ATTACHMENT A

2016 GRANT SUMMARY PAGE

MENTAL HEALTH, CHEMICAL DEPENDENCY, AND THERAPEUTIC COURTS RFP
KITSAP COUNTY HUMAN SERVICES DEPARTMENT

Proposal Title: Kitsap Crisis Triage and Withdrawal Management Center

Please Check One X New Grant Proposal ☐ Continuation Grant Proposal

Proposal Summary: The Kitsap Crisis Triage and Withdrawal Management Center reduces unnecessary utilization of emergency department, incarceration of individuals with mental health and/or chemical dependency issues, and ensures Kitsap County has the facility and treatment capacity for individuals with significant behavioral health needs in need of 24/7 crisis services. Services are for adults 18+ who do not require the level of care delivered at a mental health or chemical dependency inpatient treatment, hospital or jail. They may be homeless and/or living with untreated or poorly managed behavioral health issues, and meet criteria for short-term 24/7 crisis services. A 16 bed Crisis Triage Center will provide up to 5 days of care, offering screening, assessment, and treatment services for 1,986 adults annually (2,483 visits). Under the same roof, a separate 16 bed Withdrawal Management Center will offer services for withdrawal/detoxification, serving an estimated 1,986 adults (2,483 visits). These two Centers are co-located under one roof, adjacent to KMHS, better supporting integration of co-occurring mental health and chemical dependency treatment. A facility (KRC) has been identified, all renovation funds acquired, and as building vacates, construction of the facility will begin, with services starting July 1, 2017.

Requested Funds Amount: $ 1,039,535

Matching/In-kind Funds Amount: $ 300,000 (Salish BHO) plus State/Medicaid Funds TBD

Kitsap Mental Health Services

Agency or Organizational Name

5455 Almira Drive NE

Street Address

Bremerton	WA	98311
City	State	Zip

Stacey Devenney, Chief Clinical Officer	360-415-3905	staceyd@kmhs.org
Primary Contact	Phone	E-Mail

Non-Profit Status: 501©3 of the Internal Revenue Code? X Yes ___No

Federal Tax ID Number: 91-1020106

- If incorporated, attach a list of the members of the Board of Directors, including names and addresses.
- If not incorporated (sole proprietor or partnership), attach a list of the names and addresses of the principals.

S. Devenney — Chief Clinical Officer — 3/8/2016

Signature — Title — Date

KITSAP MENTAL HEALTH SERVICES
BOARD OF DIRECTORS
FISCAL YEAR 2015 – 2016 AS OF 1/7/16

NAME	POSITION	ADDRESS
Britt Feldman	President	2669 Rocky Point Road Bremerton, WA 98312
Leon C. Smith	Vice-President	22639 NE State Hwy #3 Belfair, WA 98528
Peter A. Douvis	Secretary-Treasurer	1363 Lakehurst Drive Bremerton, WA 98312
Jan L. Tezak, RN, MN Ret	Past President	2294 NW Vinland View Poulsbo, WA 98370
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2016 NARRATIVE FOR NEW GRANT PROPOSALS

MENTAL HEALTH, CHEMICAL DEPENDENCY, AND THERAPEUTIC COURTS RFP
KITSAP COUNTY HUMAN SERVICES DEPARTMENT

CRISIS TRIAGE AND WITHDRAWAL MANAGEMENT CENTER

1. Organizational Capacity

A. Internal Governance

Board Capacity: KMHS is a 501(c)(3) governed by an 11 member Board of Directors. Members represent Kitsap residents and consumers of MH services, experienced in health, behavioral health, law, business, public and military service. The Board of Directors is informed in their decision-making through monthly meetings, educated about programs, current service gaps, opportunities, trends, audit/regulatory compliance, and financial review. The Board of Directors set agency direction, policy, and maintain fiscal accountability; all internal policies require review and approval by the Board. A Chief Executive Officer (CEO) reports to the Board and is responsible for administrative oversight including overall direction, human and financial resources, budget and daily operations needed to meet the organization's mission as a designated community mental health agency.

Leadership Structure: Under direction of the CEO, the Executive Leadership Team (ELT) provides clinical and operational oversight and management for 400+ FTE. The CEO is supported by a Strategy Team comprised of the Chief Medical Officer, Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Human Resources Officer, Chief Advancement Officer and additional Executive Leadership Team (ELT) members including a Medical Services Manager, 2 Adult and Community Services Directors, 24/Hour Inpatient/Residential/Crisis Services Director, Child & Family Services Director, an Information Services and a Quality Improvement Director. Each Clinical Services Director is responsible for multiple interdisciplinary teams ranging from inpatient to outpatient to residential services for both adults and children. The Crisis Triage Director is a member of the ELT, reports to the Chief Clinical Officer, and has oversight of both Center programs, operations, staff, budgets, and provision of client services.

Program Management Structure: In addition to the ELT where program, staffing, budgeting and operations planning, implementation approaches and monitoring take place, the organization maintains bi-weekly meetings for system and quality assurance procedures and review, daily "huddles" for clinical Teams, weekly individual staff supervision for clinical and managerial staff, and meetings to address specific topics i.e. ongoing monthly meetings such as safety and security, Housing Triage, or emerging topics, such as Medication Assisted Treatment and others. Community Mental Health agencies operate under stringent state legislative and regulatory codes that guide the provision of many programs and client treatment, thus quality controls are well in place, and audits routinely successfully met.

Fiscal Controls and Procurement: Detailed financial information is reviewed monthly by the Finance Committee and Board. Fiscal oversight is via an accrual-based accounting system in full conformity with generally accepted accounting principles, state BARS and SAS reporting system. No staff can access check stock to initiate signing; registers require CFO approval, with extensive internal controls for recording transactions, authorizing, creating, distributing checks; signatory authority by CEO and Board Officers. KMHS policy provides fair and equitable treatment of all persons or firms, assures supplies and services are procured efficiently, effectively, and at favorable prices; provides advantage to local vendors; provides safeguards for procurement quality and integrity; assures purchasing actions comply with applicable Federal standards, State, local laws, terms/conditions of grant, contract, gift or bequest, and assures at least two competitive bids for purchases or contracts $25,000+.

Fiscal Management Capacity and Fiscal Review: KMHS has an exemplary record of meeting multiple, complex contractual deliverables and fiscal obligations. Board Policy directs the agency to strive to maintain a three month operating reserve for operational stability. The CFO identifies, implements, and manages financial systems and strategies. Fiscal policies address personnel, payroll, grants, contracts, travel and purchasing. Grant funds are coded separately. An annual audit is conducted by an independent Certified Public Accountant, in accord with the Single Audit Act; Auditor presents audit to the Board on completion. The 2015 audit report for internal controls found no deficient or material weaknesses disclosed by an audit of the financial statements. For 26 years auditors consistently cite the strength of KMHS internal fiscal controls and systems, with no disallowed, questioned costs, or administrative findings. KMHS has never defaulted on a grant award. Outside contractors must meet KMHS procurement standards. KMHS complies fully with local, state, federal laws and executive orders for national equal employment opportunity policies and provision of services. The agency is committed to affording employment and participation to all employees, volunteers, interns, and applicants for employment, to providing agency services to consumers, and administering agency contracts consistent with applicable laws to ensure non-discrimination. Cultural diversity training is conducted yearly for all staff; special population consultations are available. In 2015 KMHS provided emergency, inpatient, outpatient, and residential services to nearly 6,000 children and adults, and maintained an operating budget of $28M.

B. History of Project Management: KMHS, responding to needs expressed by the community via local boards and county/regional plans, continually demonstrates the high level of motivation and capacity necessary to develop programs and facilities that meet client needs. In 1990 KMHS secured State and Federal grants, and bank-loaned matching private monies to buy and rehabilitate 9 houses. In 1993, KMHS' facility was built by leveraging a capital campaign with County agreement to "float" bonds due to KMHS stability and management track record. KMHS has managed multiple city and county CDBG/HOME Capital awards to rehabilitate housing sites, and to renovate the Adult Inpatient Unit. In 2008 KMHS built a $4.8M 16-bed, 30-day residential stabilization facility, leveraging city, state and federal funds. All projects require managing contracts and projects with architects and construction contractors were completed on time, on cost, with award deliverables met. Post construction, KMHS assumed ongoing provision

of operations and services for each of these facility based programs. Under clinical leadership guidance, appropriately licensed directors, supervisors, clinical and support staff carry out their assigned programs. Many of these programs are co-located in community or other organization settings. Managers meet weekly with their staff. Clinical staff use daily huddles to discuss, review, and refine the various crisis, inpatient, outpatient, residential program and client services. KMHS uses benchmarking to guide progress. Computerized reports support analysis of services and client care quality; a continuous quality review process is in place. A Quality Assurance Director ensures KMHS meets clinical standards, administrative codes, and provides quality care. Services provision is regulated by WA Administrative Codes, DOH, DBHR and other bodies. The agency has consistently met its multiple program and client services audits, and has never defaulted on contracts or program deliverables.

In 2014, with its community partners, KMHS requested and was awarded funding to create a desperately needed crisis triage center by renovating an existing facility and then providing 24/7 staffing. This project proposal builds on that Award but is "New" rather than a "Continuance" because it now describes the addition of a 16-bed Withdrawal Management Center (formerly known as sub-acute detox) in tandem with the 16-bed Crisis Triage Center, and because it no longer seeks funding to renovate a facility. Early in 2015 KMHS was requested by the Kitsap County Human Services Department (KCHS) to consider Kitsap Recovery Center (KRC) as the CTC site of choice, and to include in cost of renovations a 16 bed Sub-acute Detox Center (to be known as the Withdrawal Management Center). This proposal addresses that request.

