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

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

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

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

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

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

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

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

4. Authorization Protocol.

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

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

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

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

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

5.2. Individual is not making progress toward treatment goals.

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

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

Substance Abuse Withdrawal Management – *within available resources*

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

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

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

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

Authorization Protocol.

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

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

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

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

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

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

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

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

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

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

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

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

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

5.2. Individual is not making progress toward treatment goals.

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

5.4. Loss of financial eligibility or lack of available resources

Clinically Managed Residential Withdrawal Management - ASAM Level 3.2

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

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

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

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

5. ***Authorization Protocol.***

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

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

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

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

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

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

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

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

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

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

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

6. Discharge. The individual continues in a Level 3.2 WM program until:

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

6.2. Individual is not making progress toward treatment goals.

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

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

Services that do not require medical necessity:

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

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

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

SALISH BH-ASO POLICIES AND PROCEDURES

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

POLICY

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

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

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

REVOCATION OF LR/CR ORDERS

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

COORDINATION OF CARE

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

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

SBH-ASO TRACKING OF LRA ORDERS ISSUED BY SUPERIOR COURTS

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

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

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

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

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

SALISH BH-ASO POLICIES AND PROCEDURES

Policy Name: STATE HOSPITAL CARE COORDINATION

Policy Number: CL206

Effective Date: 1/1/2020

Revision Dates: 5/14/2020; 10/25/21

Reviewed Date: 7/30/2019

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

PURPOSE

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

POLICY

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

PROCEDURE

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

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

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

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

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

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

SBH-ASO POLICIES AND PROCEDURES

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

PURPOSE

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

DEFINITIONS

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

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

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

POLICY

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. <u>The R.E.A.L. Program Staff Training Plan includes:</u>

a. Prior to First Contact:

i. LEAD CORE Principles

ii. CPR and Medical First Aid

iii. Safety Training

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

v. Harm reduction

vi. Trauma- informed responses

vii. Cultural appropriateness

viii. Conflict resolution and de-escalation techniques

ix. Crisis Intervention

x. Introduction to Regional Crisis System

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

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

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

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

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

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

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

R.E.A.L. Program Reporting Requirements

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

SALISH BH-ASO POLICIES AND PROCEDURES

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

PURPOSE:

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

POLICY:

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

Definitions:

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

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

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

Procedure:

Housing Program Facilitation:

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

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

HOUSING AND RECOVERY THROUGH PEER SUPPORTS (HARPS)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   i. Promote self-determination

   ii. Model and teach self-advocacy

   iii. Encourage and reinforce choice and decision-making

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

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

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

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

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

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

   a. To establish a peer relationship with each participant

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

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

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

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

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

COMMUNITY BEHAVIORAL HEALTH RENTAL ASSISTANCE (CBRA)

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

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

Reporting

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

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

Billing

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

Billing must be in accordance with contract budget.

SALISH BH-ASO POLICIES AND PROCEDURES

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

POLICY

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

PROCEDURE

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

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

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

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

SALISH BH-ASO POLICIES AND PROCEDURES

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

PURPOSE

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

POLICY

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

PROCEDURE

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

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

Claims can be submitted via mail to:

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

Or claims can be submitted via encrypted electronic transmission.

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

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

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

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

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

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

I. Professional Services delivered in an inpatient setting

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

SALISH BH-ASO POLICIES AND PROCEDURES

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

Effective Date: 01/01/2020

Revision Date(s): 10/14/2021

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

Executive Board Approval Dates: 11/1/2019

PURPOSE

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

POLICY

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

PROCEDURE

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

   e. Are independent from Contracted Services providers such as BHAs.
   f. Receive Individual, family member, and other interested party grievances;
   g. Are accessible to Individuals, including a toll-free, independent phone line for access;
   h. Can access service sites and records relating to the Individual with appropriate releases so that it can reach out to Individuals, and to assist the Individual through the Grievance and Appeals process and at the Individual's request, assist or represent the Individual with the State Administrative Hearing process;
   i. Receives training and adheres to confidentiality consistent with the current HCA- BH-ASO contract, WAC 182-538D-0262 and RCW 71.05, 71.24 and 70.02;
   j. Continues to be available to advocate and assist the Individual through the grievance, appeal, and the Administrative Hearing processes;
   k. Involves other persons, at the Individual's request;
   l. Coordinates and collaborates with allied systems' advocacy and Ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared Individuals. Engages local advocacy groups, and SBH-ASO's network providers.
   m. Provides reports, feedback, grievance data and formalized recommendations at least biannually to Quality Assurance and Compliance Committee (QACC), SBH-ASO Advisory and Executive Board, and to the HCA.
   n. Are integrated into the overall SBH-ASO quality management process to create opportunities for improvements and changes to the behavioral health system that are reflective of Individual voice and experience as appropriate.

2. SBH-ASO providers collaborate with the Ombuds service staff and ensure that provider staff understand the role of the Ombuds service. The provider:
   a. Ensures unencumbered and timely access to provider staff involved in Ombuds Service inquiry or investigation, including access to private office space as requested;
   b. Ensures current Ombuds service materials are continuously available to Individuals and are posted in a conspicuous place so that Individuals and family members have access at every service location without special request;
   c. Assists in problem resolution and make best efforts to resolve concerns and grievances at the lowest possible level, except where to do so would not be reasonable;
   d. Makes every effort to ensure no discriminatory, disciplinary, or retaliatory action is taken against a provider or Individual for any communications

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

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

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

SBH-ASO POLICIES AND PROCEDURES

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

PURPOSE

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

POLICY

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Necessity Determination

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

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

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

Authorization of Services

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

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

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

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

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

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

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

SERVICE TYPE AND DESCRIPTION	Prior Authorization Required?	Authorization Process
CRISIS LINE AND CRISIS INTERVENTION Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. • Services may be provided prior to intake evaluation. • Services do not have to be provided face to face. • Crisis Hotline services	**No**	**N/A**
WITHDRAWAL MANAGEMENT (IN A RESIDENTIAL SETTING) • ASAM 3.7 WM • ASAM 3.2 WM *IF INDIVIDUAL IS ADMITTED UNDER ITA, SEE ABOVE ACUTE INPATIENT CARE – MENTAL HEALTH AND SUBSTANCE USE DISORDER	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review within one business day. **Yes**, if planned – requires prior authorization and concurrent review to determine continued stay. *Initial: 3-5 days*	**A. Emergent* Admission:** 1. **Notification:** Submission *SBH-ASO Notification/Authorization Request Form* for Withdrawal Management. a. All services delivered are subject to Eligibility, Medical Necessity, and Availability of Resources. 2. **Continued Stay**: Facility submits *SBH-ASO Notification/Authorization Request Form* including clinical update within one (1) business day prior to expiration of current authorization period. a. Subject to Eligibility, Medical Necessity and Availability of Resources. **B. Planned Admission:** 1. **Prospective Review**: *SBH-ASO Notification/Authorization Request Form* for Withdrawal Management. a. Subject to Eligibility, ASAM, Medical Necessity, and Availability of Resources. ** Must include referral from Designated Crisis Responder, Emergency Department, or Law Enforcement/First Responder. See SBH-ASO P&P Level of Care for details of Emergent Admission.*

