



## **SALISH BHO**

# **EXECUTIVE BOARD MEETING**

Providing Behavioral Health Services in  
Clallam, Jefferson and Kitsap Counties

**DATE:** Friday, October 19, 2018  
**TIME:** 9:00 AM – 11:00 AM  
**LOCATION:** Jamestown S’Klallam Tribe, Council Chamber  
1033 Old Blyn Hwy, Sequim WA

---

### **AGENDA**

<https://www.kitsapgov.com/hs/Pages/SBHO-EXECUTIVE-BOARD.aspx>

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 Meeting Notes for August 17, 2018 (Attachment 5)
6. Action Items
  - a. Substance Abuse Block Grant (SABG) Recommendations
  - b. Appointment of Designated Crisis Responder (Attachment 6.b)
  - c. Reappointment of Advisory Board Members
7. Informational Items
  - a. Integration Issues
    - Transition to Behavioral Health Administrative Service Organization (BH-ASO)
    - Administrative Service Organization (ASO) Language (Attachment 7.a)
    - Coordinated Care
  - b. Preparing for the Upcoming Legislative Session (Attachment 7.b)
  - c. Opiate Treatment Program Update
  - d. 1/10<sup>th</sup> of 1% Update (Attachment 7.d)
  - e. Western State Hospital Update (Attachment 7.e)
  - f. Kitsap Behavioral Health Navigator Program Presentation
  - g. SBHO Advisory Board Update
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Adjournment

## ACRONYMS

<b>ACH</b>	Accountable Community of Health
<b>ASAM</b>	Criteria used to determine substance use disorder treatment
<b>BH-ASO</b>	Behavioral Health Administrative Services Organization
<b>BHO</b>	Behavioral Health Organization, replaced the Regional Support Network
<b>CAP</b>	Corrective Action Plan
<b>CMS</b>	Center for Medicaid & Medicare Services (federal)
<b>DBHR</b>	Division of Behavioral Health & Recovery
<b>DCFS</b>	Division of Child & Family Services
<b>DCR</b>	Designated Crisis Responder
<b>DDA</b>	Developmental Disabilities Administration
<b>DSHS</b>	Department of Social and Health Services
<b>E&amp;T</b>	Evaluation and Treatment Center (i.e., AUI, YIU)
<b>EBP</b>	Evidence Based Practice
<b>EPSDT</b>	Early and Periodic Screening, Diagnosis and Treatment
<b>EQRO</b>	External Quality Review Organization
<b>FBG</b>	Federal Block Grant (specifically MHBG and SABG)
<b>FIMC</b>	Full Integration of Medicaid Services
<b>FYSPRT</b>	Family, Youth and System Partner Round Table
<b>HARPS</b>	Housing and Recovery through Peer Services
<b>HCA</b>	Health Care Authority
<b>HCS</b>	Home and Community Services
<b>HIPAA</b>	Health Insurance Portability & Accountability Act
<b>HRSA</b>	Health and Rehabilitation Services Administration
<b>IMD</b>	Institutes for the Mentally Diseased
<b>IS</b>	Information Services
<b>ITA</b>	Involuntary Treatment Act
<b>LOC</b>	Level of Care
<b>MAT</b>	Medical Assisted Treatment
<b>LRA</b>	Least Restrictive Alternative
<b>MCO</b>	Managed Care Organization
<b>MOU</b>	Memorandum of Understanding
<b>OCH</b>	Olympic Community of Health
<b>OPT</b>	Opiate Treatment Program
<b>OST</b>	Opiate Substitution Treatment
<b>PACT</b>	Program of Assertive Community Treatment
<b>PATH</b>	Programs to Aid in the Transition from Homelessness
<b>PIHP</b>	Prepaid Inpatient Health Plans
<b>PIP</b>	Performance Improvement Project
<b>P&amp;P</b>	Policies and Procedures
<b>QUIC</b>	Quality Improvement Committee
<b>QRT</b>	Quality Review Team
<b>RCW</b>	Revised Code Washington
<b>RFP, RFQ</b>	Requests for Proposal, Requests for Qualifications
<b>SABG</b>	Substance Abuse Block Grant
<b>SAPT</b>	Substance Abuse Prevention Treatment
<b>SBHO</b>	Salish Behavioral Health Organization
<b>SUD</b>	Substance Use Disorder
<b>UM</b>	Utilization Management
<b>WAC</b>	Washington Administrative Code
<b>WM</b>	Withdrawal Management
<b>WSH</b>	Western State Hospital, Tacoma



## **SALISH BHO**

# **EXECUTIVE BOARD MEETING**

Providing Behavioral Health Services in  
Clallam, Jefferson and Kitsap Counties

**October 19, 2018**

### **6. Action Items**

#### a. SUBSTANCE ABUSE BLOCK GRANT RECOMMENDATIONS

The SABG RFP was posted on August 3<sup>rd</sup> with submissions due by October 3<sup>rd</sup>. At the August Advisory Board Meeting, Sandy Goodwick, Charles Pridgen and Sally O'Callaghan volunteered to serve on the SABG subcommittee which was tasked with reviewing and making recommendations on provider's proposals. The Advisory Board approved a motion to allow the SABG subcommittee's recommendations to serve as the overall opinion of the Advisory Board and go directly to the Executive Board. These recommendations will be shared with the Executive Board.

#### b. APPOINTMENT OF DESIGNATED CRISIS RESPONDER

Per SBHO Policy and Procedure 3.08, each Network Agency shall have a SBHO Executive Board appointed and designated employee within their respective agency as the network Designated Crisis Responder (DCR). Peninsula Behavioral Health's network agency DCR has resigned. Peninsula Behavioral Health is requesting that Kathy Stevens be appointed as the new DCR.

#### c. REAPPOINTMENT OF ADVISORY BOARD MEMBERS

On December 31, 2018, the terms for Helen Morrison, Lois Hoell, Jennifer Kreidler-Moss, Roberta Charles and Jolene George expire. Lois, Jennifer, Roberta and Jolene expressed interest in extending their terms until December 31, 2019. The Advisory Board approved a motion to recommend the one-year reappointment of Lois, Jennifer, Roberta, and Jolene.

### **Informational Items**

#### a. INTEGRATION ISSUES

- **Transition to Behavioral Health Administrative Service Organization (BH-ASO)**  
In mid-September, the SBHO's focus shifted from gaining support for a pilot project to negotiating a formal MOU with the Health Care Authority (HCA), designed to provide the best opportunities for our region moving forward. Staff submitted an initial draft of the MOU to the HCA on October 9<sup>th</sup>. Staff will provide updates about communications with the HCA.
- **Administrative Service Organization (ASO) Language**  
The Association of BHOs is planning to put forth legislation to formalize ASOs in the Revised Code of Washington (RCW). The language is attached for discussion.
- **Coordinated Care**  
Coordinated Care was awarded the statewide managed care contract to provide services for individuals under the Apple Health Foster Care Program. This change goes into effect January 1, 2019. As of January 1, 2019, the following groups of SBHO enrolled individuals will transition to Coordinated Care: Children and youth in foster care (dependencies with

DSHS Children's Administration), Children and youth in adoption support, young adults in extended foster care (18-21year-olds), Young adults 18-26 who aged out of foster care on or after their 18th birthday. Staff will provide an update about this transition.

b. PREPARING FOR THE UPCOMING LEGISLATIVE SESSION

The attachment was produced by the Senate Republican Caucus and contains a list and one page summaries of the bills they intend to introduce this session related to mental health. Staff will monitor the progress of these proposed bills.

c. OPIATE TREATMENT PROGRAM (OTP) UPDATE

BayMark is finalizing their construction timelines for their Port Angeles facility. They have not finalized their lease in Kitsap County. Staff has coordinated a meeting between BayMark and Jamestown S'Klallam to address BayMark's concern regarding financial sustainability of their clinic in Port Angeles.

d. 1/10<sup>TH</sup> OF 1% UPDATE

The Citizen's Advisory Committee made its final funding recommendations for the 2019 1/10th of 1% Mental Health, Chemical Dependency and Therapeutic Court in Kitsap County. The attachment is a high-level overview of their recommendations.

e. WESTERN STATE HOSPITAL UPDATE

Western State Hospital (WSH) is closing 2 civil wards, one by December 2018 and another by June 2019. This is impacting admissions in general, though older adults and those with medical needs are most significantly impacted. There has also been an increased push in discharges of individuals with more complicated needs. The WSH census has maintained fairly constant, though most of the admits are not from the community. The attached table shows a summary of 2018 information.