We are pleased to report that by working together with Kitsap County and the State of Washington, facility renovation funding has been obtained in full and is no longer needed, although the timeline for completion and opening was pushed back to allow for the existing KRC program to vacate to another location also under renovation. With Kitsap County Board of Commissioners approval, during 2016, KCHS and KMHS staff began to coordinate construction plans with KC Public Works. A building inspection of KRC indicated need for remediation and facility improvements, including a new roof. Also, while philosophically consistent with the move to Behavioral Health integration, current regulations demand total separation of what is now two distinct programs or Centers to be factored in. Once work can begin in the vacated building, it is anticipated to be open for services as of July 1, 2017. The County will maintain ownership of the facility; KMHS will hold operations and management agreement and assume facility management once vacated end of November 2016. Currently under the 2014 MIDD Award and with additional funding received from the Regional Support Network, in April 2015 KMHS subcontracted with an architect and construction manager experienced in CTC, Detox and Inpatient Unit design. A Program Director is coordinating the complex facility and program licensures necessary to operate the two Centers under one roof.

C. Staffing Capacity

Overall administration of CTC/WMC operations is the responsibility of a single Program Director (PD). The PD was originally hired to develop and implement the Crisis Triage Center in September 2015, under the 2014 MIDD Award. The CTC and WMC each are provided clinical and operational oversight by a Program Manager and separately dedicated Care Team staff, as the two units are required by the State to be treated as distinct programs both in their physical building footprint and their clinical services.

Administratively, KMHS will provide in-kind services of a .1 Chief Clinical Officer and .1 Chief Medical Officer for clinical guidance as the two programs open their doors July 2017. Operation of the 24/7 Crisis Triage Center and Withdrawal Management Center (CTC/WMC) requires an intensive staffing model like that of an inpatient or hospital unit. Positions are distinct to each of the Centers and described accordingly as below.

2015-2017 PHASE I: Project Planning and Development Staffing

KMHS Program Director - 1 FTE (shared function .5 CTC and .5 WMC). Masters Level (MA) Licensed Mental Health Professional (LMHP) with residential, crisis services and/or detox experience. Directs full project implementation; regulatory/licensing requirements, partner relationships, oversight operations/services. Damian Uzueta, MBA, MSN, RN-BC RN, was hired 9/14/2015 to begin project planning and implementation. Mr. Uzueta has five years extensive experience including homeless outreach services, bringing both breadth and depth of knowledge to Center operations.

2017 PHASE II: 24/7 WMC and CTC Center Staffing Models

The following staffing models described for each Center constitute 24/7 staff coverage. Staff will be hired 1 – 3 months prior to opening assuming a 7/1/17 start date. Hiring date is dependent on position, with Program Managers to be hired in April for program preparations, and remaining staff hired in May, to begin 6/1 for training and program roll-out. As a designated community behavioral health agency, all staff are required to have the knowledge, education, experience, licensure, guidance and supplemental training to understand needs of the mentally ill and substance abusing population.

WITHDRAWAL MANAGEMENT CENTER MODEL - 19 FTE

The following positions comprise the 24/7 WMC staffing model. Staff ratio is 1 staff to every 3.2 clients. The Program Director has .5 FTE oversight for WMC operations.

Program Manager - CDP, MHP Preferred (1 FTE) Provide training, management and supervision of WMC team and staff in daily operations. Monitor and manage program integrity, policy and procedures, and budget. Oversee admissions process, facilitate shift changes, communications, clinical and administrative documentation, chart review.

Chemical Dependency Professional - BA/MA CDPs (6 FTE) Assess and treat for substance use, develop treatment plans using recovery oriented, harm reduction best practices for detox and co-occurring, integrated care. Provide therapy, recovery skill building groups, crisis intervention, arrange for post services care, community reentry. On rotating basis, oversee, coordinate shift operations, supervise staff, perform CDP services. Strong detox, crisis stabilization, recovery skills; COD MH capable preferred.

Chemical Dependency Professional Trainee - BA CDP (2 FTE) Under supervision of CDP, assess and treat for substance use including development of substance use treatment plans using recovery oriented, harm reduction best practices for detox, co-occurring, integrated care. Support individual, family, group therapy, psycho-education and recovery skill building groups and crisis intervention. Carry out stabilization plan.

Psychiatric Aides - HS Diploma/GED (8.75 FTE) Assist with stabilization plans using recovery model; facilitate groups; eligible Agency Affiliated Counselor status, WDL.

Program Assistant - HS/GED/AA (1.25 FTE) coordinate operations and logistics (ie meal, laundry, supplies, data management, reporting.) Familiar with SA population.

CRISIS TRIAGE CENTER MODEL - 26.75 FTE

The following positions represent the 24/7 CTC staffing model. Staff ratio is 1 staff for every 2.8 clients. The Program Director has .5 FTE oversight for CTC operations.

Program Manager – MHP; + CDP preferred (1 FTE) Provide training, management and supervision of CTC team and staff as a whole in daily operations. Monitor and manage program integrity, policy/procedures, budget. Oversee admissions process, shift changes, communications, clinical/administrative documentation, chart review.

MHP Care Managers, Masters Level (6 FTE) Conduct assessment clinical/social needs; carry out stabilization plan, integrate MH/CD/physical healthcare using recovery principles. Coordinate shift activities; rotate oversight and coordinate shift operations and staffing, perform range of MHP services. Strong crisis stabilization, recovery skills; CD capable preferred. MHP per WAC, eligible Agency Affiliated Counselor, WDL.

Psychiatric ARNPs (3 FTE) Bio-psychosocial assessments, psychiatric prescription services, perform admissions; coordinate transfer of care. MA in nursing/psychiatric. Strong diagnostic, prescriptive knowledge, DEA authorized, Licensed WA State ARNP.

Registered Nurses, AA/BS (4 FTE) Work with ARNP's to administer, manage psychotropic medications as needed; function as MHP; assess/coordinate healthcare needs; at discharge, educate about health needs. WA St. Licensed RN.

Chemical Dependency Care Managers, MA/BA Level (3 FTE) Conduct CD assessments, establish integrated short-term stabilization plans, referral to follow-up care; provide individual, group treatment using recovery model.

Peer Counselor (4.5 FTE) Assist in assessment clinical/social needs; facilitate peer-to-peer support groups, individualized peer counseling. Past/current consumer MH services. Certified Peer Counselor status, eligible as Agency Affiliated Counselor, WDL.

Psychiatric Aides - HS Diploma/GED (4 FTE) Assist in stabilization plan using recovery model; facilitate groups; eligible for Agency Affiliated Counselor status, WDL.

Program Assistant - HS/GED/AA (1.25 FTE) coordinate operations and logistics (ie meal, laundry, supplies, data management, reporting.) Familiar with BH population.

KMHS CTC/WMC ADMINISTRATIVE CLINICAL SUPPORT *(In-Direct Cost)*

Chief Clinical Officer - .1 FTE. Stacey Devenney M.S. will provide administrative and clinical oversight. Licensed Mental Health Professional (LMHP), Chemical Dependency Professional (CDP); 20 years community MH leadership - inpatient, outpatient, crisis services, for Seriously Mentally Ill (SMI), CD, homeless, justice involved populations.

Psychiatrist & Chief Medical Director - .1 FTE. Marvin Hoffert, MD, FAAN, FACPM will provide administrative and clinical oversight of ARNP's, RN's. Develop medical protocols, CDF exclusionary criteria. Provide bio-psychological assessments, psychiatric treatment, assure licensing, DEA, regulatory compliance, related Quality Assurance. M.D., prefer Board Certified Psychiatry and/or Addictions.

SUBCONTRACT

Security: Premises will be patrolled for security 11 PM – 7 AM Monday through Friday and 24 hours daily Saturdays/Sundays. S&S Security Services contracts with KMHS for these services and will rotate two personnel familiar with and adept at providing security presence on KMHS grounds and inside buildings for this project.