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

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

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

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

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

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

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

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

WASHINGTON STATE UNIVERSITY

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

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

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

PROJECT AND FACILITATION LEAD:
Kevin Harris, William D. Ruckelshaus Center -Senior Facilitator/Health Policy
Assistant Professor
kevin.harris2@wsu.edu

PROJECT SUPPORT:
Maggie Counihan, William D. Ruckelshaus Center
Project Coordinator
maggie.counihan@wsu.edu

WILLIAM D. RUCKELSHAUS CENTER
Hulbert Hall, Room 121
Pullman, WA 99164-6248
-and-
901 Fifth Avenue, Suite 2900
Seattle, WA 98164-2040

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

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

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

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

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

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

Brief Historical Context: Behavioral Health Delivery & Financing Changes in Washington State
Washington is transforming the way that Medicaid services are delivered and reimbursed, including integration between physical and behavioral health (mental health and substance use disorder) care delivery[1]. Behavioral health integration has been a significant endeavor, involving transformative

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

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

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

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

BHO Service Examples

Mental Health:

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

Substance Use Disorders:

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

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

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

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

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

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

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

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

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

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

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

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

Engagement Initiation and Purpose

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

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

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

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

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

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

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

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

<u>Workgroup Process: Initial Assessment and Emerging Themes</u>

The Center conducted individual assessment interviews of county elected officials and staff, a WSAC executive, and a BH-ASO director during Spring 2020. Similar assessment interviews of HCA leaders were conducted during Summer 2020[3].

Individual assessment interviews accomplish multiple goals. First, the interviews allow different parties to identify relevant issues around the engagement theme and vet their diverse perspectives and experience. Second, the interviews encourage people to envision what a successful project outcome might look like, as well as the related benefits – in this case, developing an effective Communication Framework and its positive impact on behavioral health integration and person-centered outcomes. Third, the interviews allow for a candid discussion of issues and perception of history, as well as relationships between involved parties. Finally, the Center uses the information and opinions heard to assess the potential for collaborative success, as well as to design an effective convening process.

[3]Copies of both versions of assessment questions are included in Attachment B.

Assessment interview feedback broadly fell into the following themes:

- Organizational and program(s) history and evolution
- Physical and behavioral health integration vison
- Integration experience to-date
- Process history: Strengths and gaps
- Status quo risks
- Systemic impacts and concerns
- Relationships between counties, BH-ASOs and the state (HCA and prior Department of Social and Health Services history)
- Collaborative workgroup expectations and willingness to participate in good faith

In general, the assessment interview responses involved issues embedded in the evolution of behavioral health delivery and payment models over a relatively brief history – from RSNs to BHOs, to the current MCO and BH-ASO model. As noted, this evolution, combined with state agency organizational changes, federal deadlines and other relevant factors involved complicated and complex policy implementation requirements. The changes in delivery models over time and resulting systemic stressors for counties and the HCA are described more fully in the prior section.

The assessment feedback also identified county and tribal uniqueness with respect to differing population needs, workforce capacities and access to care, partner relationships, and how these and other factors have been impacted by the delivery/financing model and structural changes over time. It was interesting to note the learned experiences relayed about tribal relations and engagement over time. These lessons ultimately served as an important precedent when developing the framework's expected applications and value.

Examples of Diverse Interview Responses

- County payer-agnostic (all population) vs. HCA Medicaid focus
- Lack of universal vision
- Destigmatizing people/services
- Blending funding streams
- Capacity building
- Matching investments to policy
- COVID telehealth improvements
- Reserve balance issues
- Strong HCA tech assistance history
- Time constraints on sharing local perspectives
- Integration success indicators
- Acute challenges vs. systemic patterns
- HCA turnover
- Lack of county expert knowledge
- Loss of behavioral health providers

The assessment feedback indicated a strong desire from all parties to improve communication. Most expressed concern about the sizable amount of work ahead to continue to integrate physical and behavioral care. Others relayed stories about the unintended consequences of legislative action that didn't fully include counties in the process of policy deliberation. Many participants spoke of the ripple effects of the changing delivery models on county and BH-ASO funding flexibility, and the resulting burden of constraints that impact capacity to pay for interrelated services – for example, Involuntary Treatment Act court costs and services. Others, from counties, BH-ASOs and the HCA recalled the loss over the years of individual relationships and trust that had been built and nurtured, but sidelined due to lack of communication focus, strained timelines, program demands and staff turnover.

Several participants approached the concept of a consensus-based framework with varying degrees of skepticism, based on their experience with the program history - but they recognized the need for

improved relationships and communication to feel like they could deal with upcoming challenges related to the complexities of behavioral health integration. Several were concerned with the broader systems interconnections and impacts between behavioral health and other community-based service utilization and access, including county jails and low-income housing.

Although participants had varying images of realistic project success, all expressed a willingness for collaboration to create a consensus-based Communication Framework - to help parties build trust, work through policy and implementation challenges, mitigate future conflict, and fulfill a vision of integration success to improve individual's outcomes in Washington state.

The assessment responses emphasized a genuine desire to 'turn a corner' and leverage some recent examples of positive county/HCA interaction to rebuild trusted relationships. These examples were often rooted in frustration, without a defined process to proceed in a collaborative manner. Their success was often based on individual parties' (sometimes including the state's Medicaid Director) commitments to take personal command over a particular problem, whether local or regional (none of the shared examples were systemic). A significant amount of time and energy went into working through these problems on an acute basis, signaling both the interest in rebuilding relationships, as well the need for a type of framework to help effectively structure these and other important and burdensome issues.

Participants demonstrated both a positive and realistic perspective related to issue complexity, program history, future integration workload, co-learning benefits and the need to shift towards genuine collaboration to further integration goals - to improve holistic care, behavioral health access, capacity and outcomes, and decrease outcomes disparities. Participants were willing during the assessment interviews to commit to the focused time needed to build something significant together.