f. KITSAP BEHAVIORAL HEALTH NAVIGATOR PROGRAM PRESENTATION

Kim Hendrickson, Project Manager of the Behavioral Health Navigator Program, has requested the opportunity to address the Executive Board. She will share information about her program.

g. SBHO ADVISORY BOARD UPDATE

**MINUTES OF THE  
SALISH BEHAVIORAL HEALTH ORGANIZATION  
EXECUTIVE BOARD**

**Friday, August 17, 2018  
9:00 a.m. - 11:00 a.m.  
Jamestown S'Klallam Tribe Council Chambers,  
1033 Old Blyn Highway, Sequim, WA 98382**

**CALL TO ORDER** – Commissioner Mark Ozias, Chair, called the meeting to order at 9:00 a.m.

**ANNOUNCEMENTS** – Welcome Stephanie Lewis, the new Administrator for the Salish Behavioral Health Organization.

**INTRODUCTIONS** – Self introductions were conducted around the room

**OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS**

None

**APPROVAL of AGENDA**

**MOTION: Commissioner Kathleen Kler moved to approve the agenda as submitted. Commissioner Robert Gelder seconded the motion. Motion carried unanimously.**

**APPROVAL of MINUTES**

Appreciation was expressed over the details of the notes from the June 15, 2018 meeting.

**MOTION: Commissioner Robert Gelder moved to approve the meeting notes as submitted for the June 15, 2018 meeting. Commissioner Kathleen Kler seconded the motion. Motion carried unanimously.**

**ACTION ITEMS**

➤ **Designated Marijuana Account**

- Designated Marijuana Account (DMA) funding was included in the BHO funding stream effective April 1, 2016 as a result of a legislative fund swap which replaced state dollars with DMA funds. The funds came with specific criteria for their use, unlike the prior state funding, and those criteria have changed over time.
- The SBHO has done a public RFP process which resulted in no proposals and has solicited provider ideas for use of the funds since the inception of the SBHO. At this time, the SBHO has four proposals that will utilize most of the available funds.
- True Star submitted a proposal that included opening a 3-bed secure detox facility for adolescents. This service is not currently offered in our region and is limited across the state. True Star was also awarded a 1.1-million-dollar Department of Commerce Grant to assist with the set-up of the facility.
- Concerns were raised over the ability to use Medicaid funds for True Star's proposal as the program would be operated out of the detention center (jail) and Medicaid funds are not eligible for jail-based services. In addition, the building is on land leased from City of Port Angeles which also complicates True Stars proposal and ability to use the Department of Commerce Grant.
- True Star's proposal was tabled by the Executive Board until SBHO staff could conduct more research and clarify concerns.

- Olympic Educational Service District submitted a proposal that included implementing school-based student assistance substance use intervention program services to schools within the Port Townsend School District.
- Olympic Personal Growth submitted a proposal that includes the implementation of an Evidence Based Program, “The Matrix Model for Teens and Young Adults”.
- Reflections Counseling Services proposed a pilot program that utilizes an evidence-based practice called Interactive Journaling.
- The Advisory Board had voted at its August meeting and recommended moving ahead with the four proposals but did express concerns over restricting OESDs proposals to just one full time employee. However, SBHO staff have since clarified with the OESD that one full time employee would be sufficient to support their proposal.
- The issue of sustainability over the proposed programs and how the SBHO would handle the funds in future was discussed.
- SBHO staff clarified that the funds are for the current fiscal year and an RFP process would be done to distribute the DMA funds in the future.
- The Executive Board requested that SBHO staff include data and outcome requirements in the contracts for the proposals.

**MOTION: Commissioner Robert Gelder moved to approve the DMA Proposals for the OESD, OPG, and Reflections as submitted. Commissioner Kathleen Kler seconded the motion. Motion carried unanimously.**

#### INFORMATIONAL ITEM

##### ➤ **SBHO Administrator**

- The replacement for Anders Edgerton has been selected and announced as Stephanie Lewis. There will be a two month overlap of service, and both Anders Edgerton and Stephanie Lewis are working hard together to ensure that critical information is passed along.

##### ➤ **Opiate Treatment Program**

- The SBHO now has a signed contract with BayMark, the organization selected through a Request for Proposals (RFP) process to open Opiate Treatment Programs (OTPs) in Port Angeles and Kitsap County.
- The SBHO was recently informed that the Jamestown S’Klallam Tribe planned on opening their own OTP clinic, which would be open to the public. Tribes in Washington State are allowed to charge the current “Encounter Rate” for each service rendered to a patient, with the current encounter rate being \$427. BayMark is very concerned about this development, as they cannot compete with a Tribal program due to the vast inequities in payment; the SBHO would pay BayMark approximately \$20 per day.
- The SBHO has agreed to pay BayMark a guaranteed monthly rate until BayMark has reached the ongoing patient population listed in the contract for each site.
- Cindy Lowe, Jamestown S’Klallam Tribe, provided an update on the development plans for the tribes OTP. Jamestown S’Klallam tribe is looking for property to purchase and build a facility that would be close to its medical and dental facilities in the Sequim area. The estimated time for opening is 1.5 years to 2 years out.
- The Swinomish tribe in La Connor, Washington is currently operating an OTP clinic and has offered to provide support and share information with Jamestown S’Klallam tribe.
- The clinic will most likely include daily onsite dosing of Methadone and Suboxone, childcare, transportation to and from the facility, educational classes, individual and group counseling sessions and will be available for all individuals.
- Concerns were raised by the board over BayMark’s willingness to continue to work with our region. BayMark had initially agreed to continue with the two locations with the agreement to receive monthly guaranteed payments from the SBHO. However, this was prior to Jamestown announcing that the OTP clinic would be open to all individuals and not just the clients currently in the Jamestown medical network.

- SBHO staff will reach out to BayMark to see if they are willing to continue moving forward with the locations based on the information that was presented.

### ➤ **Integration Issues**

- **Pilot Project**

- All three counties passed the SBHO Pilot Resolution; this will provide great support as the project moves into the legislative session.
- The OCH voted the Pilot Project down at its last meeting due to the financial risk associated with the waiver funding and for the individuals who sit on the OCH board.
- Concerns were raised over primary care providers not understanding the impact fully integrated managed care will have on the behavioral health providers and the limited voice that behavioral health providers have in the Olympic Community of Health. Concerns were also raised over behavioral health providers not including primary care providers in the coordination and preparation for fully integrated managed care.
- SBHO staff are continuing to work to gain support in both the house and senate for the Pilot Project.
- A discussion was held over establishing a cutoff date for pursuing the Pilot Project. After discussing, it was determined that the legislative session dates will be used as cutoff dates so that the region can effectively plan for the future.

- **Mid-Adopter Experiences**

- SBHO staff continue to watch and monitor the mid-adopter regions to learn from and assist with preparing our region for fully integrated managed care in 2020.
- It was noted that the five mid-adopter regions all have different plans and methods for integrating.
- The board discussed rebranding the Pilot Project to assist with gaining momentum and moving it forward through the house and senate. It was suggested to rename it, so the focus is put on our region's requirements for integration.

- **Agency Preparedness**

- The SBHO continues to work with our agencies and preparing the region for 2020. SBHO staff have begun facilitating monthly meetings with our providers and the managed care organizations assigned to our region to enable direct communications and allow providers to get their questions answered.
- Concerns were raised over how the OCH, MCOs, SBHO, the providers, and primary care providers could come together to plan and coordinate to better prepare our region. It was stressed that the OCH meetings are open, honest, and great conversations. The OCH helps create an environment that brings all issues to the table to be discussed.
- After discussing, it was recommended to bring primary care providers into the monthly 2020 coordination meetings the SBHO is hosting. This was recommended as behavioral health providers are not ready to bring primary care providers into those meetings as they don't want primary care providers to derail the coordination and discussions that are happening currently amongst the behavioral health providers.
- SBHO staff are coordinating a training for the providers that would teach them how to negotiate contracts with the MCOs as rates and funding are some of the biggest concerns for providers.
- SBHO is going to look at more creative ways to leverage resources and look at ways to bringing in the OCH and primary care providers to its coordination efforts.
- The OCH would like to assist the SBHO with bringing in Qualis Health to assist with training for the providers.