2. Community Needs and Benefit: *separate assessment is detailed for each center.*

A. Needs Assessment for the Crisis Triage Center: Kitsap County (KC) providers in 2002, 2006 and 2009 commissioned experts to assess the need for a crisis triage facility for adults with acute Behavioral Health (BH) illnesses. Commissioned by KCHS, Harrison Medical Center (HMC) emergency department, KMHS and multiple health and social service providers, the purpose was to reduce inappropriate ED, psychiatric inpatient unit, Kitsap Recovery Center (KRC) and jail utilization. Each assessment revealed pressing need for a 12 bed crisis triage facility, but inadequate funding for facility and operations. In 2003, treatment was identified as severely lacking for persons in need of acute crisis services, noting 3,100+ visits could be managed in a triage stabilization facility[1] but without this option, "the criminal justice system by default becomes responsible for custodial care of this population." Lack of funding (2003 estimate for facility at $750,000, operations at $1+ M) resulted in a "truncated" 4 beds at KRC. In 2006, operations cost estimate of $1.87 M again prevented moving forward.[2] The 2009 assessment updated need estimates, and made the same recommendation.[3] By 2012, jails were "the defacto location for treatment of the mentally ill and substance abusing adults." Law enforcement (LE) from 4 jurisdictions, the WA State Patrol, Kitsap Sheriff's Office and Jail, Prosecutor's office and KMHS met to reduce inappropriate involvement in the justice system, reduce risk of violent contacts, and help people receive treatment and services supporting recovery and prioritized creation of a Crisis Triage Center. Need for a county-wide 24/7 crisis triage alternative was identified in the 2013 KC BH Needs Assessment[4]. Review of law enforcement, hospital, MH data was consistent with recommendations. The ILEADS records system used by all city and county LE agencies for reporting field events show in 2013 at least 1,565 calls for service were related to MH issues.[5] At HMC, in 2013, 2,969 persons with primary MH and/or SA concerns were seen at the ED. The average ED MH length of stay ranged from 5 hours, 40 minutes to more than 60 hours, an increase from 48 hours in 2006.[6] For 2013, the Designated MH Professionals (DMHP's) reported 2,200 crisis response team (CRT) encounters; 41% at HMC.[7] The CRT Director noted it is important who does NOT get detained to involuntary treatment because their condition doesn't meet stringent legal criteria for detention to a psychiatric inpatient facility. With no less restrictive 24/7 alternative there is no option for engaging people when in an acute state. This lack of a shared county-wide, cross system, triage facility leaves no community "step-down" option for persons in acute BH crisis who cannot be detained, are not willing or appropriate for 24/7 CD inpatient treatment, and are likely to receive services in costly, acute care or settings inappropriate for treatment, or be found among the 500+ homeless persons without adequate shelter in our communities.[8]

Needs Assessment for Withdrawal Management Center (aka Sub-acute Detox): KCHS approached KMHS in 2015 to consider management of withdrawal/sub-acute detoxification services and increasing available "beds" from the existing 8 at KRC to a

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[1] Making the Case: Compelling Need for MH/SA Crisis Triage Services in Kitsap County, 3/03, Health Facilities Planning & Development, Seattle
[2] Kitsap County Behavioral Health Strategic Plan, 3/3/06, Barbara Mauer, principal, MCPP Consulting, Seattle
[3] Behavioral Healthcare Needs in Our County, see pp 79 -83, 4/09 Bea Dixon, Consultant
[4] 2014 Kitsap County Behavioral Health Strategic Plan, February 2014, Kitsap County Human Services Department.
[5] ILEADS data provided by Corrections Division, Kitsap Sheriff's Office 3/20/14 note: number is conservative due to call coding limitations.
[6] Harrison Medical Center Emergency Department data report, 3/27/2014, courtesy ED Director.
[7] Designated Mental Health Professional record of calls for 2013, Kitsap Mental Health Services.
[8] Homelessness, Mental Health & Substance Use Disorders Fact Sheet, Kitsap County 2013.

new 16 bed Center connected to the Crisis Triage Center, in alignment with the shift to integrated behavioral health services. As of April 1, 2016 a new WA Administrative Code directs (KMHS) Designated Mental Health Professionals to evaluate individuals for substance use as well as mental illnesses potentially endangering self or others. We anticipate this will result in increased voluntary utilization of the WMC. The Center is aimed at managing acute intoxication and withdrawal, with such services often the first point of contact with the treatment system and where they can facilitate entry into the recovery process. Withdrawal and detoxification is not part of treatment per se, but is part of the continuum of care necessary for treatment of substance related disorders. Today the primary substance abuse problem of clients has shifted from alcohol and cocaine/crack to heroin and other opioids. Kitsap County is experiencing a heroin epidemic urgently in need of collective address.[9] It also has one of the highest enrollments in Medicaid insurance under Medicaid expansion thus improving access to care, but it is of note that in WA among the post expansion population there is a 24% prevalence rate of Substance Use Disorder in contrast to an earlier 9% rate, thought due to more younger males now insured in this cohort (Pew.)[10] The 2014 BH Needs Assessment notes gaps related to Veterans homelessness and substance use, homelessness as a whole and the lack of a "drop-off" center for law enforcement.[11] While the Assessment does not call out increasing withdrawal management/sub-acute detox services, the WMC offers an avenue for addressing these issues. Kitsap LE and homeless services providers report there has been a growing incidence of encounters with substance using individuals in need of services. An increased capacity to manage intoxication and withdrawal with effort directed to engagement and follow-up care can interrupt this cycle.

B. Link between Community Need and Strategic Plan: This proposal is a major collaborative, cross-system commitment to address four Strategic plan policy goals:

1. Reduce the incidence and severity of CD and/or MH disorders in adults.
2. Reduce the number of chemically dependent and mentally ill adults from initial or further criminal justice system involvement.
3. Reduce the number of people in Kitsap County who recycle through our criminal justice systems, including jails and prisons.
4. Reduce the number of people in Kitsap County who use costly interventions including hospitals, emergency rooms, and crisis services.

Key Recommendations & Local Gaps in Services this proposal addresses:

1. <u>For Adults with Mental Illness, Gap #2, Crisis Intervention/Triage Services</u>
   "Provide Crisis Triage/Respite and/or Drop Off Center alternative for individuals with Behavioral Health (MH/SA) needs not eligible for acute hospital or Evaluation and Treatment Services (inpatient psychiatric hospitalization) but are in need of short term 24 hour services, including assessment and referral."
2. <u>For Individuals with Mental Illness and Substance Use Disorders in the Adult Criminal Justice System: Gap #2 Crisis Intervention/Triage Services</u>

[9] Washington State Interagency Opioid Working Plan, January 2016, WA DOH, WA DSHS, WA L&I, WA HCA, UW
[10] Pew Charitable Trust Report Medicaid Expansion, 2016. www.pewtrusts.org/state-spending-on-medicaid
[11] 2014 Kitsap County Behavioral Health Strategic Plan, including System Map Attachment B and Citizen Advisory Committee Strategic Recommendations Attachment 4a. February 2014, Kitsap County Human Services Department.

"Provide Criminal Justice System alternative through Crisis Respite/Triage Center/Drop Off Center with dedicated beds for short term 24/7 service."

3. For Adults with Substance Use Disorders: Gap #5: Acute Inpatient Care Services Gap does not specifically address sub-acute detox services, still the WMC offers a short term option to increase the number of local residential substance abuse treatment beds and likelihood of engagement in outpatient/inpatient treatment.

CTC and WMC Project Design Meets Community Need and Plan Goals: This project creates facility and operations capacity for both a Crisis Triage and an expanded Withdrawal Management Center designed to provide 24/7 client care, for up to 5 days, at 16 bed occupancy each, a total of 32 beds. Cross-system partnerships facilitate persons with significant MH and CD issues to become engaged with local MH and CD treatment systems in a way that avoids unnecessary jail and/or hospital stays, or homelessness, while linking and connecting them to the care systems that can help address underlying issues precipitating crisis. Program development has been informed by extensive research regarding best practices of similar centers through the state and nation effective in reducing unnecessary utilization of costly and inappropriate services, and in engaging and linking individuals to the level of services necessary for recovery.

3. Project Description

A. Project Design and Evaluation

Project Purpose: Development and implementation of a CTC will provide 16 individuals with 24/7 care, for up to 5 days; development and implementation of a WMC will provide an additional 16 individuals with 24/7 care, for up to 5 days. Based on research of similar facilities, past needs assessments and local data, this proposal assumes an 85% occupancy rate during start up, at 20% repeat visits, and an average stay of 48 hours, each Center serving 1,986 persons annually for 3,972 total individuals.

Project Design: The CTC and WMC will reduce inappropriate utilization of Emergency Departments and jails by providing one-stop, facility-based, short term 24/7 screening, assessment, treatment services for 1,986 adults at the CTC with acute BH needs (2,482 visits) and 1,986 adults at the WMC annually (2,482 visits); engaging them in services, rapid referral and linkages to ongoing BH/CD treatment, social, health, and housing supporting recovery.

Services provided: 1) Psychiatric assessment and brief treatment, 2) SA assessment, withdrawal/detox, brief treatment and rapid referral/linkage to SA treatment services, 3) social assessment including housing referral, 4) brief MH/SA counseling, stabilization, rapid referral/linkage to outpatient follow-up services, 5) physical health assessment, monitoring, stabilization, referral to primary care, 6) socialization opportunities and interpersonal skill building, 7) individual, group, family therapy and 8) transition to 24/7 services or Law Enforcement, if indicated. Nearly all persons are assumed to have both a mental health and a substance use concern as co-occurring disorders are more the rule than the exception and decision will be made on entrance to the Center as to which is the most appropriate of the two options. Emphasis at the Crisis Triage Center is on psychiatric assessment, while intoxication/withdrawal assessment and treatment is the function of the Withdrawal Management Center. KMHS is dually licensed to provide MH care and CD treatment, and currently provides a continuum of services from acute inpatient evaluation and treatment (14 day), a "step down" 30-day residential treatment facility, two Programs for Assertive Community Treatment ("hospitals without walls"),

outpatient treatment services, co-occurring disorders (MH and CD) and housing. Core values, competencies and treatment approach are based on staff well-trained to provide evidence based, best, and promising practices and approaches[12] that encompass:

1. A recovery model for mental health, substance use and/or co-occurring disorders.
2. An integrated model of care for physical, mental health and chemical dependency built on multi-disciplinary teams and co-morbidity treatment.
3. Direct linkage to treatment and community supports for successful re-entry, including inpatient and outpatient MH or CD treatment, primary care, day centers/shelter/ housing, essential needs, transportation, legal services, support groups and other.
4. Commitment to best practices including motivational interviewing and engagement, trauma informed care, harm reduction, cognitive behavioral therapy and culturally appropriate services (including services for Veterans).
5. In keeping with known effective practices in crisis triage and withdrawal management centers, the focus is on Goal Based Recovery Plans with participant involvement; outcome-driven services; a utilization review process; Chief Medical Officer and/or psychiatrist involvement in daily review of emergent cases, cross-trained staff with knowledge/experience with MH, CD and criminal justice systems, and staff tracking of quality improvement measures.
6. Funding for provision of client services, whether an individual is Medicaid eligible or non-Medicaid, is not a criteria for provision of CTC or WMC services.