Workgroup Process: Separate Workgroup Facilitations

The Center began a series of Workgroup facilitations with separate county/BH-ASO and HCA working groups. The assessment interviews revealed an apparent need to begin working separately with these groups, to help them identify the similarities and differences between their principles and values, as well as their desired framework vision. These initial meetings began in Spring 2020 (county/BH-ASO workgroup) and Summer 2020 (HCA workgroup). Five county/BH-ASO meetings and two HCA meetings were held virtually. These meetings were designed to follow a similar pattern with each group:

- Development of Workgroup working structure, virtual facilitation rules of engagement and exploration of participant's needs (including meeting frequency and timing)
- Structured exercises and discussions to explore the group's understanding of the purpose and need for a communication framework.
- Collective teamwork to identify and categorize foundational qualities and attributes of a successful communication framework.
- Collaborative efforts to begin to convert those qualities and attributes into potential framework principles.

These early meetings produced a separate series of foundational qualities, attributes, and principles to help each of the two working groups define their own versions of successful Communication Framework components. In addition, the structured exercises and discussions helped align each group's foundational components with their initial framework vision, goals, and objectives.

Each working group defined more than 50 foundational qualities and attributes they felt should support a successful Communication Framework. Each group then categorized their attributes for further discussion and storytelling (note sidebar).

Examples of HCA's 50+ identified attributes ranged from 'assume good will', 'present with empathy' and 'use of respectful non-verbal communication skills' in the Positive Working Relationships category; 'honor history/traditions, be future facing for solutions' in the Acknowledge Past category; 'individual/community/tribal focus' in the Mission/Purpose category, and 'no preconceived notions or conclusions', 'follow up on items', 'inquire for clarity' and 'problem solving focus – focus on achievement of goals' in the Productive Meeting Goals category.

Examples of County/BH-ASO's 50+ identified attributes ranged from 'Come prepared to meetings', 'understand issue scope, sequence & priority' and 'when and how to engage knowledgeable staff' in the Foundational Tenets category; 'personal accountability/understanding', 'freedom to push back to learn specifics', 'transparent conversations' and 'celebrate successes' in the Desired Relationship category; 'allow for vulnerability', 'availability', 'learn from each other' and 'communication investment on all sides' in the Relationship Building category; 'respect local value re: systems design & management', 'avoid blindsiding', 'planning when transitioning staff' and 'respect different goals' in the Potential Pitfalls category, and 'a yes instead of a no bias', 'right scope & sequence', and 'building together – not just negotiation' in the Results/Outcomes category.

Many of the attributes that each of the initial working groups independently chose were similar. Common attributes included qualities each group felt were important to rebuild trust and credibility, recognize past failures, work towards better future solutions, maintain a common vison, and generally seek a more humane and collaborative process to team as partners, rather than negotiate as adversaries. In addition, the desire for a person-centered perspective to drive underlying system change and operational problem solving was frequently discussed.

CATEGORIES OF ATTRIBUTES

County/BH-ASO Working Group:

- Foundational Tenets
- Desired Engagement
- Relationship Building
- Potential Pitfalls
- Results/Outcomes

HCA Working Group:

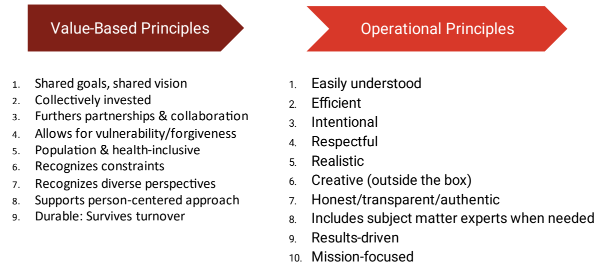
- Positive Working Relationships
- Acknowledge Past & Positive Future Direction
- Mission/Purpose
- Productive Meeting Goals

Workgroup Process: Combining the Two Working Groups

The two working groups were combined into one Ruckelshaus Workgroup in September 2020. A series of facilitated, structured exercises helped the group share their foundational ideas, including their model qualities and attributes, as well as reaching agreements on Workgroup focus and engagement responsibilities. From this stage forward, monthly Workgroup sessions made liberal use of breakout group discussions and large group debrief formats, to allow for appropriate prompting, participant voice and equity of idea-sharing, and a positive learning environment. The Workgroup decided early to limit their meetings to once a month for only two hours. While this extended the duration of the total engagement, the time in between meetings was often used to engage individually with workgroup members, plan interventions when appropriate, and adjust the planned

focus of upcoming meetings. On occasion, other parties were invited to join meetings, to share their lived experience, or provide additional subject matter expertise. This took on significant importance in later testing phases.

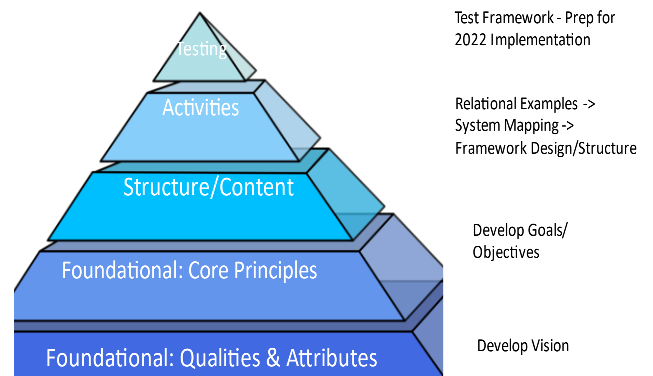
The group's sharing of their prior qualities and attributes helped define their core communication principles. These included both value-based and operational components to help design the Communication Framework. A high-level summary of the Workgroup's framework principles is noted in the sidebar graphic[4].



Subsequent Workgroup meetings began to focus on subject matter content (based on lived experience, history of program and systems change, and stratification of past and projected issues into framework categories). This preliminary work helped build and eventually test collective needs, framework structure and integrity. This content was based on the stories and memories that each Workgroup member brought to the collaboration. A series of 'learning' circles' were planned to give Workgroup members the chance to host different issues that would elicit both breadth and depth of discussion to help test the framework needs. For example, one early learning circle focused on the importance of physical/behavioral health integration (from an individual holistic perspective). The ensuing discussion opened a wide diversity of perspectives on systems design, program implementation, unintended consequences, capacity constraints, tribal history and mental health parity.

Another learning circle focused on different perspectives on measuring integration 'success', beyond program metrics. This discussion gave participants a broader understanding of the diversity of program vision, service gaps, different partner/contractor roles and responsibilities, future funding streams, different county needs, the broad scope of the behavioral health continuum, and HCA's role relative to behavioral health and non-Medicaid populations.

Many participants commented that the sharing of different viewpoints within the Workgroup around the history of a specific issue helped them broaden their understanding, empathy, and ability to creatively brainstorm together. These shared learning exercises were one example of the use of facilitated systems thinking tools (mental models) to help the Workgroup progress through both sequential and iterative processes to maintain momentum towards a tested framework design[5]. Continued monthly meetings attempted to balance process and content, with growing emphasis on content as the teamwork progressed.