- **Behavioral Health Administrative Service Organization (BH-ASO)**

- Staff continue to track the progress of the regions which are becoming fully integrated in January. Several of our peer organizations have been very forthcoming with materials,

and we are analyzing these for feasibility for our organization. The relationship between the Managed Care Organizations (MCOs) and the Administrative Services Organization appears to be the most problematic area, as the MCOs are requiring that the BH-ASO have policies and structures in place that meet National Committee for Quality Assurance (NCQA) standards. NCQA standards, while generally mirroring the Federal standards that BHOs (and RSNs before them) are measured against by our annual External Quality Assurance review, are much more detailed. While we believe that adherence to these standards will be possible, whether we can maintain compliance with reduced staff will be the question we focus on in the upcoming months.

- The draft ASO contract is out for review right now. Staff are currently reviewing the contract.
- The MCOs and the state are making it extremely difficult for regions to become ASOs.

#### ➤ **Interlocal Agreement**

- The current Interlocal Agreement is set to expire at the end of December 2018. SBHO staff requested the board to extend the end date of the Interlocal Agreement to June 30, 2020. This will ensure the SBHO can transition into 2020.
- The board discussed potential candidates to replace Commissioner Kler on the Executive Board as she is retiring at the end of December 2018.

**MOTION: Commissioner Kathleen Kler moved to extend the end date of the Interlocal Agreement to June 30, 2020. Commissioner Robert Gelder seconded the motion. Motion carried unanimously.**

#### **PUBLIC COMMENT**

- The Executive Board and guests in attendance all expressed appreciation for Anders Edgerton and thanked him for many years of service and dedication to our region.

#### **GOOD OF THE ORDER**

- The next meeting is Friday, October 19<sup>th</sup>.
- The board discussed different options for the October meeting due to all the moving parts and are entertaining a different format.

**ADJOURNMENT** – Consensus for adjournment at 10:55 a.m.

#### **ATTENDANCE**

<b>BOARD MEMBERS</b>	<b>STAFF</b>	<b>GUESTS</b>
<b>Present:</b>	Anders Edgerton, SBHO Admin	Cindy Lowe, Jamestown S'Klallam Tribe
Commissioner Robert Gelder	Stephanie Lewis, SBHO Admin	Joe Roszak, KMHS
Commissioner Kathleen Kler	Alexandra Hardy, Recording Secretary	Wendy Sisk, PBH
Commissioner Mark Ozias		Colleen Bradley, FYSPRT
Elya Prystowsky, Olympic Community of Health		Lisa Rey Thomas, Olympic Community of Health
		Vicki Lowe, AIHC
		Charles Pridgen, SBHO Advisory Board
<b>Excused</b>		G'Nell Ashley, Reflections Counseling
Liz Mueller, Jamestown S'Klallam Tribe		
Russ Hartman, SBHO Advisory Board		

**NOTE: These meeting notes are not verbatim**



## SALISH BHO

### NETWORK MANAGEMENT POLICIES AND PROCEDURES

**Policy Name:** DESIGNATION OF DESIGNATED CRISIS RESPONDERS

**Policy Number:** 3.08

**Reference:** RCW 71.05, RCW 71.34, WAC 388-865-0238; WAC 388-877-0200; 2017 Designated Mental Health Protocols (RCW 71.05.214)

**Effective Date:** 2/1990

**Revision Date(s):** 11/2010; 5/2016; 6/2017; 6/2018

**Reviewed Date:** 5/2016; 6/2017; 6/2018

**Approved by:** SBHO Executive Board

#### PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure that it maintains an adequate network of Designated Crisis Responders (DCR) to fulfill the requirements of the Involuntary Treatment Act.

#### DEFINITIONS

Designated Crisis Responder is a mental health professional who has been designated by the SBHO to conduct the activities set forth in RCW 71.05 AND 71.34.

Mental Health Professional (MHP) means:

- A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;
- A person who is licensed by the department of health as a mental health counselor or mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;
- A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, experience that was gained under the supervision of a mental health professional recognized by the department or attested to by the licensed behavioral health agency;
- A person who meets the waiver criteria of RCW 71.24.260, and the waiver was granted prior to 1986; or

---

#### Designation of DCRs 3.08

- A person who had an approved waiver to perform the duties of a mental health professional (MHP), that was requested by the behavioral health organization (BHO) and granted by the mental health division prior to July 1, 2001.

## **PROCEDURE**

1. Designated Crisis Responders (DCR) are employed by the SBHO's Network Mental Health Providers (Kitsap Mental Health Services, Discovery Behavioral Health, Peninsula Behavioral Health, and West End Outreach).
2. Each Network Agency shall have a SBHO Executive Board appointed and designated employee within their respective agency as the network agency DCR.
  - a. Designations are made annually or upon change of agency staff.
3. Individuals designated as the network agency DCR may deputize additional qualified employees, as necessary, to conduct business.
  - a. Each agency and DCR shall ensure that all deputized individuals:
    - i. Meet the qualifications listed in WAC.
    - ii. Receive the necessary and required safety trainings to successfully complete their work.
    - iii. Are employed by the same Network Provider Agency that the DCR represents.
4. Each agency shall provide the SBHO with a current list of deputized employees.
  - a. Agencies shall provide a new/updated list annually, each time there is a personnel change, and/or upon request.
5. The SBHO shall review qualifications of deputized individuals during annual Administrative Reviews.
6. Each network agency shall appoint one representative to attend the SBHO quarterly DCR meeting.

## **MONITORING**

This SBHO policy is mandated by statute.

1. This policy will be monitored through use of SBHO:
  - Annual SBHO Provider and Subcontractor Administrative Review.
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval. Reference SBHO Corrective Action Plan policy.

---

### **Appointment of DMHPs 3.08**

## Concerning Behavioral Health Administrative Service Organizations

An Act Relating to defining the Behavioral Health Administrative Service Organizations, their role, and establishing a structural framework and vital crisis service standards for behavioral health administrative service organizations.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

**NEW SECTION:** Sec. . A new section is added to chapter . to read as follows:

The legislature finds that in order to ensure a smooth transition to integrated managed care in Regional Service Areas (RSAs) and to maintain the existing regional behavioral health crisis and diversion continuum of care, the following vital services shall be provided by behavioral health administrative service organizations:

- (1) **Crisis Services:** Each behavioral health administrative service organization shall provide a behavioral health crisis hotline; crisis response services at all times; mobile crisis response teams; services related to the administration of the Involuntary Treatment Act and Involuntary Commitment; monitoring Less Restricted Alternatives and Less Restrictive Orders; court for Involuntary Treatment Act, outreach to individuals with mental health and substance abuse disorders; [TK1][ST2] and other non-Medicaid behavioral health services; crisis stabilization services (up to 14 days) for individuals who are not eligible for Medicaid and/or do not have third party insurance; voluntary withdrawal management admissions for individuals who are not eligible for Medicaid and/or do not have third party insurance; sobering; and law enforcement drop off facility (e.g. triage centers).
- (2) **Care Coordination and State Hospitals:** Each behavioral health administrative service organization shall provide involuntary admissions to a psychiatric or secure withdrawal management and stabilization services facility to serve the regions non-Medicaid population; monitor lesser restrictive alternative court orders and conditional release for individuals ineligible for Medicaid to ensure compliance; mental health and substance abuse disorder treatment services to non-Medicaid individuals on less restrictive alternative and conditional release; hospital liaison and discharge planning for non-Medicaid individuals at or below the two-hundred twenty percent federal poverty level who do not have Medicaid; voluntary behavioral health inpatient psychiatric admissions for individuals who are not eligible for Medicaid and/or do not have third party insurance; step down beds, including residential placement in Assisted Living Facilities or Adult Residential Treatment Facilities to reduce hospitalization length and use of state hospital beds; participate in Children Long-term Inpatient Program (CLIP) screening and diversion when appropriate for non-Medicaid families at or below the 220% Federal Poverty Level and without third party insurance and within available resources; and facilitate sharing of information and care transitions among jails, residential treatment centers, detox centers, homeless shelters, and others.
- (3) **Community Coordination and Capacity Building:** Each behavioral health administrative service organization shall develop tribal Crisis Coordination Plans and ensure ongoing coordination between Tribes/Recognized American Indian Organizations (RAIOs) and allied system partners;

coordinate the response of participating behavioral health agencies as part of a coordinated community disaster response as required for medium to large scale response or continued post-disaster response; coordinate and actively participate in building and developing systems of care (e.g. interlocal leadership structures); contract for state funded jail transition and diversion services within available resources; and actively coordinate the development and implementation of community capacity plans for behavioral health services, including: treatment facilities, innovative programs, evidence based programs, improved population health data, school based services, opioid response strategies; develop and implement protocols that promote coordination, continuity, and quality of care including use of GF-S and federal block grant funds, and develop strategies to reduce unnecessary crisis system utilization.