PHASE I: Project Planning Planning and development of a 24/7 facility that can assess medical, chemical dependency and mental health status and provide short term stabilization for persons meeting services criteria is a substantial endeavor. Post the 2014 MIDD award, a Clinical Program Director (PD) responsible for conducting facility and program development and services delivery was hired. The PD's initial focus is working with the Department of Health (DOH) and DSHS to secure all necessary licensing and certifications 2) participating in design of facility, facilitating and monitoring design and construction processes, and 3) developing a clinical program operating a recovery-oriented BH milieu for assessment, treatment, and rapid referral for the two programs' services. The PD carries out the evaluation process, works with KMHS IT to ensure data collection capacity, ensures outcome measure benchmarks can be captured for analysis, and guides a structure for continuous quality improvement process. The PD provides reports for stakeholder, advisory, and governmental bodies annually or as requested, and works closely with partners and affiliated community providers so services are consistent with intended outcomes, meeting monthly with partners for the first six months of operations, and quarterly thereafter.

Renovation of Existing Facility for Services Delivery *No new funds are requested for facility renovation; it is described as integral to services delivery and the PD is involved in its renovation/licensure for operations.* Kitsap Recovery Center is located at 1975 NE Fuson, Bremerton. KRC offers ideal siting as it is immediately adjacent to the main KMHS campus with outpatient, inpatient, and a 30 day residential unit, Designated Mental Health Professionals, and 24/7 security staff on site. The location affords needed supports for CTC/WMC clients and services and is within two miles of ED, EMS and Police. The facility holds existing licenses for allied operations. Renovation provides 16

[12] See www.samhsa.gov for description of evidence based practices and approaches including recovery model, integration model, motivational interviewing, trauma informed care, harm reduction, culturally sensitive care.

beds for CTC, 16 beds for WMC as separate and distinct units with 32 beds total in a 15,250 total square feet footprint. ADA access and facility security measures meet DOH Residential Treatment Facility licensing requirements; the design has been approved by DBHR and DOH. On entry, the Center offers a shared welcome area for assessment/ triage, intake/interview capacity; medical exam room, bathroom with shower, laundry, storage for extra clothing. Shared facilities include commercial kitchen, food storage, generator, a center courtyard, storage for earthquake supplies, facility laundry area, stocked clothes closet, and a large group room. Each program has 3 large rooms, within each room are 5 single privacy cubicles/beds and bathroom; a single bedroom; 3 client baths; a large "Day" room, 2 group rooms, dining area, staff office, resident laundry and janitorial room. There are exterior and interior cameras for line of site monitoring as well as duress alarms/systems support security. Construction is to be completed May 2017 (assumes 11/30/16 vacate for renovation to begin 12/1/16). One month is allowed post remodel for DOH facilities clearance for provision of services 7/1/17.

PHASE II Service delivery under design, staff hired and trained to program models with oversight provided by Program Director; assigned staff perform functions as described in the staffing model by professional capacity, using a multi-disciplinary team model.

***Description of CTC and WMC client services*:** Upon arrival at the CTC, persons will be fully assessed within 3 hours by Psychiatrist, ARNP, or RN, and an MHP. At the WMC, individuals will be fully assessed within 3 hours by a CDP. For both Centers, engagement begins with warm welcome, clear explanation of rules and resources, introduction to all shift staff. Immediate needs and wants are identified and addressed. Bathing facilities, nutritious food, basic medical care, communication with family or friends, laundry facilities, and a bed are offered. If indicated, medications can be prescribed for CTC participants; at the WMC participants requiring medication will have them made available for self-administration under observation. Philosophically, crisis is viewed as a temporary relapse in progress toward recovery; the approach is to promote hope, connections & supports. Because participants are either present as part of LE diversion or are referred by HMC ED, KRC, KMHS, DMHP or EMS, staff use engagement strategies, a trauma informed approach, a welcoming and relaxed environment while assessing and providing crisis stabilization services focused on recovery. Disposition planning begins on entry; releases for information sharing are immediately sought for collaborative care, and a practical Goal Plan established. Electronic records are maintained and describe diagnosis, recent MH/SA status, relevant criminal history, current medication treatment, physical health status, current conditions requiring monitoring/treatment. Staff are trained to make speedy, effective referrals for next step services, accompany client to initial appointments as possible and desired. Protocols for clients transitioning back to LE for disposition are in place, with collaborative agreements to address transportation functions where needed (i.e. EMS). Tight care coordination is made between psychiatric, chemical dependency, medical institutions for transitions between care facilities and providers. The client's Discharge Plan includes transportation options to return home or to shelter/housing, inpatient/ outpatient treatment, or jail. Much like wrap-around services models, should staff transport client home, stops for groceries and medications, and observations regarding living conditions can be made that lend additional support for successful re-entry. Follow-up contact is made or attempted post discharge at 24 hours, 7 and 30 days.

Timeline for Implementation: July 2015 – December 2017

Month/Activities: Planning		Facility	Staffing
FY 2015 /2016	✓ *Initiate DOH RTF application discussion and DSHS notifications* *Community meetings with stakeholders* ✓ *Visits to other models* *Program research*	✓ *Work with County staff re facility & funding* ✓ *Determine site (KRC)* ✓ *Secure $400,000 facilities funding -State* ✓ *Review build design* ✓ *Secure architect,mgr*	✓ *Recruit/hire Program Director* ✓ *Write job descriptions* ✓ *Set recruitment plan*
July – Sept	Set monthly Planning Group meetings w/stakeholders. Draft partner agreements. Set operation protocols Meet IT Director re data plan Baseline data collected. Set measure collection process	Approve architectural plans, ensure meet DOH requirements. Let bid for Contractor/s. Determine Contractor/s	
Oct-Dec	Review RTF license w/DOH; Meet w/key partners;sign MOU Security, communications Computer, internet plans Plan meal/transport protocols	Begin space remodel Make supply inventory; furniture/office equipment Ensure connectivity & desktops w/IT Director	Finalize position descriptions
Jan – Mar 2017	Review progress with DOH, secure approval of license. Develop client program. Write procedure manual, Continue stakeholder mtgs. Develop program linkages Prep CQI measures/outcomes	Continue remodel. Establish janitorial/ facility protocols, Order equipment and supplies. Regular walk-throughs for monitoring remodel	ID interview team. Design training plan Begin targeted ARNPs, RNs, MHP/CDP positions
April - June	Plan to hold RTF license on or by month 10. Plan for opening Staff meet with referral partners to clarify processes and ensure understandings.	Continue remodel & pass inspections. Test systems security, communications, etc. Complete remodel Plan/ Opening Ceremony	Advertise, screen, interview all jobs Finish hiring-May Train team in roles, policies, procedures clinical approach
July		- Facility operations functioning well **Open July 1, 2017**	Monitor, problem solve. ID, conduct training
July 1	Expect daily review/problem solving new service next 6 mo including w/stakeholders Data collect. CQI, measures. Monitor operation/service Prepare & share reports	Program opens & client services begin Service re client recovery needs/outcomes Frequent interaction w/community linkages.	Deliver services. Continued oversight Team Operations. Daily Team huddles Discuss solutions to challenges w/staff

Plan for Data Collection, Management and Analysis: The Chief Clinical Officer (CCO) and Program Director (PD) are responsible for managing full evaluation processes, and refining evaluation plan prior to service delivery, including inclusion of both programs in the evaluation plan and adhering to the evaluation plan put forward in this proposal. In Fall 2016, in consultation with the KPHD epidemiologist to ensure consistency with the MIDD evaluation plan, the PD will finalize data collection design with baseline measure data secured congruent with the evaluation measures plan, and will meet with KMHS IT Director to ensure Electronic Health Record fields function to capture data. Monthly, quarterly, bi-annual and annual outcome data will be analyzed and used to inform the Project's written continuous quality improvement (CQI) process, with input from staff and partners for ongoing program refinement. Analysis of data illustrating outcome measure performance and adjustments made through the CQI process will inform short, mid, long-term adjustments to program and practice, and to communicate progress to governing and advisory bodies, partners, stakeholders and funders. The goals, activities and objectives as outlined in Attachment D are aligned with the project's phased approach and performance outcome measures. The project's purpose, goals and objectives are sustained by highly invested partnerships committed to developing and operating less costly, more effective, more appropriate alternative "step down" facilities, providing the right care in the right setting rather than at the ED, and avoidance of inappropriate jail utilization. Client goals are based on research about "what works," learning from visits to other sites what are achievable Center outcomes.