[4] Note that these embedded graphics were originally developed for 'slide' visuals used during Workgroup facilitations and may be difficult to read in this confined report format. Please use your 'View-Zoom' function in Microsoft Word (or similar application) to expand your view to 200%.

[5] Other employed systems-thinking tools included behavior over time graphs, connection circles, causal mapping, components of stock-flow maps and systems archetypes.

The Workgroup proceeded on a path to finalizing framework design and moved towards testing. Their momentum was demonstrated on a monthly graphic - a progress 'pyramid' tracked their collaboration and kept them focused on their design efforts and discussion purpose (Note: embedded graphic on the prior page).

Throughout these engagement stages, the Workgroup was simultaneously refining their goals, objectives, and vision, based on their foundational components work (qualities, attributes, and principles). This part of the process was iterative – many discussions looped back to the central points to test the purpose, meaning and intent of the framework. It was often helpful to structure these conversations around the types of issues that might benefit from the framework's use. Those issues were often redefined through 'What'-'Why'-'Who'-'How' conversations:

- 'What' is the real problem or issue?
- 'Why' should this issue be on our collective radar?
- 'Who' will need to be involved to plan for and potentially solve this issue?
- 'How' should the issue be applied to relevant framework model components?

This phase allowed the Workgroup to invest the up-front time to benefit later conversations, when they eventually structured the final framework venues, communication loops and strategic questions to ask. This also began the process of thinking about the types of tools they might need to develop to support the framework.

Communication Framework: Value & Benefits

The Workgroup considered the value and benefits that a new Communication Framework might offer. A version of the existing multi-level tribal/state engagement model helped define the breadth of functions that an effective framework might support. The Workgroup believed that solving the types of issues identified (either county-specific/regional, or systemic) will often require strategic advocacy to build coalitions to approach policy and/or decision makers. The framework can be used to help build those collaboratives to seek solutions or systems change. For example:

- If an existing county/regional/tribal operational problem is identified that the HCA has the authority and means to independently correct - the framework can help facilitate that process (for example, correcting the consequences of changes to provider contracting impacting a particular region).
- If the HCA knows that the legislature has appropriated new funding for a portion of the behavioral health continuum (or is leveraging federal funding), the framework can help parties improve preparation for tight implementation deadlines to roll out program improvements – using a much-improved communications process. In this case, the parties can use the framework to proactively plan for and avoid downstream unintended consequences. For example, responding to potential 988 crisis line implementation expectations and associated crisis response system issues; or ripple effects from judicial rulings, such as Washington Supreme court's Blake decision.

- If an issue is thought to be systemic, the framework helps parties test that assumption, evaluate the issue based on agreed-to principles, prioritize it based on the same principles, and identify the internal or external partners that may be needed to help craft the longer-term solution. The Workgroup agreed that the HCA, as the single-state Medicaid agency would be the logical advisor for this planning. Examples of internal/external partners might include other state agencies (WA Department of Health), the legislature, federal agencies/departments (Centers for Medicare and Medicaid Services; Substance Abuse and Mental Health Services Administration). Such issues could require the proposal of federal Medicaid waivers, new state plan amendments, or new legislation.
- The framework may be used to support collaborative advocacy to evaluate larger systemic issues that are barriers to achieving program and integration vision and outcomes, and propose systems change. Work began to align HCA and WSAC legislative steering committee calendars across session years and to start to build collective legislative strategy.

In April 2021, a smaller sub workgroup was formed with six volunteers: three HCA officials, two county commissioners and one BH-ASO director. The Workgroup had reached a point that required additional meeting time beyond once a month; in particular, to convene a group of detail-minded participants to work through the 'nuts and bolts' of finalizing the framework design. This sub workgroup met eleven times between April and November 2021 to work through the many framework details. They relayed their suggestions to the full Workgroup on a regular basis, where discussions led to consensus. During the project's last several months, this sub workgroup was opened to anyone from the Workgroup who wished to join the meetings. This helped keep the discussions fresh with diverse perspective.

Finally, the Workgroup took the opportunity to 'pressure test' the framework in real-time. Examples from Clallam County's provider contracting process were demonstrated by their regional BH-ASO and County Commissioner – the Workgroup used framework concepts to test for communications gaps and address several external 'shocks' that occurred outside of the framework's boundaries. The test included a Workgroup debrief with corrective action points for both the HCA and county.

The test highlighted several important points:

- If other parties (internal or external) with influence aren't aware of the framework and/or are unwilling to work with the improved communication process, they can negatively impact or delay issue resolution. The Workgroup expects a longer-term effort to educate people about the framework's benefits, and how they can engage in productive and collaborative problem-solving efforts, to reduce the probability of external shocks to the process.
- The framework may not fit all the issues that surface; but it does have the capability of providing useful guard rails that can keep an issue from moving off track from resolution. The framework should be adaptive and improved over time to address as many types of issues as possible.
- Lessons learned from existing conflicts should be quickly evaluated as a team, and improvement steps implemented as soon as possible. For example, assumptions of new policy implementation requirements may cause misinterpretation, especially evident during tight deadlines. A quick contracting checklist, or other universal tool might help all parties quality-control their processes in advance of implementation, to avoid unnecessary misinterpretation.

The Workgroup's expectation is that the framework will need to be demonstrated, taught, and reinforced to pass along important lessons learned throughout the twenty-month collaborative process. Time and patience will help guide other willing county, BH-ASO and HCA participants to experience their own trust and capacity building, as the Communication Framework is used to help structure collaborative problem-solving. As willing legislators, providers, Accountable Communities of Health, MCOs, other state agencies and other behavioral health partners gain exposure to and experience within the framework, partners should experience fewer external shocks. The Workgroup expects that WSAC can provide a significant role with both the educational aspect (exposure to the framework, to inform existing County Commissioners and staff, as well as the large percentage of newer elected officials who are unfamiliar with behavioral health issues), as well as noted legislative strategic efforts.

Workgroup Process: The Two Communication Framework Elements

The two Communication Framework graphics follow in Attachment C. Although these graphics are simple in design, successful application of the Communication Framework will require consistent effort and teamwork from all participants, to develop new meeting and discussion patterns that intentionally break from existing meeting agendas and status quo formats.

County-Specific/Regional Issues Communication Framework:

The county-specific/regional framework is based on a communication flow that deliberately uses (mostly) existing meeting structures; the group wanted to avoid, if possible, unnecessarily adding more meetings to partner's already crowded calendars. The Workgroup looked at a wide range of existing behavioral health-related meetings, to identify those that could potentially match the needs of the framework design, partner and issue requirements for effective collaboration, and participation mix. In some cases, these existing meetings may require agenda and process changes. Other meetings are already semi-structured, allowing for flexibility.

