King County Physical and Behavioral Health Integration Design Committee

Meeting Summary
July 13, 2016; 1:30– 4:30 PM
Navos-Revelle Hall
Burien, WA

Members Present: *Susan McLaughlin- King County Department of Community & Human Services, Betsy Jones- King County Executive's Office, Jennifer DeYoung- Public Health- Seattle & King County, Maria Yang- King County Behavioral Health and Recovery Division, Emily Transue- Coordinated Care, Angie Riske- Multicare, Julie Lindberg- Molina Healthcare, Vicki Evans- Molina Healthcare, Steve Daschle- Southwest Youth and Family Services, Katherine Switz- Many Minds, Melet Whinston- United Healthcare, Torri Canda- Amerigroup, Daniel Malone- DESC, Darcy Jaffe- Harborview, Anne Shields- UW AIMS Center, Erin Hafer-Community Health Plan of Washington, Tashau Asefaw- United Health Care, Roger Dowdy- Neighborcare, Tory Gildred-Coordinated Care Health, Stacy Fennel- Sea Mar Community Health Services, Suzanne Peterson-Tanneberg- Seattle Children's Hospital, Marc Avery- Community Health Plan of Washington*

Members Not Present: *Tom Trompeter- HealthPoint, Maureen Linehan- City of Seattle Human Services, Aileen DeLeon- WAPI, Vicki Isett- Community Homes, Ken Taylor- Kent Youth and Family Service, David Johnson- NAVOS, Patricia Quinn- Therapeutic Health Services, Lin Payton-Washington State Health Care Authority, Molly Donovan- REWA, Victoria Cates- Amerigroup, Dan Cable-Muckleshoot Tribe*

Staff: *Liz Arjun- King County, Jen Martin- Community Change, Travis Erickson- King County, Martha Gonzalez- King County, Deb Srebnik- King County*

Guests: *Andrea Yip- City of Seattle Aging Services, Nicoleta Alb-Sea Mar Community Health Centers, Vanessa Gaston, Clark County Human Services, Isabel Jones- Health Care Authority, Ruth Bush- Coordinated Care, Ann Meegan, Public Health- Seattle & King County, DJ Wilson – Wilson Strategies, Sarah Arnquist- Beacon Health Options*

Welcome & Introductions

Liz Arjun welcomed the committee members and gave a review of the agenda. Jen Martin reviewed the overall timeline.

Adoption of Principles

Jen Martin asked the group to review the principles once more and asked if anyone had opposition to the principles before voting. The IDC unanimously voted to adopt the principles. (Please see the attachments for the final version).

Southwest Washington Update

The IDC heard from six speakers about early adoption of full integration in Southwest Washington including Vanessa Gaston, Director of Clark County Community Services, Isabel Jones from the Health Care Authority, Sarah Arnquist from Beacon Health Options, Julie Lindberg from Molina Healthcare, Erin Hafer from Community Health Plan of Washington and Nicoleta Alb, from Sea Mar Community Health Centers.

Vanessa Gaston, Director of Clark County Community Services began the presentation by sharing an overview of operations, with a specific focus on the county role of coordination and advocacy. Vanessa shared that the decision to pursue early adopter was influenced by many factors including their desire to have influence with the state to determine how the move towards integration will result in changes to help individual services. She suggested King County involve supporting services like transportation, housing etc. in the discussions around physical and behavioral health integration. They also spend time educating their legislative officials- local and state- about their integration efforts. Vanessa shared a document with the IDC about lessons learned from the work on full integration in Southwest Washington (attached). A Behavioral Health Advisory Board (a formal committee of the SW Regional Health Alliance, the Accountable Community of Health for the region) similar to the King County Behavioral Health Advisory Board here in King County. A second group, the Behavioral Health Strategic Planning Council which includes representatives from health care care organizations, health care providers, housing providers, the MCOs, the County, the Mental Health Ombudsman and a peer organization has come together to work on implementation and monitoring of fully integrated managed care.

Isabel Jones, Medicaid Integration Manager for the Washington State Health Care Authority presented their timeline and key milestones to FIMC Implementation (see the attached presentation for more detail). Some key specifics she mentioned to the IDC: through the RFP process it is required that there be at least two 2 managed care plans for consumer choice and that they must prove network adequacy. She reviewed the MCO contracts and how they support, Medicaid and Non-Medicaid services. She described two different types of enrollment- enrollment in the Behavioral Health Services Only (BHSO) and Apple Health – Fully Integrated Managed Care (AH-FIMC). Services not included in MCO Contracts include Crisis Services for all community members, regardless of Apple Health (Medicaid) enrollment. The Crisis System is managed by Beacon by Beacon Health Options. They determined the number of beds available to Beacon (7) for crisis services at Western State Hospital by looking at historical use for non-Medicaid clients. The remainder of the beds allocated to the region at Western State Hospital are allocated to the other organizations. For purpose of a waitlist for the region, Beacon is included in the overall regional count, which is 40. Part of the work in Southwest Washington has involved establishing an early warning system that is relatively new with measurement. The Behavioral Health Advisory Board is responsible for making decisions and recommendations about the use of local and federal block grant dollars in the region that support behavioral health services.

Julie Lindberg from Molina Healthcare shared some slides to demonstrate the flow of the different funds and how they interact together (see attached materials).