B. Community Collaboration, Integration and Collective Impact

Kitsap Mental Health Services (KMHS) serves as fiscal lead for project and budget management; designs and oversees CTC/WMC program, staff and client services, ensures suitable facility remodel, provides immediate 24/7 phone screening to referring partners for admits, coordinates with partners and service providers, conducts evaluation processes/reports with stakeholders. While KMHS serves essentially as the backbone organization and project manager, the project itself was designed by myriad providers to create, implement and effect a collective impact. The project strengthens the efforts to develop a full continuum of recovery oriented services seen in proposals now being submitted for consideration: a Public Health proposal for a Crisis Response and Care Coordination Team for high utilizing adults, a Coffee Oasis proposal similarly designed, and a law enforcement proposal strengthening interface with the DMHPs in the field. The CTC/WMC affords these projects and clients a place for disposition and care for treatment, recovery and restoration to community. It builds on the original partnership of agencies involved in repeated needs assessment for crisis triage resolution, and who subsequently remain involved as referring agents, or are providing treatment for client at discharge. Referral partners meet quarterly for planning and CQI.

Referring Partners: In priority order, referrals for services are limited to hospitals, law enforcement, DMHPs, EMS, Jail Services, KRC/CD providers and KMHS. Referring partner roles are to: 1) identify participants, 2) contact for Center phone screening in advance of arrival to determine if referral meets protocol for services, 3) actively participate in services planning, 4) participate in continuous quality review process first 6 months, and bi-annually thereafter. Explicit MOU's with referral protocols, clinical level of care criteria defined and care coordination guidance for care management of shared clients, and "rule-out" criteria will be in place. MOU's are refined quarterly thru year one.

- **Law Enforcement jurisdictions (7) including: Bainbridge Island, City of Bremerton, City of Port Orchard, City of Poulsbo, Kitsap County Sheriff's Office, Suquamish Tribal Police Department, and the Washington State Patrol.** LE referrals are first priority for CTC/WMC services; LE to transport to Centers. On admit, person is seen within 3 hours by MHP and a Psychiatrist, ARNP or RN for full assessment (CTC), or CDP (WMC). If indicated, DMHP will be contacted to assess person for possible detainment to involuntary treatment. For clients completing services or leaving voluntarily, travel back to home community will be arranged.
- **Harrison Medical Center Emergency Department:** 1) provides medical clearance, subsequent referral to CTC/WMC. CTC/WMC may send clients to ED if indicated.
- **Designated Mental Health Professionals (DMHPs):** 1)provide Involuntary Treatment Assessment as requested and appropriate; 2) may refer to CTC/WMC.
- **Emergency Responders (EMS):**may refer to CTC/WMC for BH needs not requiring hospital ED disposition. *Note:* Transportation arrangements to be detailed in MOU. **Kitsap County Jail Services:** may refer to CTC/WMC as appropriate at release. **KRC/CD Providers:** 1) may refer to CTC/WMC when more appropriate services setting.2) CTC/WMC may refer for CD inpatient or outpatient treatment at discharge.

Coordinating and Leveraging with Other Organizations for Shared Clients PCHS, CD Providers, HMC *Harrison Health Partners* for primary and medical care; Kitsap Legal Services; KCR and Housing Solutions Center for social services/ housing needs; DSHS for entitlements. Multiple organizations are contacted dependent upon client needs i.e. linking clients to food banks, NAMI, AA/NA or other support groups.

4. Project Financial Feasibility

A. **Budget Narrative**: The CTC/WMC requires high intensity staffing (1 staff: 3 clients) to safely serve 3,972 adults each year. The target population requires a 24/7 crisis care setting with medical, psychiatric, mental health and chemical dependency professionals to screen, treat, stabilize, connect to supports, housing and treatment.

Personnel: Description of staff titles, salary, all benefits by number of months they will work in this proposal period, total number FTEs for each position is shown below:

Staff Title	1 FTE salary time period	Salary by total FTEs	taxes	retirement	benefits	Total	# of Mon	# staff
PROGRAM DIRECTOR	$ 116,860.50	$ 116,860.50	$ 11,063.07	$ 5,842.88	$ 30,888.00	$ 164,654.45	18	1
Program Managers	$ 38,008.88	$ 76,017.75	$ 7,938.83	$ 3,800.89	$ 15,444.00	$ 103,201.47	9	2
Psychiatric ARNPs	$ 67,335.33	$ 202,006.00	$ 17,930.84	$ 10,100.30	$ 18,018.00	$ 248,055.14	7	3
RN	$ 38,948.00	$ 155,792.00	$ 15,221.27	$ 7,789.60	$ 24,024.00	$ 202,826.87	7	4
MHP Care Managers	$ 26,055.75	$ 156,334.50	$ 16,914.36	$ 7,816.73	$ 36,036.00	$ 217,101.58	7	6
CD Care Managers	$ 27,868.75	$ 83,606.25	$ 8,873.26	$ 4,180.31	$ 18,018.00	$ 114,677.82	7	3
Chemical Dep. Professional	$ 26,826.92	$ 160,961.50	$ 17,268.32	$ 8,048.08	$ 36,036.00	$ 222,313.90	7	6
Chem. Dep. Prof.I Trainee	$ 25,297.85	$ 50,595.71	$ 5,522.16	$ 2,529.79	$ 12,012.00	$ 70,659.65	7	2
PEER COUNSELOR	$ 16,831.50	$ 75,741.75	$ 9,510.32	$ 3,787.09	$ 27,027.00	$ 116,066.16	7	4.5
PROGRAM ASSISTANT	$ 19,331.08	$ 48,327.71	$ 5,761.56	$ 2,416.39	$ 21,021.00	$ 77,526.65	7	2.5
PSYCH AID	$ 14,857.50	$ 189,433.13	$ 25,020.52	$ 9,471.66	$ 78,078.00	$ 302,003.30	7	12.75
Shift Diff,Temp,Beeper,On Call		$ 206,384.09	$ 20,092.22			$ 226,476.32	6	
(MA, ARNP, BA, Psych. Aid)	**TOTALS**	$1,522,060.88	$ 161,116.73	$65,783.69	$316,602.00	$2,065,563.30		46.75

Subtotal Personnel is $2,065,563

Supplies & Equipment $3,000 for copy machine, computers; Office supplies at $2,500;other-copier/printer/fax leases $3,036. ***Subtotal Supply /Equipment is $8,536***

Administration Advertising at $2,000 for extensive ads needed for competitive hire of medical and BH staff; Professional Services at $6,000 for medical consult and tests, special population/translation services; Communications (phone/cabling) based on KMHS service, pro-rated at $12,000; Fees at $10,000 include Health Dept. licensing operations, building occupation, $500 for DSHS satellite office fee; Insurance and Bonds at $10,412 pays agency professional liability, pro-rated by staff/ months worked, includes property insurance. Training/Travel staff travel at $15,000 (40 miles x $0.54 x 6 months x 3.61 trips/month x 32 residents. Transportation – commercial at $15,000 for client taxi rides, travel vouchers, staff mileage for linkage services (32 residents x $15 X 5 trips/month per bed). Indirect Expenses at $250,892 are at 10% for HR, accounting, chief officer clinical supervision. ***Subtotal Administration is $311,304***

Ongoing Operations & Maintenance (O & M)

Janitorial Service daily at $20,000; Laundry Services, $12,012 commercial loads at $2000/month; Contracts $50,000 for night/weekend security and $5,000 maintenance HVAC, kitchen, copier if needed; Operating Supplies $20,000 mealware, TP, sheets, first aid kits, etc based on KMHS 24/7 units; Meals 3 meals for 32 persons daily ($5.27/ meal plus 2 snacks) at $70,000; Repair of equipment/property at $5,000; Utilities at $10,000 using KMHS 25 bed inpatient units cost. Pharmacy/ Medical supplies at $5,000/month based on 24/7 services budget. ***Subtotal O&M: $272,012***

Other: Client Security Deposit Assistance of $15,000 is to supply 30 individuals with $500 rental deposit to secure housing over 6 months - routine, monthly, ongoing expense. Client expenses at $7,400 ($1,200/mo) to procure clothing, hygiene articles.

Existing Resources and other anticipated support: Facility renovations are fully funded at $2.1 M from previously committed MIDD, local, and state funding sources. Operations are challenging to project, WA State has not finalized funding commitments for "bed rates" for either CTC or WMC beds, the method for budgeting 24/7 residential services. Rates will be set by July 1, 2016 when State Fiscal Year begins anew. Lack of information makes it impossible to forecast a true proposal request that covers possible shortfall of income to expense based on these yet unknown reimbursement rates. Thus total MIDD request is for (up to) $1,039,535. This request would be reduced if bed rate reimbursement through Salish BHO contractual Medicaid/State funds is higher than we conservatively projected. The WMC bed rate projection is based on what is assured at this time of at least $190. CTC reimbursement rates are totally unknown as the State has given Salish BHO no CTC rates to date. The Salish BHO has committed $300,000, set aside for withdrawal management, included in "other funds" as income.
Given this, we have budgeted CTC/WMC operations conservatively as in table below:

BED RATE	Start-up cost per Bed Day 6/1/1 -12/31/17	(?) State/BHO reimbursement per Bed day	Other funds: Total State/BHO Reimbursement	**Difference = 2017 MIDD Request**	*Annual cost per Bed Day 1/1/18, on*	**Total 2017 Budget**
CTC	$606	$350	$868,700 (?)	$634,761	$571	
WMC	$353	$190	$471,580 (?)	$404,774	$358	
BHO Funds			$300,000			
Total			$1,640,280	**$1,039,535**		**$2,679,815**

Evidence of Non-Supplanting of Funds: No crisis triage center or withdrawal management center with co-occurring psychiatric and chemical dependency treatment exists in Kitsap County; this proposal does not supplant existing resources.