This portion of the framework identifies four existing meetings that can provide the input, expertise, collaboration, brainstorming, and feedback loops needed to identify and test county-specific/regional issues (non-systemic), as well as provide momentum and accountability to team problem-solving functions:

- The **monthly BH-ASO meetings** are key to this part of the framework. In addition to their awareness and knowledge about local behavioral health issues, the BH-ASO directors also serve as a logical 'collection point' for issue/problem input from:
    - County ASO directors and Beacon Health (serving as the BH-ASO in three of the ten regions);
    - additional related communication from County Commissioners (who often hear of issues from the public, providers, and others), and
    - the Association of County Human Services ('ACHS'), an affiliate of WSAC, and co-chaired by one of the Ruckelshaus Workgroup members.

  The Workgroup identified certain communication 'gaps' when developing this flowchart. The group felt that bringing Beacon Health Options into more conversations would benefit collaborative problem-solving results, as well as tighten relationships between county elected officials, county staff and Beacon in the three regions they serve[6].

[6] Beacon serves as BH-ASO in the following regions: Pierce (Pierce County), Southwest (Clark, Klickitat and Skamania Counties), and North Central (Chelan, Douglas, Grant and Okanogan Counties).

The monthly BH-ASO full-day meetings are an efficient way to identify what may be county-specific or regional issues and bring them to the BH-ASO/HCA meeting the following day.

- The 'next day' **BH-ASO/HCA meeting** can serve first as an evaluation point for each raised issue. The team can discuss the context of each issue and determine if it is truly county-specific or regional; if the issue is systemic, the team can move the issue to the framework's second process. In some cases, issues may include both county-specific/regional and systemic components. The team will need to determine (with or without external guidance) if one or both of the framework's two processes will fit best. These decisions will likely consider urgency, expected scope of resolution requirements, and resource capacity.

The Workgroup discussed constructing simple scheduling/prioritization tools and lists that can support the maintenance of resolution steps, accountability, and responsibility for these efforts, provide visibility of progress, and generally support the framework principles and attributes developed in the Workgroup facilitations.

The problem-solving process itself is dependent on the scope of the issue, team agreement on context and cause, and evaluation of the pros/cons of potential solutions and downstream consequences. Again, the problem-solving process is embedded within the framework's communication flow and venues, but not specifically prescribed by the Communication Framework. Some issues can be resolved simply and efficiently with minimal intervention; others require complicated steps involving multiple parties and consensus-building. Regardless, the framework provides the means to raise, evaluate and vet the issues, share diverse opinions and perspectives, and create feedback loops that keep the team informed through resolution to avoid missteps, communication gaps and misunderstandings.

- The **individual BH-ASO/HCA meetings** (county ASOs and Beacon) are relatively new and less structured. The HCA began these meetings as a learning experience, to share information between the parties. The Workgroup felt these would be ideal collaboration spaces to share frank and open discussion to identify both regional opportunities and challenges in a smaller group setting. The meeting frequency will likely need to be adjusted over time, but the content could add valuable input to share at the monthly BH-ASO meetings, and then at the following BH-ASO/HCA meeting.
- The existing every other month **ACHS meetings** (noted above) bring county administrative, planning and service delivery staff together to discuss county implementation around state executive and legislative actions involving behavioral health and intellectual/developmental disabilities services. The HCA has been attending these meetings this past year. The Workgroup felt that this group's 'ground-level' perspective would help provide valuable input to the BH-ASO/HCA next day meeting issue content and perspective. Isabel Jones currently serves as a behavioral health co-chair with ACHS, as well as having participated as one of our framework Workgroup members for the past twenty months.

These four existing meetings make up the 'bones' of the county-specific/regional issue framework. The Workgroup agreed that this portion of the Communications Framework in no way prevents County Commissioners or others from direct contact with the HCA or others – rather, it is intended to provide a logical structure and communication flow that is meant to create more efficient and effective outcomes, avoid communication gaps, and maintain a shared level of visibility and accountability to support a collaborative process. As noted, the meetings' agendas, content and issue

resolution processes should remain flexible and adaptable – and changes to the Communication Framework are expected and welcomed over time.

Workgroup Examples of Emerging and Ongoing Complex Issues

- 988 Crisis Lifeline implementation and changes to WA crisis response system
- Impacts of 1/10th of 1% sales tax and differing county applications
- Impacts from the WA Supreme Court Blake decision
- CMS payment disconnect with WA-defined Eval & Treatment centers
- Behavioral Health Navigator program for student suicide prevention and support
- HB1310: Police use of force
- Quality of crisis response
- Small BH provider capacity and turnover
- Variability of BH treatment & interventions
- Re-org of health boards
- Opportunities include new legislative investments

Systemic Issue Communication Framework Steps

The second framework applies if the BH-ASO/HCA meeting team evaluates an issue or opportunity and determines it is systemic in nature. The Workgroup concluded that the existing quarterly **legislatively mandated behavioral health 'coordination' meetings** will be revised to accommodate this systemic work using the framework's collaborative principles. The HCA will work to redesign these meetings to address these systemic opportunities and issues and host the meetings. Meeting frequency may be reconsidered, to match the intensity and breadth of the expected work.

Rather than proceed with another communication flowchart, the Workgroup concluded that a strategic planning framework would best fit communication needs around systemic issues. The Workgroup developed a set of guiding steps within the framework to help structure, evaluate, and prioritize an appropriate strategic approach to address the systemic issue or opportunity:

- Evaluate the issue: Appropriate time will be invested to examine 'what is the problem/issue/opportunity?' from diverse team perspectives. Where does the issue fall on the overarching behavioral health continuum? Is the issue proactive or reactive (or both)? Is the issue urgent? If so, to whom? What's the probable impact(s) on individuals/communities/providers/community partners/budgets and costs?
- Prioritize the issue(s): It's unlikely that many major systemic issues can be tackled at once. The Workgroup suggests building framework tools that can help prioritize issues and opportunities, based on impact to individuals and communities, collective capacity to invest the time, external partner (e.g., CMS; legislature) interest and support and other relevant factors.
- Who should be at the table? The Workgroup discussed a mix of diverse perspectives, lived experience, subject matter expertise and funding authority, among other considerations. Once again, the Workgroup reminded themselves that re-centering around a person-centered perspective/impact is an important litmus test for collective action.
- Convening partners and parties: Any convening should be consistent with the principles and attributes of successful communication that the Workgroup developed. Consensus-building processes sometimes require a facilitative role – not necessarily a third party, but certainly persons experienced in process design; facilitative methods, structures and exercises, and

skilled in conflict resolution/intervention practices. The scope of the issue and breadth of the strategic partnership will help determine the time and effort requirements, as well as the need for differing levels of skills and expertise.