(4) Workforce Development: Each behavioral health administrative service organization shall develop strategies to meet the workforce needs for crisis services, actively participate in regional task forces to improve the recruitment, retention, and training of workforce for all behavioral health services.

(5) Other Non-Medicaid Services: Each behavioral health administrative service organization shall manage administration of federal block grants. The following may be coordinated by the behavioral health administrative service organization: interim services for individuals with substance use disorders; criminal justice treatment account and drug court funding (in counties who select to maintain criminal justice treatment account funding with the behavioral health administrative service organization); state targeted responses to opioid crisis grants<sup>[573]</sup>; family youth system partner roundtables; behavioral health Ombuds; dedicated marijuana account funded programs; support the behavioral health advisory boards; and other administrative provisos and services.

Sec. 2. Behavioral health administrative service organizations and managed care organizations shall work with the governor's office and the health care authority in determining the base funding necessary for each behavioral health administrative service organization to support the continuum of care and the vital services requirements listed in Section 1. An adequate funding methodology will be provided to the behavioral health administrative service organizations to meet the vital service needs listed in Section 1 in terms of reasonable operational, inpatient, and administrative costs.

Sec. 3. Funds for additional crisis programs and services beyond those listed in section 1 shall be the responsibility of local governments, managed care organizations and community partners.

Sec. 4. The behavioral health administrative service organizations shall coordinate and support the RSA's community behavioral health advisory boards (BHABs) and interlocal leadership structures, and MCOs shall respond and act on BHAB's requests and participate in RSA's BHAB meetings. [Note: Section 4 requires a change to RCW 71.24.]

Sec. 5. Local county authorities shall maintain the right of first refusal to operate the behavioral health administrative service organization for their Regional Service Areas.

# Table of Contents

Title/Subject
Integrating risk for long-term civil involuntary treatment into managed care
Development of community long-term involuntary treatment capacity
Relating to increasing behavioral health workforce participation by addressing certification and licensing requirements
Relating to increasing the behavioral health workforce by establishing a reciprocity program to increase the portability of behavioral health licenses and certifications
Relating to increasing options for peer support services in behavioral health
Relating to establishing a risk responsive methodology to calculate periods of competency restoration treatment
Create the Diversion Incentive Fund for creation, continuation, and continuity of Trueblood-related Diversion programming
Extending county authority to collect reimbursements from the department when conducting panel competency evaluations
Concerning the equitable geographic distribution of community placements for institutionalized persons with a history of criminal justice involvement
Limiting the placement of institutionalized persons with a history of criminal justice involvement in adult family homes
Expanding the reentry community safety program
Concerning veteran diversion from involuntary commitment through increased coordination between the veterans administration and the department of social and health services
Expanding community-based behavioral health facilities through issuance of state bonds
Relating to incentivizing engagement by publicly-funded health systems in efforts to reduce criminal justice system involvement for clients with acute behavioral health disorders
Creating a guardianship program for persons who are gravely disabled ("incapacitated person") to provide them individualized treatment, supervision, and appropriate placement to support successful transition to the community
Create an innovative tele-health care delivery model in schools to prevent school violence, adolescent suicide, and substance abuse. Implement a high quality training program for school professionals.

**Title:** Integrating Risk for Long-Term Civil Involuntary Treatment into Managed Care

**Background:** The Office of Financial Management (OFM) contracted with Public Consulting Group (PCG) to examine the structure and financing of the adult mental health system, as required by Engrossed Substitute Senate Bill 6656 (2016), to identify key challenges in the state's existing mental health system and recommend potential solutions that address critical challenges to effective behavioral health treatment and prepare the state for the original date of 2020 for transition to full integration of physical and behavioral health. The findings and recommendations are in the *Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report* submitted in December 2016.

In the *Inpatient Psychiatric Care Risk Model Report* submitted in December 2017, PCG further analyzed, and submitted findings and recommendations on how best to develop a psychiatric managed care capitation risk model that integrates long-term civil inpatient psychiatric hospital services into managed care capitation rates and non-Medicaid contracts, and holds managed care entities at full financial risk.

**What the bill does:**

- Requires the health care authority (HCA) to fully integrate long-term inpatient risk for long-term involuntary civil treatment provided by state hospitals into managed care contracts by July 1, 2023.
- Requires the department of social and health services (DSHS) and HCA to develop a detailed transition plan to move the cost of state hospital civil treatment into managed care, taking into account the recommendations derived from the PCG Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report and the Inpatient Psychiatric Care Risk Model Report.
  - A preliminary draft of the transition plan must be submitted, in compliance with RCW 43.01.036, to the relevant committees of the legislature by January 1, 2021.
  - DSHS and HCA must consider the input of the relevant committees of the legislature and external stakeholders before submitting a final transition plan by December 1, 2021.
- Requires HCA to develop a psychiatric managed care capitation risk model, taking into account the recommendations derived from the PCG Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report and the Inpatient Psychiatric Care Risk Model Report, that integrates long-term inpatient risk for long-term involuntary civil treatment provided by state hospitals.
  - This risk model must:
    - Include adult inpatient civil populations, including geropsychiatric patients and patients with intellectual or developmental disabilities;
    - Apply to all new and current individuals committed to long-term inpatient care;
    - Exclude individuals committed under RCW 71.05.280(3) with an affirmative special finding under RCW 71.05.280(3)(b) - These are the "1114" "felony flip" cases.
  - A preliminary draft of the risk model must be submitted, in compliance with RCW 43.01.036, to the relevant committees of the legislature by January 1, 2021.
    - A final draft of the risk model must be submitted by December 1, 2021.
- Requires HCA and DSHS to request legislation, as appropriate, extending institution for mental health diseases disproportionate share hospital payments to community hospitals as an option to maximize any reductions brought on by changes in the forensic to civil ratio for the state hospital population.
- Specifies that courts must remand to the custody of department or designee, not a specific facility. The payer (BHO/FIMCO/state) must designate patient placement, provided they must place in an open bed if available.

Staff: Keri Waterland (360-786-7490)

**Title:** Development of Community Long-Term Involuntary Treatment Capacity

**What the bill does:**

- Declares the intent to purchase, as much as practicable, the State's capacity for 90/180-day involuntary treatment in willing and able community facilities that come to the table to contract with the State.
- Each regional or local governing body, county, or county within a region, in concert with the BHOs/FIMCOs, will determine and notify the Health Care Authority (HCA) of the preferred method of allocating and providing 90/180-day involuntary treatment services.
  - These methods may include fully contracting with community facilities, a mix of state and community facilities, or continuing with state run services.
- Beginning December 1, 2021, requires the HCA to begin to contract for 90/180-day involuntary treatment services to the BHOs/FIMCOs, according to the preferred method.
- Requires the State to develop rules to certify 90/180-day facilities and must consult with Washington State Hospital Association (WSHA) to determine what short-term rules are inappropriate to long-term facilities.

Staff: Keri Waterland (360-786-7490)

**Title:** Relating to increasing behavioral health workforce participation by addressing certification and licensing requirements

**What the bill does:**

- Allows approved supervision towards the experience requirements for chemical dependency professional (CDP) certification to be provided under regular or alternative training pathways by a supervisor who meets or exceeds the requirements of a CDP and would be eligible to take the exam for certification, or a supervisor who is licensed as a psychologist, social worker, mental health counselor, or marriage & family therapist and has at least one year of experience in the treatment of substance use disorders.
- Eliminates a 60-day limitation for applicants for registration as an agency-affiliated counselor to work while their application is being processed under RCW 18.19.210.
- Directs DOH to conduct a sunrise review under chapter 18.120 RCW to evaluate the creation of a bachelor's level behavioral health professional credential combining the functions of a chemical dependency professional with clinical mental health functions appropriate to the bachelor's level of education to facilitate the work of all professionals at the top of their scope of license.