B. Additional Resources and Sustainability

Additional Resources: KCHS and KMHS have leveraged over $2.1 M for facilities renovation. An agreement between HMC and KC to support KRC's 4 triage beds ends 12/31/16; KMHS will seek new commitment of $100,000/funds annually to begin at CTC/WMC opening. KMHS in-kind includes .1 FTE Chief Medical Officer and .1 Chief Clinical Officer, costs included in the indirect rate of 10%. Referring agencies and partners engage in planning/evaluation sessions, make referrals, giving in-kind time, funds and resources, and are engaged in the collective impact by working together in delivery of this service, pre-admit when clients are in crisis, and at exit as people are engaged and more connected to needed services. In-kind donations of clothing, hygiene articles, and cash donations are anticipated as for our KMHS inpatient and 24/7 residential services units. Federal, state and local funding opportunities will be routinely reviewed and applied for to reduce amount of MIDD funding request. We are in regular discussion with the KCHS and the BHO to ensure any and all options for bed rate reimbursement are acted upon. Private insurance will be billed for CTC/WMC whenever possible, however past experience with 24/7 inpatient services is that the population is mostly Medicaid eligible and rarely covered by Tri-Care/private insurers.

Sustainability: KMHS, KCHS, and BHO staff have explored other possible funding sources but were unable to identify additional monies outside of the State/BHO "bed rate" contract funds for ongoing operations. A State solicitation for crisis triage centers will be released this summer but it is not known if it is for capital or operations. If for operations, we will apply and if funding is received, KMHS would seek to reduce the amount of this request accordingly. Should "bed rate" reimbursement be established higher than our conservative estimate, we would similarly ask for a reduction in request. We appreciate the KCBOC, CAB and KCHS Department is invested in and has worked diligently to support construction and secure funding of the proposed CTC/WMC. The challenge remains that operations of a 24/7 facility providing intensive services for ill and vulnerable adults is costly and ongoing operations is reliant upon sufficient Federal and State funds to ensure meeting regulations and certain staffing requirements. For two decades this conundrum is what has three times prevented the opening of a Crisis Triage Center. The prioritizing of a Center in 2014 was a courageous and much needed step forward in our community's continuum of care for persons with 24/7 behavioral health needs when they are in crisis. For long term sustainability, while the seeking of MIDD grant funding is essential for the short term and one-time start-up costs, the ongoing operations of a 24/7 crisis facility requires solid commitment of sufficient funding through time. For this 2017 request, if it is found that the forthcoming bed rate reimbursement is sufficient for safe operations, there will not be a need to draw upon these requested MIDD funds. However, should these reimbursement rates fail to meet cost, we respectfully request the CAB set aside funding to meet operational expense gap for a multi-year commitment (no less than 5 years) and that the KCBOC, BHO, KCHS and KMHS meet again over the course of 2016/7 to identify future options for ongoing operational stability of the Crisis Triage and Withdrawal Management Center.

ATTACHMENT D

EVALUATION WORKSHEET

PROJECT NAME: Crisis Triage and Withdrawal Management Center

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F.BASELINE Data and time	G.TARGET	H. RESULTS Continuation grants	I. SOURCE	J. BH Strategic Plan Goal #
Reduce unnecessary incarceration and unnecessary use of hospital emergency and inpatient services among adults with mental illness and/or chemical dependency issues.	Provide crisis triage and withdrawal services for adults in need of short term (5 day) 24/7 assessment, withdrawal management, brief intervention/ treatment and rapid referral to appropriate services.	1,986 adults will be served totaling 2,483 crisis triage services visits annually, and another 1,986 distinct adults will be served with withdrawal management services totaling 2,483 visits annually	☒Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☐Outcome: Practice or behavior ☐Outcome: Impact on overall problem	☐Short ☒Medium ☐Long Start date: July 1 2017 Frequency: biannual	0, Crisis Triage Center new. 3,100 visits expected (2003 needs assessment). No baseline exists for Withdrawal management Center. X Assessment of need	1,986 unduplicated adults 2,483 visits to crisis triage 1986 unduplicated adults 2,483 visits to crisis triage		Fields will be in place for data collection recorded in Electronic Health Record at Center. daily collection for # served and services provided	#3 Reduce the number of chemically dependent and mentally ill youth and adults from initial or further criminal justice system involvement.
		25% of Center participants post discharge do not have an incarceration event by 3 months of discharge.	☐Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	☒Short ☐Medium ☐Long Start date: July 1 2017 Frequency: biannual	None. X Assessment of need Click here to enter text.	25% (497) of crisis triage participants 25% (497)of withdrawal management participants		Fields will be in place for data collection in Electronic Health Record at Center. Jail data sharing of public record utilized for data.	#3
		60% of crisis triage admits and 60% of withdrawal admits were engaged, as measured by length of stay 48 hours or more.	☐Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	☒Short ☐Medium ☐Long Start date: July 1 2017 Frequency: biannual		60% (1192 adults) using crisis triage services 60% (1192 adults) using withdrawal management services		Fields will be in place for data collection in Electronic Health Record at Center. # with length of stay 48 hours or more.	#3
		60% of Center admits considered stabilized by staff at discharge (40% choose exit	☐Output ☐Outcome: Participant satisfaction ☐Outcome:	☐Short ☒Medium ☐Long		60% of total participants complete the staff recommended length of stay.		Fields will be in place for data collection in Electronic	3

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F.BASELINE Data and time	G.TARGET	H. RESULTS Continuation grants	I. SOURCE	J. BH Strategic Plan Goal #
		prior to stabilization.)	Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	Start date: July 1 2017 Frequency: biannual				Health Record at Center. # with BH crisis at admit that are stabilized at discharge.	
		100% of admits reporting being homeless were connected to housing options at discharge.	☐Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	☐Short ☒Medium ☐Long Start date: July 1 2017 Frequency: biannual		100% of persons reporting homelessness are referred to housing.		Fields will be in place for data collection in Electronic Health Record at Center. # reporting homeless status, # connected to housing options.	3
		90% of admits referred to range of needed services, ie inpatient outpatient MH or CD treatment, public benefits, shelter, housing, family reunification at discharge. (10% stay less than 24 hour period, exit refusing referral engagement)	☐Output ☐Outcome: Participant satisfaction ☒Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	☐Short ☒Medium ☐Long Start date: July 1 2017 Frequency: biannual		90% of admits referred to services by category of needed service.		Fields will be in place for data collection in Electronic Health Record at Center. For each specific service: # referred	3
		100% of admits choosing outpatient MH services with 1st appointment scheduled at discharge.	☐Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill	☐Short ☒Medium ☐Long Start date: July 1 2017		100% admits choosing to seek MH appointment have appointment scheduled at discharge		Fields will be in place for data collection in Electronic Health Record at Center. #	3

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F.BASELINE Data and time	G.TARGET	H. RESULTS Continuation grants >	I. SOURCE	J. BH Strategic Plan Goal #
			☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	Frequency: biannual				needing outpatient MH, # with appointment scheduled.	
		100% of admits choosing CD treatment had 1st appointment scheduled at discharge.	☐Output ☐Outcome: Participant satisfaction ☒Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	☐Short ☒Medium ☐Long Start date: July 1 2017 Frequency: biannual		100% admits choosing CD treatment had 1st appointment scheduled at discharge.		Fields will be in place for data collection in Electronic Health Record at Center. # needing CD treatment, # with appointment scheduled.	3
		70% of admits with existing MH provider were re-engaged in services within 14 days of discharge.	☐Output ☐Outcome: Participant satisfaction ☒Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	☐Short ☒Medium ☐Long Start date: July 1 2017 Frequency: biannual		70% admits are reengaged in MH services within 14 days of discharge.		Fields will be in place for data collection in Electronic Health Record at Center. # with MH provider, # reengaged	3
		50% of admits with existing CD provider were re-engaged within 14 days of discharge.	☐Output ☐Outcome: Participant satisfaction ☒Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	☐Short ☒Medium ☐Long Start date: July 1 2017 Frequency: biannual		50% of admits reengaged in CD services within 14 days of discharge.		Fields will be in place for data collection in Electronic Health Record at Center. # with CD provider, # reengaged.	3
		100% of admits received follow-up contact attempt at	☒Output ☐Outcome: Participant satisfaction	☐Short ☒Medium ☐Long		60% with f/u at 24 hours 50% with f/u at 7 days 25% with f/u at 30 days		Fields will be in place for data collection in	3

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F.BASELINE Data and time	G.TARGET	H. RESULTS Continuation grants	I. SOURCE	J. BH Strategic Plan Goal #
		a) 24 hours, b) 7 days, c) 30 days post discharge.	☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem	Start date: July 1 2017 Frequency: biannual				Electronic Health Record at Center. Documented 24 hour, 7 day, 30 day follow-up attempt made.	
		85% of admits report satisfaction with Center experience at planned discharge.	☐Output ☒Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☐Outcome: Practice or behavior ☐Outcome: Impact on overall problem	☒Short ☐Medium ☐Long Start date: July 1 2017 Frequency: biannual	☐ Assessment of need	85%		Fields will be in place for data collection in Electronic Health Record at Center. Participant satisfaction survey at exit.	3
Reduce unnecessary utilization of Emergency Department and inpatient services	Provide crisis triage and withdrawal services for adults in need of short term (5 day) 24/7 assessment, withdrawal management, brief intervention/ treatment and rapid referral to appropriate services.			☐Short ☒Medium ☒Long Start date: July 1, 2017 Frequency: biannual	Click here to enter text. ☐ Assessment of need Click here to enter text.	20 % ED and 60% Inpatient records do not show visit/admit at 3, 6, 12 month interval post Center admit.		Fields will be in place for Data collection in EHR at Center. ED &Inpatient records will be reviewed for visit 2X year via agreement with HMC ED, KMHS Inpatient: alternately EDIE alerts will be utilized but are currently limited to existing KMHS clients.	5. Reduce the number of people in Kitsap County who use costly interventions including hospitals, emergency rooms, and crisis services.