- Solution/agreement seeking: Which parties have the authority to enable the systemic changes proposed? Which partnerships need to be tapped? What are the administrative, legislative, judicial, or other options to move the strategy forward? The Workgroup determined that the HCA would be the lead partner to research potential and likely strategic options[7], but the HCA may seek guidance from others (e.g., other WA state agencies; other state's Medicaid agencies; third party experts; federal partners). How will the strategic process be documented to maintain responsibility, accountability, transparency, and other shared communication attributes? How can feedback loops be used to help maintain momentum, collaboration, and trust between team members? Will the process have resilient backup strategies in case external shocks temporarily upset progress? How can team members build in both flexibility and durability to maintain trust and confidence throughout potentially longer-term strategies? What are the best collaborative methods that can be employed to broadcast 'wins', admit and manage mistakes, and work with the media? How can the team use lessons learned to augment trainings for policymakers and elected officials, to keep them current and the systemic issues relevant?

The Workgroup believes that this process is not expected to be linear. It should have built-in feedback loops and process checks to help keep a potentially longer-term process on track. A significant amount of dedicated project management may be required but should be consistent with the defined Communication Framework principles and attributes. Many of the concepts and partnerships suggested in the county-specific/regional framework may apply to systemic issues. It will likely make sense to link the revised legislatively mandated coordination meetings with input from some of the groups identified in the prior framework section.

<u>Workgroup Process: Planning for 2022 Communication Framework Roll-Out</u>

The Workgroup has initiated the planning process for framework implementation. Roll-out is expected to begin in the first calendar quarter of 2022. The Communications Framework was introduced to a group of county-elected officials and staff at WSAC's Annual Statewide County Leader's Conference in Spokane in November 2021. Executive Director Eric Johnson moderated a panel (Commissioner Mark Ozias, Sindi Saunders, and Kevin Harris) who introduced the twenty-month process and the Communication Framework to audience members. Commissioners Jill Johnson and Chris Branch added Workgroup comments and perspective during the subsequent Q&A session. Interest was high.

The Workgroup is in the process of reaching out to introduce the Communication Framework concepts and structure to the five key groups identified in the graphic representations. Key meetings during the first quarter of 2022 have been identified, and Workgroup members are expecting to build a set of discussion and talking points, as well as presentation stories to convey their shared experience to others[8]. WSAC and HCA legislative teams will work on aligning legislative calendars. Workgroup

[7] The Health Care Authority is the 'single state agency' for Medicaid and is the primary point of contact with federal partners such as CMS. Many systemic issues (and program or systems change) require Medicaid state plan amendments, different versions of federal waivers, or other initiatives that are highly dependent on this state/federal relationship.

[8] For example, the Workgroup suggested versions of the general framework statements in Attachment D.

members are enthused and looking forward to sharing their experience and work with counties, BH-ASOs, other HCA staff and others who serve throughout the behavioral health continuum.

Our thanks and gratitude to all Ruckelshaus Workgroup members for their participation, leadership, enthusiasm, and collaboration throughout the past twenty months. We look forward to hearing of your continued Communication Framework progress and success.

Ruckelshaus Center Recommendations

The 2020/2021 Communication Framework Workgroup collectively produced great energy, effort, and results. From a facilitative perspective, the Workgroup maintained a consistent effort throughout a slower, deliberate process. Comments throughout and at the end of the engagement were heartening – team members felt happy with the end results and appreciated the process to help guide them from a prior (and sometimes) contentious program history toward a genuine trusted and credible partner relationship. They have no illusions about the hard work ahead – but look forward to conveying their shared experiences to others, to help embed the collaborative communication principles they worked hard to achieve to improve behavioral health services to Washingtonians, and enact meaningful systems change.

The following Ruckelshaus Center recommendations are suggested to augment the positive progress and results that the Workgroup achieved:

a. Build a consistent 'de-brief' mechanism into each of the framework's component meetings for quality improvement purposes. While this requires an additional investment in time, it will help the teams remain nimble and adaptive, especially if the de-briefs are scheduled soon after each meeting ends. This may be especially important in the early stages of implementing the framework, as most existing meetings will experience some degree of modification, or a more significant re-design (e.g., current quarterly legislatively mandated meetings).
b. When facilitating the larger meetings (more than 20 participants), make intentional and frequent use of breakout groups (regardless of virtual or in-person meeting status), as we did in the first half of this engagement. This will help develop initial trust – most people are more comfortable speaking frankly in smaller groups. As confidence builds and people mix between breakout groups (with time for larger group debriefs to share smaller group work), begin to phase in progressively larger breakout groups, until the value of the full group's discussion outweighs the value of using breakouts.
c. Be intentional about improving and adapting the Communication Framework:
    - Calendar 'tune-up' meetings with a core workgroup or framework steering committee on a regular basis (perhaps quarterly to begin) to review progress, consider adjustments, celebrate wins and evaluate bottlenecks and barriers.
    - Prepare practical examples of 'wins' and 'losses' to evaluate and brainstorm process improvements, which may include meeting modifications, facilitative improvements, identifying continuing patterns of communication gaps and other lessons learned.
    - Seek diverse opinions on recommended improvements before implementing them.
    - Create a forum to efficiently update everyone on modifications, including 'why' and 'how' statements. For example, consider a twice a year Communication Framework Bulletin for broad distribution. This could also serve as education updates for newer staff and newly elected officials.