Staff: Kevin Black (786-7747)

**Title:** Relating to increasing the behavioral health workforce by establishing a reciprocity program to increase the portability of behavioral health licenses and certifications

**What the bill does:**

- Requires the Department of Health (DOH) to establish a reciprocity program for applicants for licensure or certification as a chemical dependency professional, mental health counselor, or marriage & family therapist in Washington who hold or have held within the past 12 months a license or certification with an equivalent or greater scope of practice in any other state or territory, and have no disciplinary record or disqualifying criminal history.
  - Requires DOH to issue a probationary license or certification to an applicant who meets these requirements allowing the applicant to practice while their application for full licensure or certification in Washington is pending and permits DOH to establish a reasonable time limit for the probationary licensee to make up any deficiencies in training and education requirements and, if required, take a jurisprudential exam.
  - Requires DOH to maintain and publish a list of foreign state licensing or certification requirements which it has determined to have equivalent or greater scope of practice and training or education requirements to a counterpart license or certification in Washington.
  - Requires DOH to explore options for adoption of an interstate compact for counselor licensure supporting license portability and to report recommendations to the Legislature by November 1, 2020.

**Title:** Relating to increasing options for peer support services in behavioral health

**What the bill does:**

- Directs the Health Care Authority (HCA) to continue work proposed by Governor Inslee and started by proviso in the 2018 supplement budget to expand its peer support certification program to:
  - Incorporate education and training for substance use disorder peers; and
  - Include reimbursement for peer support services by substance use disorder peers in its behavioral health capitation rates by July 1, 2019.
- Allow third parties to conduct peer support certification trainings using the state approved curriculum.
- Directs the Department of Health (DOH) to conduct a sunrise review under chapter 18.120 RCW to evaluate the need for creation of an advanced peer support specialist and advanced peer support specialist trainee credential for mental health, substance use disorder, and forensic peers accessible to persons in recovery that:
  - Provides education, experience, and training requirements that lie between the requirements of the current peer support certification administered by HCA and the requirements of other behavioral health credentials administered by DOH;
  - Provides oversight, structure, discipline, and continuing education requirements typical for other professional licenses and certifications;
  - Maximizes the range of clinical and mentoring activities appropriate for peer participation and the opportunities for behavioral health providers to bill for services provided by peer specialists;
  - Provides a path for career progression to other credentials for those who are interested in pursuing them; and
  - Incorporates consideration of common barriers to licensure related to criminal history and recovery from mental illness and substance use disorder and accommodates these lived experiences to the greatest extent consistent with prudence and client safety.

**Staff:** Kevin Black (786-7747)

**Title:** Relating to establishing a risk responsive methodology to calculate periods of competency restoration treatment.

**Background:** Competency restoration treatment is state-funded involuntary mental health treatment provided to criminal defendants who have been judicially determined to be incompetent to stand trial, provided with the goal of enabling criminal prosecution. State law provides for limited periods of competency restoration treatment based on the nature of the current charges: up to 29 days for a nonfelony offense, up to 315 days for a felony nonviolent offense, and up to 360 days for a felony violent offense.

In April 2015, the U.S. District Court for Western Washington found in the case of *Trueblood v. DSHS* that Washington State is violating the rights of incompetent criminal defendants by imposing excessive wait times for services related to competency to stand trial. The court ordered Washington to eliminate excessive wait times, and since July 2017 has assessed contempt fines against the state for noncompliance. The largest source of contempt fines is the wait time for competency restoration treatment, which as of June 2018 was averaging 41.0 days, instead of the court-ordered standard of seven days. Contempt fines imposed by the court range from \$500-\$1,000 per impacted defendant per day, and through September 2018 have totaled \$76.8 million.

**What the bill does:**

- Requires criminal courts to calculate competency restoration periods using a point system that takes into account both the defendant's current charges and criminal history, including prior charges that were acquitted by insanity or dismissed based on incompetence to stand trial.
  - Increases the competency restoration period available for some defendants who have a history that includes a violent, serious violent, or felony sex offense;
  - Limits the competency restoration period available for other defendants whose current charges and criminal history do not contain these types of offenses;
  - Decreases overall utilization of competency restoration treatment based on lower prevalence of violent, serious violent, and felony sex offenses in current charges and criminal history compared to other crimes.
- Allows judges to override calculation and impose additional competency restoration based on factors related to the circumstances of the particular case.
- Details of scoring system are provided on the reverse side of this paper.

Staff: Kevin Black (786-7747)

**Available Competency Restoration Treatment Period Calculation Table**

**I. Current Charges** -- choose ONLY ONE category representing the highest-level offense included among the defendant's current charges.

Highest Offense Category--Current Charges	Circle One Number Below
Nonfelony offense, or felony escalator offense, meaning conduct which would be a nonfelony offense but for the occupational status of the alleged victim under <a href="#">RCW 9A.36.031</a> , subsections (1)(b), (1)(c), (1)(e), (1)(g), (1)(i), (1)(j), (1)(k).	1
Nonviolent felony offense, excluding felony sex offenses or felony escalator offenses.	2
Violent offense under <a href="#">RCW 9.94A.030(55)</a> or felony sex offense under <a href="#">RCW 9.94A.030(47)</a> , excluding serious violent offenses .	3
Serious violent offense under <a href="#">RCW 9.94A.030(46)</a> .	4

**II. Criminal History** -- choose ONLY ONE category representing the highest-level scorable offense included among the defendant's criminal history, including charges acquitted by reason of insanity or dismissed without prejudice due to incompetency under chapter 10.77 RCW.

Highest Offense Category--Criminal History	Circle One Number Below
Nonfelony offense, nonviolent felony offense other than a felony sex offense, or no criminal history.	0
Violent offense under <a href="#">RCW 9.94A.030(55)</a> or felony sex offense under <a href="#">RCW 9.94A.030(47)</a> .	1
Serious violent offense under <a href="#">RCW 9.94A.030(46)</a> .	2

<b>Total Score (Number from 1 to 6):</b>	
--	--

**Available Competency Restoration Treatment Period**

Score of 1: No competency restoration allowed.

Score of 2: One competency restoration period of up to 60 days.

Score of 3: One competency restoration period of up to 60 days, followed by a second period of up to 90 days.

Score of 4+: One competency restoration period of up to 60 days, followed by second period of up to 90 days, followed by a third period of up to 180 days.

**Title:** Create the Diversion Incentive Fund for creation, continuation, and continuity of Trueblood-related Diversion programming

**What the bill does:**

- Creates a diversion incentive fund and pilot program between state and counties/ regions for Trueblood diversion programming; attempts to provide incentive for counties to fund diversion programming after Trueblood contempt fines stop.
- **Pilot explained:**
  - 3 year pilot
    - Initial state money infusion based on lifetime cost of current Trueblood diversion programs
      - State required to fund diversion programming through three year period in participating jurisdictions/ regions/ counties currently without diversion programming
      - If county/ region currently receives funding for diversion programming, state must fund based on current levels plus incentive dollars
      - Funding amount based on cost of diversion programming over three period + incentive funding for pilot county (based on related care costs if the individual had not been diverted).
    - **During 3 year pilot the following work would be completed:**
      - County/ region must demonstrate how it will pay for diversion services after pilot expires (example: local tax option)
      - Participating county/ region must submit proof of effectiveness via diversion outcomes; demonstrate number of individuals diverted and related cost savings
      - Participating county demonstrates cost savings (based on related care costs if the individual had not been diverted) and keeps any leftover incentive money at end of pilot

**Why this bill is needed:**

- Counties should have some skin in the game when it comes to diversion
- Current Trueblood diversion programming is a critical piece of the puzzle in terms of diverting people away from the behavioral health system
- Diversion programming is shown to save the state money in care costs
- Once the contempt fines stop, the legislature and/or regions will still be on the hook for funding these programs.
- This bill eases the state burden regarding these programs and incentivizes participating counties to get some skin in the game when it comes to maintaining outcomes-based diversion programming.

**Staff:** Matthew Tremble (786-7891)

S-0067.1

**Title:** Extending county authority to collect reimbursements from the department when conducting panel competency evaluations.

**What the bill does:**

- Extends current statutory authority for counties to conduct panel competency evaluations and collect reimbursement from DSHS through June 30, 2024.

**Why this bill is needed:**

- Pierce County currently uses this authority and receives reimbursement from the department for 5551 panel competency evaluations.
- Authority is currently set to expire June 30, 2019; want to ensure counties have all tools at their disposal when it comes to addressing wait times for competency evaluations and ensuring compliance with statute.