ATTACHMENT E

Total Agency or Departmental Budget Form

Agency Name: Kitsap Mental Health Services

Project: Crisis Triage and Withdrawal Management Center

☑ Accrual ☐ Cash

AGENCY REVENUE AND EXPENSES	2014 Actual	2014 Percent	2015 Actual	2015 Percent	2016 Budget	2016 Percent
AGENCY REVENUE						
Federal Revenue	$ 1,014,174.00	4%	$ 660,558.00	2%	$ -	0%
WA State Revenue	$ 20,138,108.00	83%	$ 24,481,664.00	82%	$ 23,081,612.00	82%
Local Revenue	$ 1,222,336.00	5%	$ 2,916,802.00	10%	$ 3,178,926.00	11%
Private Funding Revenue	$ 1,783,384.00	7%	$ 1,729,486.00	6%	$ 1,809,722.00	6%
Agency Revenue	$ -	0%	$ -	0%	$ -	0%
Miscellaneous Revenue		0%	$ -	0%	$ -	0%
Total Agency Revenue (A)	**$ 24,158,002.00**		**$ 29,788,510.00**		**$ 28,070,260.00**	
AGENCY EXPENSES						
Personnel						
Managers	$ 1,307,513.00	5%	$ 1,362,243.00	5%	$ 1,487,475.00	5%
Staff	$ 2,072,433.00	9%	$ 2,315,814.00	8%	$ 2,762,454.00	9%
Total Benefits	$ 1,340,650.00	6%	$ 1,458,894.00	5%	$ 1,685,726.00	6%
Subtotal	**$ 4,720,596.00**	**20%**	**$ 5,136,951.00**	**19%**	**$ 5,935,655.00**	**20%**
Supplies/Equipment						
Equipment	$ 36,450.00	0%	$ 49,249.00	0%	$ 43,389.00	0%
Office Supplies	$ 23,831.00	0%	$ 24,231.00	0%	$ 31,395.00	0%
Other (Describe)General Operating Expenses	$ 84,956.00	0%	$ 154,031.00	1%	$ 159,473.00	1%
Subtotal	**$ 145,237.00**	**1%**	**$ 227,511.00**	**1%**	**$ 234,257.00**	**1%**
Administration						
Advertising/Marketing	$ 7,100.00	0%	$ 14,403.00	0%	$ 16,400.00	0%
Audit/Accounting	$ 57,000.00	0%	$ 57,697.00	0%	$ 59,000.00	0%
Communication	$ 138,420.00	1%	$ 180,253.00	1%	$ 202,541.00	1%
Insurance/Bonds	$ 336,240.00	1%	$ 320,779.00	1%	$ 332,505.00	1%
Postage/Printing	$ 138,491.00	1%	$ 136,623.00	0%	$ 141,941.00	0%
Training/Travel/Transportation	$ 261,669.00	1%	$ 243,420.00	1%	$ 224,489.00	1%
		0%		0%		0%
Other (Describe)taxes, fees, fundraising, prof svcs	$ 522,973.00	2%	$ 584,274.00	2%	$ 573,736.00	2%
Subtotal	**$ 1,461,893.00**	**6%**	**$ 1,537,449.00**	**6%**	**$ 1,550,612.00**	**5%**
Ongoing Operations and Maintenance						
Janitorial Service	$ 27,623.00	0%	$ 27,623.00	0%	$ 27,654.00	0%
Maintenance Contracts	$ 77,269.00	0%	$ 10,667.00	0%	$ 208,998.00	1%
Maintenance of Existing Landscaping	$ 14,230.00	0%	$ 15,520.00	0%	$ 15,560.00	0%
Repair of Equipment and Property	$ 401,205.00	2%	$ 327,966.00	1%	$ 418,890.00	1%
Utilities	$ 238,074.00	1%	$ 247,710.00	1%	$ 251,418.00	1%
Other (Describe) Building Leases	$ 140,173.00	1%	$ 221,320.00	1%	$ 315,340.00	1%
Other (Describe) Adult Program Services	$ 8,558,703.00	36%	$ 10,458,133.00	38%	$ 11,220,803.00	37%
Other (Describe) C&F Program Services	$ 2,936,807.00	12%	$ 3,362,517.00	12%	$ 4,046,550.00	13%
Other (Describe) Emergency &ITA Services	$ 1,086,340.00	5%	$ 1,317,968.00	5%	$ 1,320,083.00	4%
Other (Describe) Inpatient (E&T) Services	$ 4,291,651.00	18%	$ 4,673,896.00	17%	$ 4,739,131.00	16%
Subtotal	**$ 17,772,075.00**	**74%**	**$ 20,663,320.00**	**75%**	**$ 22,564,427.00**	**75%**
Other Costs						
Debt Service	$ -	0%	$ -	0%	$ -	0%
Other (Describe)	$ -	0%	$ -	0%	$ -	0%
Subtotal	**$ -**	**0%**	**$ -**	**0%**	**$ -**	**0%**
Total Direct Expenses	**$ 24,099,801.00**		**$ 27,565,231.00**		**$ 30,284,951.00**	

NOTE: If an expenditure line item is larger than 10% of the budget, include an attachment showing detail.

ATTACHMENT TO TOTAL AGENCY BUDGET A-2
FY 2016 EXPENSE LINE ITEMS AND % OF TOTAL TO COST

		%
Managers	$1,487,475	4.91%
Staff	$2,762,454	9.12%
Total Benefits	$1,685,726	5.57%
Equipment	$43,389	0.14%
Office Supplies	$31,395	0.10%
Other (Describe)General Operating Expenses	$159,473	0.53%
Advertising/Marketing	$16,400	0.05%
Audit/Accounting	$59,000	0.19%
Communication	$202,541	0.67%
Insurance/Bonds	$332,505	1.10%
Postage/Printing	$141,941	0.47%
Training/Travel/Transportation	$224,489	0.74%
0	$0	0.00%
Other (Describe)taxes, fees, fundraising, prof svcs__	$573,736	1.89%
Janitorial Service	$27,654	0.09%
Maintenance Contracts	$208,998	0.69%
Maintenance of Existing Landscaping	$15,560	0.05%
Repair of Equipment and Property	$418,890	1.38%
Utilities	$251,418	0.83%
Other (Describe) Building Leases	$315,340	1.04%
Other (Describe) __Adult Program Services_	$11,220,803	37.05%
Other (Describe) _C&F Program Services___	$4,046,550	13.36%
Other (Describe) _Emergency &ITA Services_	$1,320,083	4.36%
Other (Describe) _Inpatient (E&T) Services	$4,739,131	15.65%
TOTAL	$30,284,951	100.00%

STAFF: INCLUDES ALL NON MANAGERS, NON PROGRAM STAFF. INCULUDES ADMIN, SUPPORT, CLINICAL RECORDS, ACCOUNTING, INFORMATION SERVICES, HUMAN RESOURCES, FACILITIES TECHNICIANS AND CUSTODIANS, PURCHASING, RECEPTION AND DEVELOPMENT.

ADULT: INCLUDES ALL OUTPATIENT PROGRAMS SERVING THE ADULT POPULATION AND THEIR RELATED PROGRAM EXPENSES, WAGES AND BENEFITS.

C&F: INCUDES ALL OUTPATIENT PROGRAMS SERVING THE ADOLESCENT POPULATION AND THEIR RELATED PROGRAM EXPENSES, WAGES AND BENEFITS.

INPATIENT: TWO 24 HOUR INPATIENT FACILITIES WITH 25 BEDS AND RELATED COSTS.