d. Leverage WSAC's capacity to build an education plan to update existing County Commissioner's knowledgeable about behavioral health, less experienced Commissioners, and newly elected officials to promote interest and subject matter context. Teach elected officials how to engage, work with and leverage the framework concepts.
e. Identify a key set of legislators and staffers who are most knowledgeable of behavioral health systems and issues; develop a separate introductory demonstration of the Communication Framework for them.
f. Engage willing tribal support to help add important issue/opportunity evaluation from a tribal/state and tribal/community behavioral health perspective. Tribal mental models and systemic evaluation are compatible in many ways and can add valuable context and diversity of thought to systemic issues.
g. Build framework tools that can be universally used or adapted to meet issue and process requirements. For example:
    - A checklist of communication-based steps for policy implementation rollouts.
    - An issues inventory list for county-specific/regional issues to maintain and document progress, responsibilities and milestones reached.
    - A systems-mapping and/or cause & effect mapping tool to help the team fully evaluate systemic issues. Mapping helps to identify root causes, interdependencies, potential unintended consequences, and possible points of leverage to trigger larger systems impacts. This may also help the team prioritize certain systemic issues, if teamwork invested in one issue has significant impacts on others (see systems-thinking questions in 'i' below).
    - A minimum checklist of media or legislative exposure talking points to promote consistency between team members when describing the Communication Framework. The Workgroup agreed to two general framework statements, noted in Attachment D.
    - A tool that helps the group screen issues for urgency, based on agreed-to concepts. The Workgroup had several discussions about a simple 'red-yellow light' type of tool that elevates urgent (red light) issues and prepares the group for issues of upcoming concern (yellow light). Developing consensus-based rules can support agreement about re-prioritizing issues when necessary.
h. For those issues that may not 'fit' the framework, consider use of a conflict-resolution process or steps that can help parties test their willingness to collaborate (or at least come to an acceptable joint resolution over the issue). This may also be helpful when interventions are sometimes required during longer-term processes.
i. Use systems-thinking tools and habits to help expand the systemic framework team's thorough evaluation of an issue, to identify root causes and interconnectivity to gain productive team momentum, refine prioritization competencies and broaden options for lasting solutions. For example, questions to consider include:
    - How are differing attitudes and beliefs advancing or hindering efforts to achieve desired results?
    - Has the issue been considered fully? Have we resisted the urge to come to a quick conclusion? Are we all aligned in seeing the 'big picture'? Have we openly tested our theories and shared assumptions with others, to improve performance?
    - Have we identified the many parts of our behavioral health system and structure to understand the whole, and how our system's relationships affect behavior?

- Have we considered the unintended consequences of a proposed action, and the trade-offs to consider? What are the short and long-term consequences, and are we willing to accept short-term pain for long-term gain?
- Do we understand the circular nature of complex cause and effect relationships?
- What indicators should we expect to see as we look for progress? Are we pausing enough to assess the effects of our current plan and work together?
- Are we identifying how elements of our system have changed over time? How quickly are they changing, and what patterns or trends have emerged?
- How have our own perspectives changed over time? How has that influenced our decision-making?
- How can we use what we know about our behavioral health system to identify possible leverage actions? Where might a small change have a long-lasting and desired effect?

j. When it's appropriate to use a facilitator for systemic issue evaluation and prioritization (either internal or external), seek out people who are skilled in facilitating strategic planning efforts.
k. Consider developing a team member agreement that includes commitment to the Communication Framework's principles and process. For example, other workgroups have developed Declarations of Cooperation, or Memoranda of Collaborative Intent. This is not intended to add a legally binding component to the process, but to instead solicit further commitment of 'buy-in' from engaged parties. In addition, this could represent a creative tool to further framework durability.

Attachment A – Roster of WA Behavioral Health Communication Framework Team Members (including retired)

Team Member	Organization
Jessica Blose	Health Care Authority/WA State Opioid Treatment Authority
Chris Branch	Okanogan County Commissioner
Teresa Claycamp	Health Care Authority/Division of Behavioral Health and Recovery
Diana Cockrell	Health Care Authority/Division of Behavioral Health and Recovery
Jessie Dean	Health Care Authority/Office of Tribal Affairs
Dr. Charissa Fotinos	Health Care Authority/Interim Medicaid Director
Edna Fund	Lewis County Commissioner
Eric Johnson	Washington State Association of Counties
Jill Johnson	Island County Commissioner
Isabel Jones	King County/Behavioral Health and Recovery Division
Michael Langer	Health Care Authority/Division of Behavioral Health and Recovery
Ruth Leonard	Health Care Authority/Medicaid Programs Division
Alice Lind	Health Care Authority/Medicaid Programs Division
MaryAnne Lindeblad	Health Care Authority/Medicaid Director
Sarah Mariani	Health Care Authority/Division of Behavioral Health and Recovery
Jason McGill	Health Care Authority/Medicaid Program’s Division
Mark Ozias	Clallam County Commissioner
Melodie Pazolt	Health Care Authority/Division of Behavioral Health and Recovery
David Reed	Health Care Authority/Division of Behavioral Health and Recovery
Sindi Saunders	Greater Columbia BH-ASO
Keri Waterland	Health Care Authority/Division of Behavioral Health and Recovery

Attachment B

WASHINGTON STATE UNIVERSITY

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

WA Behavioral Health Communication Framework
Questions: Counties and BH-ASOs

1. *Please describe your position, professional background and organization/constituents as they relate to physical/behavioral health integration in your community. What are your (organization's) most important responsibilities relative to integration goals?*
2. *Imagine your community's ideal health status beyond the finite Demonstration timeline and existing barriers. What would integration success look like from your perspective in 5-10 years? How would you gauge that success?*
3. *How would you describe your current relationship with the Health Care Authority, and with other stakeholders? What specific past events led to any change in those relationships?*
4. *What are some positive examples of behavioral health integration to-date (in either your community or others)?*
5. *Which key components/processes have been missing in building relationships and trust between parties throughout this process?*
6. *What are you most concerned about right now relative to integration issues? What are the risks of remaining 'status quo'?*
7. *Has your own thinking around integration issues and the need for collaboration evolved since the 1115 Waiver began? How?*
8. *What expectations do you have about entering a collaborative process? What do you hope to achieve? What concerns do you have?*
9. *Who else should I speak to with respect to these issues, if and when this initial group expands? Why?*
10. *Are there other questions I should have asked? Do you have any additional questions for me?*