**Staff:** Matthew Tremble (786-7891)

S-0057.2

**Title:** Relating to the equitable geographic distribution of community placements for institutionalized persons with a history of criminal justice involvement

**Background:** Civil commitments in Washington occur at state hospitals (Western State Hospital, Eastern State Hospital, and Child Study & Treatment Center) and at the Special Commitment Center, among other venues. A long-term civil commitment at a state hospital may occur through a civil path (commitment based on likelihood of serious harm or grave disability) or a forensic path (commitment following dismissal of criminal charges based on incompetency to stand trial or acquittal by reason of insanity). Since 2013, a subset of state hospital patients on the forensic path are committed subject to a finding that prior to hospitalization they committed acts constituting a violent felony, pursuant to E2SHB 1114 (2013). Commitments at the Special Commitment Center are predicated on a finding that the committed person is a sexually violent predator, meaning that the person is convicted of or charged with a crime of sexual violence and suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

**What the bill does:**

- Applies "fair share principles" to persons committed to a state hospital following a judicial finding that they committed acts constituting a felony which were the subject of charges dismissed without prejudice based on incompetency to stand trial immediately prior to hospitalization by:
  - Requiring DSHS to develop a discharge plan within the county of origin, defined as any county within the regional service area in which the person was enrolled in services prior to commitment, or if the person was not enrolled in services, any county within the regional service area of the county of where criminal charges were filed.
  - Allowing DSHS to make an exception if placement in county of origin is inappropriate considering any court-issued protection orders, victim safety concerns, the availability of appropriate treatment, negative influences on the person, or the location of family or other persons or organizations offering support to the person.
  - Requiring that when DSHS does not discharge an 1114 patient to their county of origin, it must develop a discharge plan in a manner that does not have a disproportionate effect on a single county and must provide a written explanation to the Law and Justice Council of the county where the person is discharged.
- Expands fair share provisions applicable to the release of sexually violent predators on less restrictive alternative orders by requiring state placement efforts when the person cannot be released to their county of commitment to be directed towards placing the person in a neighboring county.
- Requires DSHS to report on the adequacy of resources to support less restrictive alternative placements for sexually violent predators in each regional service area and present a plan for procuring such services in any region with inadequate services.

Staff: Kevin Black (786-7747)

S-0055.1

**Title:** Related to limiting the placement of institutionalized persons with a history of criminal justice involvement in adult family homes.

**Background:** Civil commitments in Washington occur at state hospitals (Western State Hospital, Eastern State Hospital, and Child Study & Treatment Center) and at the Special Commitment Center, among other venues. A long-term civil commitment at a state hospital may occur through a civil path (commitment based on likelihood of serious harm or grave disability) or a forensic path (commitment following dismissal of criminal charges based on incompetency to stand trial or acquittal by reason of insanity). Since 2013, a subset of state hospital patients on the forensic path are committed subject to a finding that prior to hospitalization they committed acts constituting a violent felony, pursuant to E2SHB 1114 (2013). Commitments at the Special Commitment Center are predicated on a finding that the committed person is a sexually violent predator, meaning that the person is convicted of or charged with a crime of sexual violence and suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

**What the bill does:**

- Prohibits the Department of Social and Health Services from discharging a state hospital patient to an adult family home if:
  - there is a judicial finding that the person has committed acts constituting a violent felony; and
  - these acts were the subject of criminal charges that were dismissed without prejudice immediately prior to the current period of hospitalization based on incompetency to stand trial.
- Prohibits courts from placing a person committed as a sexually violent predator in an adult family home pursuant to a less restrictive alternative order after the effective date of the act; and
  - requires such a person, if otherwise be appropriate for adult family home placement, to be placed in an enhanced services facility or other setting that provides an at least equivalent staffing ration and level of security and supervision; and
  - amends eligibility requirements for enhanced services facilities to include persons who have been judicially determined to meet the statutory definition of sexually violent predator.

Staff: Kevin Black (786-7747)

S-0056.3

**Title:** Relating to expanding the Reentry Community Safety Program

**Background:** The Offender Reentry Community Safety Program (ORCSP) was established in 1999 as the Dangerous Mentally Ill Offender Program.<sup>1</sup> ORCSP identifies prisoners with serious mental illness within six months of release from prison who pose a potential threat to public safety. ORCSP uses a partnership between the Department of Corrections (DOC), Health Care Authority (HCA), and contracted community behavioral health providers to provide enhanced case management, treatment, and other services to these offenders following release.

A series of studies by the Washington State Institute for Public Policy (WSIPP) concluded that ORCSP reduces new felony recidivism by 42 percent and new violent felony recidivism by 36 percent.<sup>2</sup> WSIPP currently identifies ORCSP as a cost-effective program which returns \$1.90 of benefits to taxpayers for every dollar spent on the program.<sup>3</sup> A meta-analysis of 59 reentry programs published by WSIPP in 2017 revealed that ORCSP has the largest effect size in reducing recidivism than any other reviewed program, twice as large as the next most effective program.<sup>4</sup>

**What the bill does:**

- Renames ORCSP as the Reentry Community Safety Program (RCSP).
- Expands the RCSP to include state hospital patients who are committed as incompetent to stand trial following commission of a violent felony (known as "1114 patients" based on [E2SHB 1114 \[2013\]](#)) and state hospital patients who are committed based on criminal insanity.
  - Requires the Department of Social and Health Services to model the expanded RCSP off the current ORCSP in consultation with behavioral health experts, DOC, and HCA.
  - Redirects current monies appropriated for 1114 patients to support the RCSP expansion.
  - Requires notification to the Public Safety Review Panel (PSRP) and information sharing with PSRP when state hospital patients are referred to the program.
  - Authorizes community corrections officers to supervise 1114 patients participating in the RCSP and provides training.
- Requires all behavioral health organizations and fully-integrated managed care entities to ensure adequate provider capacity in their region to support the operation of the RCSP.
- Allows RCSP staff, agency staff, or state hospital staff to accompany a state hospital patient on temporary leaves from custody.

Staff: Kevin Black (786-7747)

<sup>1</sup>The program has also been known as the Community Integration Assistance Program. It was renamed ORCSP by the Legislature in 2009 (see [SHB 1201 \[2009\]](#)).

<sup>2</sup> See [http://www.wsipp.wa.gov/ReportFile/1036/Wsipp\\_The-Dangerous-Mentally-Ill-Offender-Program-Four-Year-Felony-Recidivism-and-Cost-Effectiveness\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1036/Wsipp_The-Dangerous-Mentally-Ill-Offender-Program-Four-Year-Felony-Recidivism-and-Cost-Effectiveness_Full-Report.pdf).

<sup>3</sup> See <http://wsipp.wa.gov/BenefitCost/Program/8>

<sup>4</sup> See Exhibit 2, Bitney, K., Drake, E., Grice, J., Hirsch, M. & Lee, S. (2017). *The effectiveness of reentry programs for incarcerated persons: findings for the Washington Statewide Reentry Council* (Document Number 17-05-1901). Olympia: Washington State Institute for Public Policy, pages 7-8. Available at: [http://www.wsipp.wa.gov/ReportFile/1667/Wsipp\\_The-Effectiveness-of-Reentry-Programs-for-Incarcerated-Persons-Findings-for-the-Washington-Statewide-Reentry-Council\\_Report.pdf](http://www.wsipp.wa.gov/ReportFile/1667/Wsipp_The-Effectiveness-of-Reentry-Programs-for-Incarcerated-Persons-Findings-for-the-Washington-Statewide-Reentry-Council_Report.pdf)

S-0065.2

**Title:** Veteran diversion from involuntary through increased coordination the veterans administration and the department of social and health services

**What the bill does:**

- Directs facilities (E&Ts, crisis stabilization units, emergency department of local hospital, triage facility, secure detox facility, or approved SUD treatment program) to inquire as to a person's veteran status or eligibility for veterans benefits and coordinate with the Veteran's Health Administration in Seattle as soon as reasonably possible.
- Requires facilities to consider emergency care when a person eligible for veteran's services in being treated for a mental health or substance abuse disorder
- Requires the facility to request transfer and release to a VHA facility for treatment.

**Why this bill is needed:**

- Currently there is no separate ITA system for veterans.
- Washington's ITA system does not do an adequate job of coordinating with the Veteran's Health Administration
  - This results in veterans receiving improper treatment or being unable to utilize their benefits with the VHA.
  - Increased coordination between facilities and the VHA will improve diversion of veteran's away from facilities and would free up resources.
  - Seattle VHA is the only VHA facility in Washington with a secure ward, so coordination with Seattle is particularly important.
  - Veterans receive care that is more informed when it is provided by the VHA, rather than providing state crisis intervention or ITA services.