Special Project Budget Form

Agency Name:
Kitsap Mental Health Services

Project:
Crisis Triage and Withdrawal Management Center

Enter the estimated costs assoicated with your project/program	Total Funds Budget	Percent	Requested Funds Budget	Percent	Other Funds Budget	Percent
Personnel						
Managers	192,877	7%	97,069	9%	95,808	6%
Staff	1,329,182	50%	668,937	64%	660,245	40%
Total Benefits	543,504	20%	273,529	26%	269,975	16%
SUBTOTAL	**2,065,563**	**77%**	**1,039,535**	**100%**	**1,026,028**	**63%**
Supplies & Equipment						
Equipment	3,000	0%	0	0%	3,000	0%
Office Supplies	2,500	0%	0	0%	2,500	0%
Other:Equipment Leases, copier/fax/printers	3,036	0%	0	0%	3,036	0%
SUBTOTAL	**8,536**	**0%**	**0**	**0%**	**8,536**	**1%**
Administration						
Advertising/Marketing	2,000	0%	0	0%	2,000	0%
Professional Services	6,000	0%	0	0%	6,000	0%
Communication	12,000	0%	0	0%	12,000	1%
Fees and Taxes	10,000	0%	0	0%	10,000	1%
Insurance and Bonds	10,412	0%	0	0%	10,412	1%
Training/Travel	15,000	1%	0	0%	15,000	1%
% Indirect (Limited to 10%)	240,892	9%	0	0%	240,892	15%
Other: Commercial Transportation	15,000	1%	0	0%	15,000	1%
SUBTOTAL	**311,304**	**12%**	**0**	**0%**	**311,304**	**19%**
Ongoing Operations & Maintenance						
Janitorial Service	40,000	1%	0	0%	40,000	2%
Laundry	12,012	0%	0	0%	12,012	1%
Contracts (Maintenance, Security)	55,000	2%	0	0%	55,000	3%
Operating Supplies	20,000	1%	0	0%	20,000	1%
Meals	70,000	3%	0	0%	70,000	4%
Repair of Equipment & Property	5,000	0%	0	0%	5,000	0%
Utilities	10,000	0%	0	0%	10,000	1%
Pharmacy/Medical Supplies	60,000	2%	0	0%	60,000	4%
SUBTOTAL	**272,012**	**10%**	**0**	**0%**	**272,012**	**17%**
Other						
Client Security Deposit Assistance (30)	15,000	1%	0	0%	15,000	1%
Client Expenses (clothing etc)	7,400	0%	0	0%	7,400	0%
SUBTOTAL	**22,400**	**1%**	**0**	**0%**	**22,400**	**1%**
Total Project Budget	**2,679,815**		**1,039,535**		**1,640,280**	

NOTE: Indirect is limited to 10%

Project Salary Summary

Description		
Number of Professional FTEs		44.25
Number of Clerical FTEs		2.50
Number of All Other FTEs		0.00
Total Number of FTEs		**46.75**
Salary Information		
Salary of Executive Director or CEO	$	-
Salaries of Professional Staff	$	1,267,346.00
Salaries of Clerical Staff	$	48,328.00
Other Salaries (Describe Below)	$	206,386.00
Description: Shift Differentials, Temp Sup Pay, Beeper Pay	$	33,638.00
Description: On Call MA/RN/ ARNP	$	108,153.00
Description: On Call BA or below	$	64,595.00
Total Salaries	**$**	**1,522,060.00**
Total Payroll Taxes	$	161,117.00
Total Cost of Benefits	$	316,602.00
Total Cost of Retirement	$	65,784.00
Total Payroll Costs	**$**	**2,065,563.00**

ATTACHMENT G
Anders Edgerton
Administrator

Salish Behavioral Health Organization

Providing Behavioral Health Services in
Clallam, Jefferson, and Kitsap Counties

LETTER OF COMMITMENT

March 3, 2016

Kitsap County Citizens Advisory Board
C/O Kitsap County Human Services
614 Division Street MS-23
Port Orchard, WA 98366

Re: Letter of Commitment to provide Mental Health, Chemical Dependency and Therapeutic Court Programs

Dear Citizens Advisory Committee:

I am writing to express my support and commitment for the Kitsap Crisis Triage and Withdrawal Management Center program being proposed by Kitsap Mental Health Services. This Center is an essential component in the Kitsap community's Mental Health, Chemical Dependency and/or Therapeutic Court Programs and Behavioral Health Strategic Plan.

Kitsap Mental Health Services, our community's designated community mental health service provider, is a 501(c)(3) non-profit organization that provides a full continuum of crisis, inpatient and outpatient treatment and residential services for nearly 6,000 children and adults in Kitsap County each year. The Kitsap Crisis Triage and Withdrawal Management Center will provide 32 adults in our community with 24/7 behavioral health services for up to five days. The Crisis Triage (16 beds) Center will serve people who are struggling with significant episodes or ongoing behavioral health issues that can be best addressed in a 24 hour therapeutic residential setting, but who do not need the level of services at a psychiatric facility or other hospital, need treatment not jail, or would otherwise be at risk of or homeless due to behavioral health issues. The Withdrawal Management Center (previously known as "sub-acute detox") provides a similar environment but focuses on persons in need of withdrawal support.

As the Behavioral Health Organization serving Kitsap County, the Salish BHO is highly committed to the sound functioning of this long needed resource in our community's continuum of care. While I do not yet have a finalized designated daily rate for these services and cannot commit to a "daily rate"

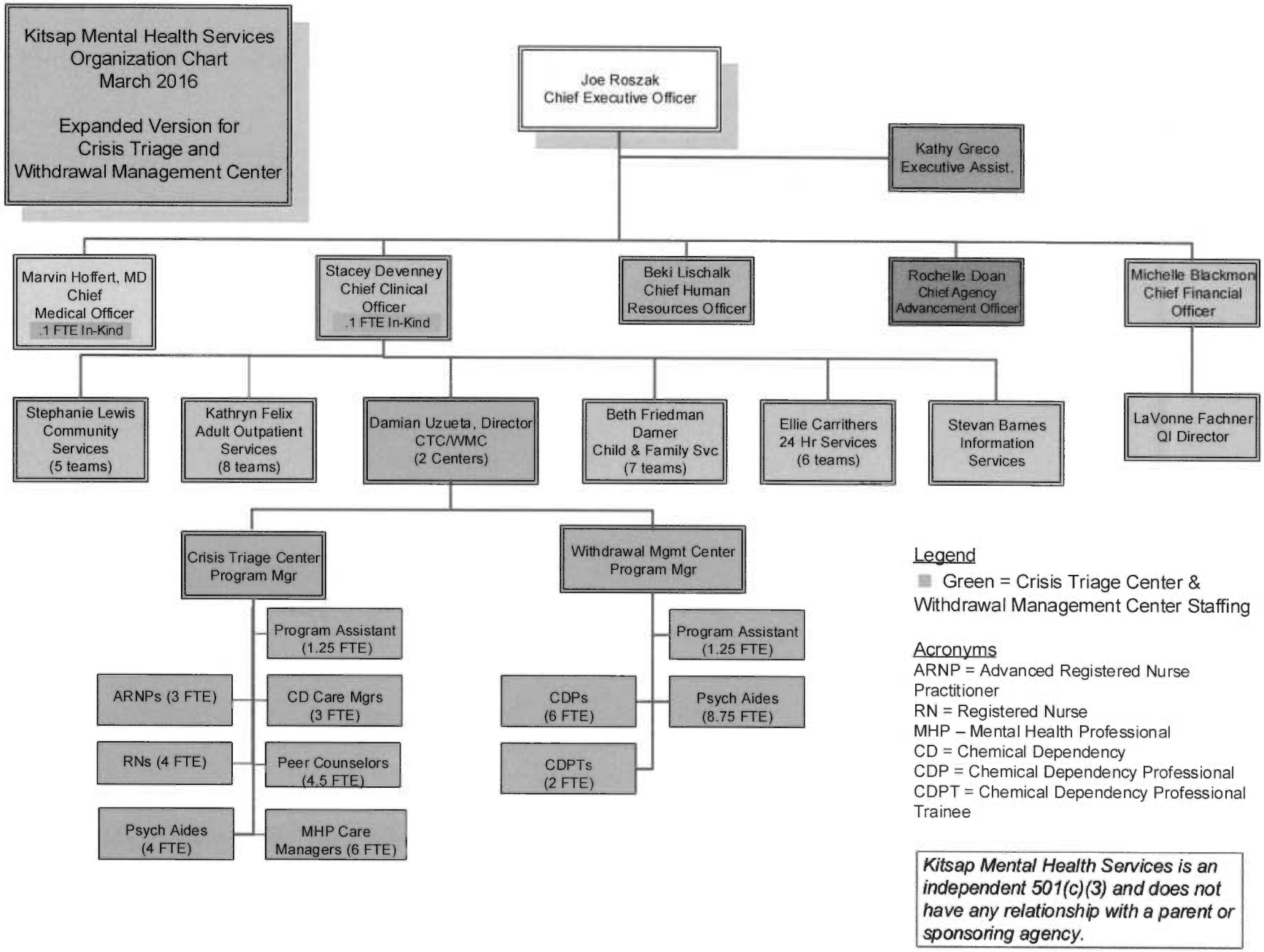
for its operations at this point, I can offer assurance that the Salish BHO has set aside $300,000 to pay for withdrawal management/detox at the Center and that the BHO will dedicate all appropriated funds received from the state for this purpose to the Crisis Triage and Withdrawal Management Center, and will work diligently to secure such dedicated funding.

The Salish BHO staff provide administrative oversight of funding and services accountability associated with Kitsap County's Medicaid service delivery providers. As such we will be in close working relationship with KMHS regarding this project, including ensuring accountability for use of funds and quality of services delivery. We are familiar with the Kitsap County Behavioral Health Strategic Plan and the advisory group and work with KMHS and local providers to work towards eliminating service gaps identified in that plan.

We believe our support and commitment will significantly improve the availability of Mental Health and Chemical Dependency services to some of the most vulnerable adults in Kitsap County and we look forward to working with you on this important endeavor.

Sincerely,

Anders Edgerton



Legend

Green = Crisis Triage Center & Withdrawal Management Center Staffing

Acronyms

ARNP = Advanced Registered Nurse Practitioner
RN = Registered Nurse
MHP – Mental Health Professional
CD = Chemical Dependency
CDP = Chemical Dependency Professional
CDPT = Chemical Dependency Professional Trainee

Kitsap Mental Health Services is an independent 501(c)(3) and does not have any relationship with a parent or sponsoring agency.