WASHINGTON STATE UNIVERSITY

THE WILLIAM D. RUCKELSHAUS CENTER

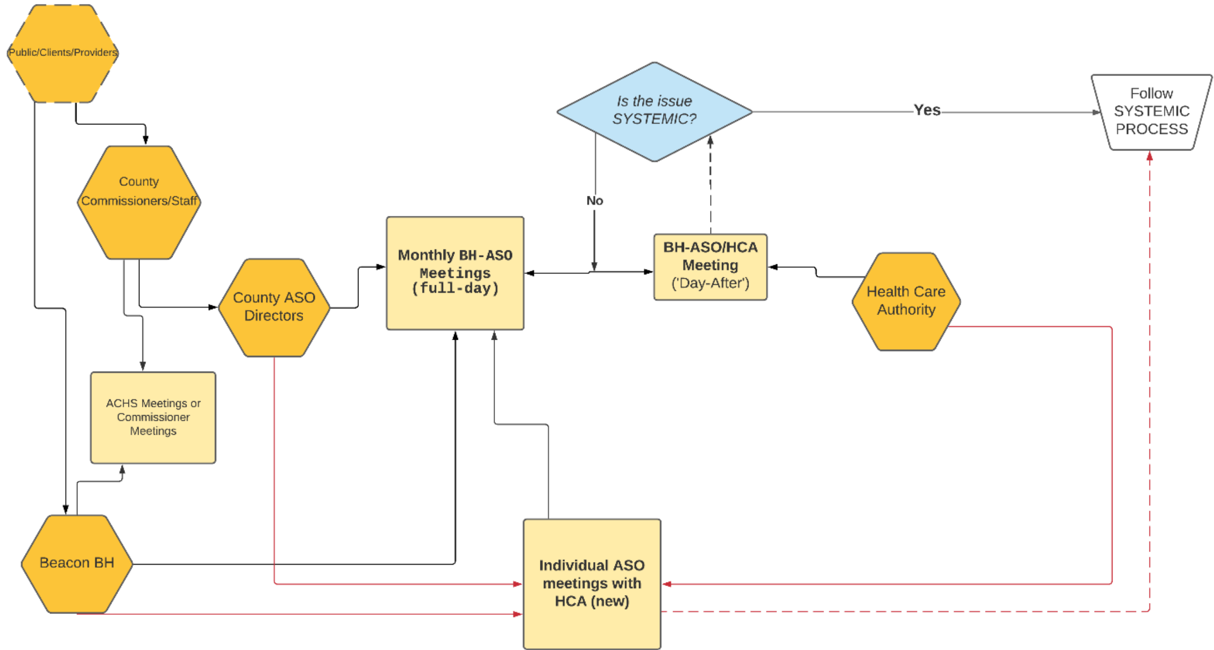
UNIVERSITY OF WASHINGTON

WA Behavioral Health Communication Framework
Questions: Health Care Authority

1. *Please describe your position, professional background and organization/constituents as they relate to physical/behavioral health integration. What are your (organization's/team's) most important responsibilities relative to integration goals?*
2. *Imagine our state's and communities' ideal health status beyond the finite Demonstration timeline and existing barriers. What would integration success look like from your perspective in 5-10 years? How would you gauge that success?*
3. *How would you describe your current relationship with counties, and with other stakeholders, including the MCOs, ACHs and relevant legislators? What specific past events led to any change in those relationships?*
4. *What are some positive examples of behavioral health integration to-date (either statewide or within specific communities)?*
5. *Which key components/processes have been missing in building relationships and trust between parties throughout this process?*
6. *What are you most concerned about right now relative to integration issues? What are the risks of remaining 'status quo'?*
7. *Has your own thinking around integration issues and the need for collaboration evolved since the 1115 Waiver began? How?*
8. *What expectations do you have about entering a collaborative process? What do you hope to achieve? What concerns do you have?*
9. *Who else should I speak to with respect to these issues, if and when this initial group expands? Why?*
10. *Are there other questions I should have asked? Do you have any additional questions for me?*

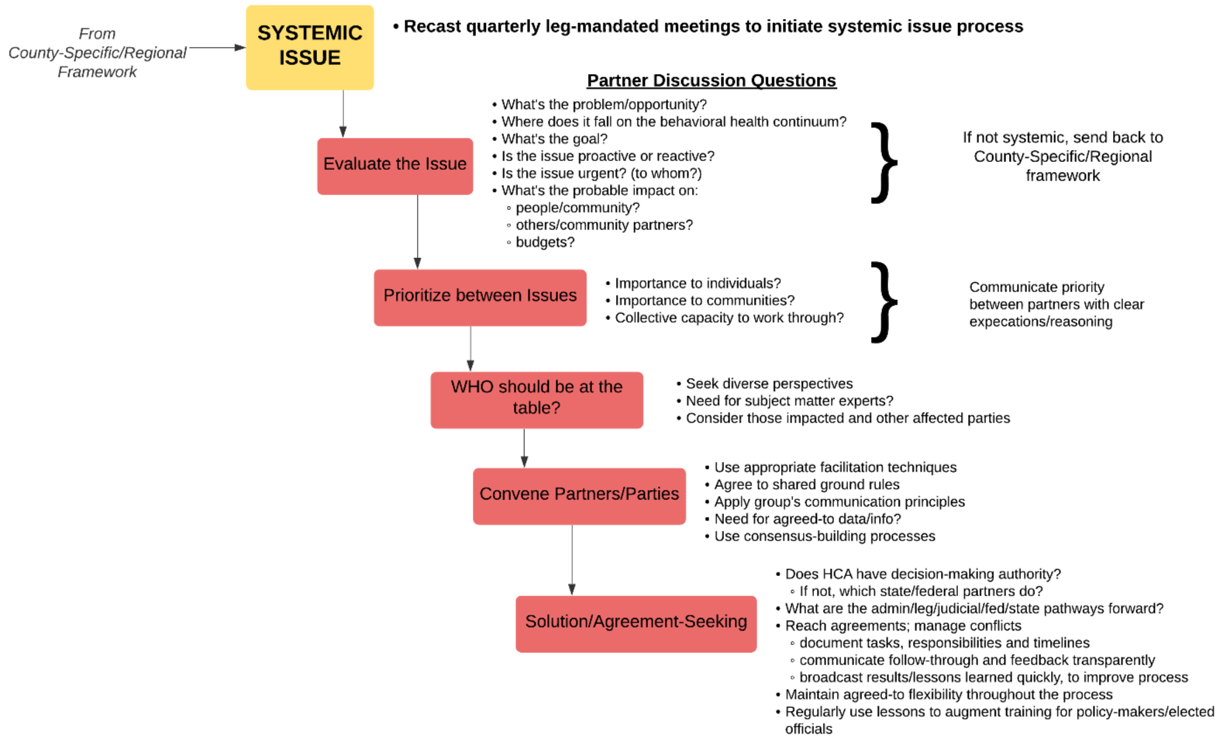
Attachment C

County-Specific/Regional Issue Communication Framework



- Individual ASO meetings to maintain unstructured 'open discussion space'
- Helps to identify regional/systemic issues and share opportunities
- Allows breathing room to listen, plan, align and problem-solve collaboratively

Final Workgroup Version
as of 12/31/221



Final Workgroup Version as of 12/31/21

Attachment D

General Framework Statement Draft: What it is

The behavioral health communication framework creates a collaborative structure to help counties, BH-ASOs and the Health Care Authority to:

- *Work collaboratively and flexibly to help solve county-specific, regional and statewide (systemic) behavioral health integration issues that require teamwork.*
- *Help build and expand trusted relationships that outlast leadership, management and elected official turnover.*
- *Grow into a long-standing partnership culture that is inclusive, transparent and accountable.*
- *Change and improve behavioral health status and systems for the benefit of all Washingtonians.*

General Framework Statement Draft: What it is not

The behavioral health communication framework is not:

- *A problem-solving process (it is a communications framework that enables problem-solving)*
- *Meant to address 100% of all behavioral health problems in our state*
- *A guarantee for 100% successful resolution, or a process to always avoid conflict*
- *A means to play 'gotcha'*