Staff: Matthew Tremble (786-7891)

**Title:** Relating to expanding community-based behavioral health facilities through issuance of state bonds

**What the bill does:**

- Authorizes the State Finance Committee to issue up to \$500 million in general obligation bonds to finance community-based mental health facilities;
  - \$500 million will be subject to the debt limit and \$500 will be outside of the debt limit and subject to a vote of the people.
  - Provides that the bonds would be issued over ten years.
  - Directs the Secretary of State to submit the bond authorization to a vote of the people.

**Why the bill is needed:**

- The Legislature and Governor's agreed upon plan is to move long-term civil commits out of Western and Eastern State Hospitals and into community facilities
  - This allows civil commitments to be treated closer to their support systems.
  - Currently, we do not have adequate bed capacity in local communities
  - In order to establish and maintain capacity, we need to provide financing for the capital build out of our community mental health facilities
- Allows the state to focus on forensic mental health services at the state hospitals
- Helps address local need for mental health services; community facilities will allow for quicker treatment, easier access for families, and will help with diversion away from the justice system.

**Staff:** Matthew Tremble (786-7891)

**Title:** Relating to incentivizing engagement by publicly-funded health systems in efforts to reduce criminal justice system involvement for clients with acute behavioral health disorders;

**Background:**

- Washington state law requires state contracts for publically-funded behavioral health services to be managed in order to achieve the following improved outcomes related to criminal justice:
  - Reduced involvement in the criminal justice system;
  - Reduced involvement in the juvenile justice system;
  - Reductions in avoidable jail and prison costs; and
  - Enhanced public safety.
- Certain indicators of criminal justice involvement by persons with behavioral health disorders, such as jail costs for behavioral health services and referral rates for services related to competency to stand trial, are rising at rates that sharply exceed growth in state population and in overall criminal filings.
- Existing state managed health care contracts do not incorporate performance metrics or value-based purchasing provisions that would incentivize improvement in achieving criminal justice outcomes for clients with behavioral health disorders.

**What the bill does:**

- Requires the Health Care Authority (HCA) to amend managed health care contracts to include mandatory performance improvement projects related to achieving outcome goals related to criminal justice among clients with an identified behavioral health need by July 1, 2020, and to begin reporting regional measures relevant to these outcomes by January 1, 2021.
- Requires HCA to integrate value-based purchasing terms relating to criminal justice outcome goals into managed care contracts by January 1, 2021.
- Requires the Performance Measures Coordinating Committee to devise performance measures that track rates of arrest, incarceration, and referral for competency services among publicly-funded health care clients who have an identified behavioral health need and to report to the Legislature by December 1, 2019.

Staff: Kevin Black (786-7747)

**Title:** Creating a guardianship program for persons who are gravely disabled ("incapacitated person") to provide them individualized treatment, supervision, and appropriate placement to support successful transition to the community

**What the bill does:**

- Authorizes the courts to refer a person, upon petition for a guardianship, for an assessment by a local mental health professional to determine if the person is gravely disabled
- Authorizes a mental health professional to make a referral for guardianship and initiate a guardianship investigation
- Requires a guardianship investigation and for the investigator (guardian ad litem, e.g.) to determine all available alternatives to guardianship and submit a report to the court that contains certain recommendations for the guardian and incapacitated person if no alternatives to guardianship exist
- Authorizes the courts to provide a temporary guardianship for persons in order to arrange for care of a person until a guardianship is determined, including the authority to detain the person in a facility for intensive treatment, and to preserve the person's place of residence
- Authorizes guardians to require incapacitated persons to receive treatment
- Requires a treatment plan to be established within 10 days of the court establishing a guardianship
- Authorizes guardians who place incapacitated persons in an inpatient facility to require the person to undergo outpatient treatment
- Provides placement and transfer options for the incapacitated persons, dependent upon severity of the incapacitation as determined by the court, mental health professional, and/or guardian
- Limits guardianships to one year, not including any time served by a temporary guardian, except to allow the guardian to resolve financial obligations of the person or if the guardian petitions the court to allow another one-year guardianship period
- Defines "gravely disabled" as a condition in which a person, as a result of a mental disorder, or as a result of the use of alcohol or other psychoactive chemicals -
  - Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or
  - Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety

**Title:** Create an innovative tele-health care delivery model in schools to prevent school violence, adolescent suicide, and substance abuse. Implement a high quality training program for school professionals.

**What the bill does:** The goal is to start treatment at early onset by identifying those that may need two visits through telemedicine, those that need to have more in-depth treatment, those that need to be hospitalized and those that need life time hospitalization due to the degree of their illness. Our goal is also to make patients better not just make good patients and that will be done through measuring the effectiveness of the treatments and making adjustment to training to continue the focus on patient improvement.

1. The identified agency will undertake a digital survey of each school district to ascertain their specific needs along with the community's structure and available services.
2. The bill will address identifying and treating youth from 8-9<sup>th</sup>? Grade to graduation.
3. Risk Focus:
  - Mental Health
  - Suicide prevention and harm to others
  - Substance abuse, including opioid abuse
4. Training is the key to identifying above described conditions. Training shall be provided through project Echo based at the University of Washington. Criteria for training shall be developed within the mental health community and shall address all identified areas in #3.
4. Schools currently have employees that can be trained to help identify students demonstrating symptoms at their level of training. Administration, school bus driver's counselors, teachers, food service workers, janitors shall participate in digital based training provided by project ECHO.
5. Students identified from a trained school employee or a community worker shall have access to two telehealth treatments. If determined a student needs additional treatment a referral to the telemedicine program based at the University of Washington shall be made and paid for by insurance carriers, commercial and Medicaid alike while the student remains on the school campus.
6. Funding: The state shall apply for grants to fund said training through project ECHO through various entities. Funds shall be distributed through requirements. State will participate in funding.

Staff: Matthew Tremble (786-7891)

**Citizens Advisory Committee**

**2019 Mental Health Chemical Dependency and Therapeutic Court Recommendations**

Attachment 7.d

<b>Score</b>	<b>Entity</b>	<b>Project</b>	<b>New or Continuation</b>	<b>Initial Request</b>	<b>Modified Request</b>	<b>% Reduction</b>	<b>Recommendations</b>
<b>90%</b>	Kitsap County Superior Court	Adult Drug Court	Continuation - 4 years funded	\$ 376,144.00	\$ 369,144.00	-1.86%	\$ 369,144.00
<b>90%</b>	Kitsap County Superior Court	Veteran's Treatment Court	Continuation - 2 years funded	\$ 72,312.00	\$ 72,312.00	0.00%	\$ 72,312.00
<b>90%</b>	Kitsap County District Court	Behavioral Health Court	Continuation - 1 year funded	\$ 232,711.00	\$ 232,711.00	0.00%	\$ 232,711.00
<b>89%</b>	City of Poulsbo	Behavioral Health Outreach	Continuation - 3 years funded	\$ 319,669.00	\$ 296,784.00	-7.16%	\$ 296,784.00
<b>89%</b>	Kitsap Public Health District	Nurse Family Partnership	Continuation - 4 years funded	\$ 127,828.00	\$ 127,828.00	0.00%	\$ 127,828.00
<b>86%</b>	Kitsap County Sheriff's Office	CIT for Law Enforcement	Continuation - 4 years funded	\$ 78,700.00	\$ 21,500.00	-72.68%	\$ 21,500.00
<b>85%</b>	Kitsap County Sheriff's Office	Reentry Officer and Coordinator	New	\$ 210,720.23	\$ 210,720.23	0.00%	\$ 210,720.00
<b>84%</b>	Kitsap County Juvenile Services	Juvenile Therapeutic Courts	Continuation - 4 years funded	\$ 185,400.00	\$ 185,400.00	0.00%	\$ 151,466.00
<b>84%</b>	Coffee Oasis	Homeless Youth Intervention	Continuation - 2 years funded	\$ 306,279.00	\$ 301,479.00	-1.57%	\$ 301,479.00
<b>82%</b>	Aging and Long Term Care	Partners in Memory Care	Continuation - 1 year funded	\$ 104,214.46	\$ 104,214.46	0.00%	\$ 104,214.00
<b>77%</b>	Kitsap Public Health District	Kitsap Connect	Continuation - 2 years funded	\$ 410,105.00	\$ 380,105.00	-7.32%	\$ 380,105.00
<b>75%</b>	West Sound Treatment Center	New Start Program	Continuation - 4 years funded	\$ 364,000.00	\$ 339,000.00	-6.87%	\$ 339,000.00
<b>75%</b>	Peninsula Community Health Services	Wellness on Wheels	New	\$ 199,628.96	\$ 199,628.96	0.00%	\$ 199,628.00
<b>74%</b>	Kitsap Mental Health Services	Permanent Supportive Housing Pre-Development	New	\$ 119,900.00	\$ 119,900.00	0.00%	\$ 119,900.00
<b>72%</b>	Olympic Educational Service District	Behavioral Health Counseling	Continuation - 4 years funded	\$ 656,220.00	\$ 580,301.00	-11.57%	\$ 580,301.00
<b>71%</b>	Bremerton School District	Social and Emotional Learning	Continuation - 1 year funded	\$ 333,000.00	\$ 313,500.00	-5.86%	\$ 100,050.00
<b>69%</b>	Kitsap County Prevention & Youth Services	Substance Abuse Prevention Program	New	\$ 64,610.00	\$ 64,610.00	0.00%	\$ 64,610.00
<b>67%</b>	Kitsap Community Resources	Housing Stability Support	Continuation - 1 year funded	\$ 144,331.00	\$ 144,331.00	0.00%	\$ 144,331.00
<b>65%</b>	Kitsap Mental Health Services	Housing Navigation Center	New	\$ 1,685,943.00	\$ 1,685,943.00	0.00%	\$ -
<b>64%</b>	Kitsap County Prosecuting Attorney's Office	Therapeutic Courts Alternative to Prosecution	New	\$ 298,854.00	\$ 298,854.00	0.00%	\$ 298,854.00
<b>58%</b>	Kitsap Strong	Trauma Informed Community	New	\$ 134,032.00	\$ 108,032.00	-19.40%	\$ -
<b>51%</b>	Kitsap County Sheriff's Office	Crisis Intervention Coordinator	New	\$ 183,792.00	\$ 183,792.00	0.00%	\$ -
<b>42%</b>	Kitsap Recovery Center	Kitsap County Drop In Center	New	\$ 367,518.00	\$ 367,518.00	0.00%	\$ -
<b>27%</b>	Sound Integrated Health, LLC	MAT (Medication Assisted Treatment)	New	\$ 328,766.83	\$ 328,766.83	0.00%	\$ -
<b>19%</b>	Eagles Wings	Coordinated Care	New	\$ 103,500.00	\$ 103,500.00	0.00%	\$ -
	<b>Disqualified</b>		<b>Total</b>	<b>\$ 7,408,178.48</b>	<b>\$ 7,139,874.48</b>	<b>-3.62%</b>	<b>\$ 4,114,937.00</b>
				\$ -			
				\$ -			
			<b>Total Disqualified</b>	<b>\$ -</b>			
		Estimated 12 Month Revenue					\$ 4,500,000.00
		<b>Total Funding Available</b>					<b>\$ 4,500,000.00</b>
	<b>SBHO Executive Board</b>	<b>Balance</b>					<b>\$ 385,063.00</b>
			Page 31				October 19, 2018

WSH Census and Waitlist Report for 8/2018

Attachment 7.e

Date	WSH SBHO Census	WSH Clallam/PBH	PBH Over 7	WSH Clallam/WEOS	WSH DBH	WSH Kitsap
8/1/2018	27	8	1	1	2	16
8/2/2018	27	8	1	1	2	16
8/3/2018	27	8	1	1	2	16
8/4/2018	27	8	1	1	2	16
8/5/2018	27	8	1	1	2	16
8/6/2018	26	8	1	1	2	15
8/7/2018	25	7	N/A	1	2	15
8/8/2018	25	7	N/A	1	2	15
8/9/2018	26	7	1	2	2	15
8/10/2018	26	7	1	2	2	15
8/11/2018	26	7	1	2	2	15
8/12/2018	26	7	1	2	2	15
8/13/2018	26	7	1	2	2	15
8/14/2018	25	7	1	2	2	14
8/15/2018	25	7	1	2	2	14
8/16/2018	25	7	1	2	2	14
8/17/2018	25	7	1	2	2	14
8/18/2018	25	7	1	2	2	14
8/19/2018	25	7	1	2	2	14
8/20/2018	25	7	1	2	2	14
8/21/2018	25	7	1	2	2	14
8/22/2018	25	7	1	2	2	14
8/23/2018	25	7	1	2	2	14
8/24/2018	25	7	1	2	2	14
8/25/2018	25	7	1	2	2	14
8/26/2018	25	7	1	2	2	14
8/27/2018	25	7	1	2	2	14
8/28/2018	25	7	1	2	2	14
8/29/2018	25	7	1	2	2	14
8/30/2018	25	7	1	2	2	14
8/31/2018	25	7	1	2	2	14

<b>9/12/2018</b>			
	Target	Actual	Difference
<b>Beacon</b>	<b>8</b>	<b>4</b>	<b>-4</b>
<b>CHPW</b>	<b>6</b>	<b>5</b>	<b>-1</b>
<b>Great Rivers</b>	<b>29</b>	<b>29</b>	<b>0</b>
<b>King</b>	<b>210</b>	<b>208</b>	<b>-2</b>
<b>Molina</b>	<b>23</b>	<b>15</b>	<b>-8</b>
<b>North Sound</b>	<b>106</b>	<b>94</b>	<b>-12</b>
<b>Optum Pierce</b>	<b>84</b>	<b>86</b>	<b>2</b>
<b>Salish</b>	<b>30</b>	<b>25</b>	<b>-5</b>
<b>Thurston/Mason</b>	<b>31</b>	<b>24</b>	<b>-7</b>
WSH-WA Census		490	
BHO/FIMO Defined Target	527		
Over/Under			-37

Great Columbia	1
North Central	1
Spokane	1
 Total Census	 502

	Total Individuals Placed on Waitlist	Those on the Waitlist that Were Admitted	Those on the Waitlist that Were NOT Admitted	Percentage of Clients Not Admitted	Total Bed Days All Clients on Waitlist	Average LOS All Clients on Waitlist	Bed Days Those Admitted	Average LOS Those Admitted	Bed Days Those Not Admitted	Average LOS Those NOT Admitted
Jan-18	5	0	5	100%	183	36.6	NA	NA	183	36.6
Feb-18	7	0	7	100%	184	26.3	NA	NA	184	26.3
Mar-18	4	0	4	100%	81	20.3	NA	NA	81	20.3
Apr-18	4	1	3	75%	108	27.0	85	85.0	23	7.7
May-18	5	0	5	100%	127	25.4	NA	NA	127	25.4
Jun-18	1	0	1	100%	21	21.0	NA	NA	21	21.0
Total First Six Months 2018	26	1	25	96%	704	156.5	85	85.0	619	137.2
Jul-18**	5		4	0%		0.0		0.0		0.0
Aug-18**	5		4	0%		0.0		0.0		0.0

\*\*Data incomplete due to individuals still pending on waitlist

Current waitlist houses 2 individuals who are pending placement on E wards (medical/geriatric). The hospital is closing one full E ward by the end of December. They are closing a second E ward by June 2019. Current individuals will be relocated internally making waitlist individuals lower in priority and do not expect much movement on this waitlist through the end of the year.

Admits and Discharges by Agency															
(Total column = Admit minus Discharges) The goal is a negative number, leading to a reduction in the census															
	KMHS ADMIT	KMHS D/C	KMHS TOTAL	PBH ADMIT	PBH D/C	PBH Total	DBH ADMIT	DBH D/C	DBH TOTAL	WEOS ADMIT	WEOS D/C	WEOS TOTAL	BHO ADMIT	BHO D/C	bho TOTAL
Jan-18	1	3	-2	0	0	0	0	0	0	0	0	0	1	3	-2
Feb-18	1	0	1	1	1	0	0	0	0	0	0	0	2	1	1
Mar-18	1	1	0	1	1	0	0	0	0	0	0	0	2	2	0
Apr-18	0	1	-1	0	0	0	0	0	0	0	0	0	0	1	-1
May-18	0	4	-4	0	0	0	0	0	0	0	0	0	0	4	-4
Jun-18	1	2	-1	0	0	0	0	0	0	0	0	0	1	2	-1
Jul-18	1	0	1	1	0	1	0	0	0	1	0	1	3	0	3
Aug-18	0	2	-2	0	1	-1	0		0	1		1	1	3	-2