Questions from Committee

Q: How do you bring that funding to support a service that is not 100% Medicaid funding?
A: Local funds are not in the mix. The Behavioral Health Advisory Board determines how that money is spent: prevention, housing etc. For Medicaid members they are covering all services, but they are not necessarily tapping into all funding sources, they are able to close gaps. Behavioral health providers are now able to contract with Beacon for non-Medicaid services.

Q: How does it look different for clients?
A: It's similar to having 2 different insurance plans one for behavioral health needs and one for medical needs. For a client it's one single managed care organization that are administered the same. A big benefit is that behavioral providers are not seeing obstacles with rejected clients for physical health. Nicoleta Alb from Sea Mar Community Health Centers noted that at this point things have been seamless for their clients. They have provided a lot of training to the front-line staff about the change in agencies and the services provided.

Q: For Medicaid-funded Behavioral Health Services-what are the differences in rates and mechanisms and how similar are the MCO to what was previously provided?
A: The MCOs have replicated the system that was previously in place. There have been no changes yet to how much providers are paid and which providers are in the networks. They will look to make changes in payment mechanisms, etc. in the second year of implementation of FIMC. The motto for implementation has been crawl, walk, run. The initial implementation has been to maintain the status quo so they contracted with existing providers including mobile crisis teams. They are meeting with crisis stakeholders and exploring how to expand these services- the community would like to see more mobile crisis. They are exploring a triage center that could serve as a diversion point for the community rather than the emergency room.

Q: How do you delineate between the clients who are Apple Health enrollees and those who aren't?
A: Beacon receives a daily eligibility report from Molina and CHPW, the use of crisis services is shared and coordinated with the MCOs. Beacon contracts for the services- they do not provide the direct services. If a client goes into crisis, the outpatient provider service is still being worked out. It depends on the capability of the providers. Some providers have more robust service to care delivery systems. Staff makes a decision how to exchange information. Providers are able to send out crisis alerts and can create a plan for individuals, they are tracking the system.

Q: How many BHO providers are there?
A: Clark has about 15 providers and more outside of the region.

Q: If someone goes to ER can they pull up crisis alert?
A: Not yet- they do not have a link to the case manager. At present, Beacon dispatches a mobile crisis team to the ER.

Q: Is it better?
A: They haven't asked consumers yet, they would like to. There is an interesting challenge with the consumer- because many of them are unaware of the changes- they only interact with the system at the provider level. What is notably better is care coordination because of the information exchange and

communication happening between MCOs and Beacon. This could have been done previously, but was not. It is now easier to strategically invest in a continuum of care for the region that prioritizes keeping people out of medical beds, and has shortened waiting time to see providers.

Overall Suggestions for King County from Southwest Washington Panel

- Double the timeline for implementation
- Learn more about funding and budgeting
- Have respect for one another and be humble through the process
- Allow enough time to focus on data systems- this was very problematic for Southwest Washington
- Ensure training and assistance for providers about what an integrated approach to care means, professional development, operations/billing and support on using data and IT systems to support treatment and maintenance.

Clinical Model Core Elements- Small + Large Group Discussion

Jen Martin asked the sub groups to review the elements for the ACH and look for elements that are missing.

The feedback included:

- Getting the right amount of care for the person at the time of need.
- With more expensive/intensive intervention need to get missing care.
- People still not getting what they need (hard to reach)
- Community wellness
- Population education
- Screen where patient is at
- Transforming system to be able to address multiple complex situations.
- Assessment issue with hard to reach individuals. Non medical folks that engage with population trained to help.
- Identify early intervention and prevention, making it efficient for young people.
- Training non-Medicaid providers on how to engage
- Respite Care
- Trauma Informed Care
- ACES
- Generating results to further reform the system. Evidence based treatment.
- Infant mental health
- Post-partum treatment
- Access pathway how to get identified. More than a handoff but an engagement of all services necessary.
- Social determinants- food, childcare and housing.

These suggestions will be incorporated into the core service elements and reviewed by the workgroups in the interim and by the full committee in August.

Next Steps

The Infrastructure Discussion scheduled for the meeting will be rescheduled for the August meeting. The clinical workgroups will meet once again before August meeting.

Updated 6/13/2016

KING COUNTY PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION DESIGN COMMITTEE

GUIDING STATEMENTS

WORKING VISION

By 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities. A key factor in achieving this vision is moving from an environment where health and human services are delivered in programmatic siloes determined by funding source, to an integrated health care system that is able to address whole person health (physical and behavioral) needs, is person-centered and determined by an individual's unique needs.

WHAT DOES THIS LOOK LIKE: WORKING DEFINITION OF INTEGRATED CARE

An integrated health care system is one where providers and payers work collectively to meet the physical and behavioral health needs of an individual in a timely, holistic and culturally responsive fashion where the person receiving services is engaged in their care. In this system, there is "no wrong door"- individuals receiving services are able to access the services when and where they need them. Care coordination happens across providers, payers and other organizations serving the person to minimize duplication and complexity. There is accountability to the individual, to those involved in providing services another and payers for achieving outcomes that the individual has helped identify. Those involved in providing services are supported by a shared care plan, shared data and have an understanding of their respective roles. Financing supports the integrated system by paying for overall outcomes and value for the person receiving services, not individual services.

KING COUNTY PRINCIPLES FOR FULL INTEGRATION
(still to be adopted by IDC)

Client-Centered Care

Driving Value-Based Care Delivery

Maximizing Resources

Updated 6/13/2016

Individuals experience significant gains in health and well-being because the system shifts from a costly, crisis-oriented response to health and social problems, to one that **focuses on prevention, embraces recovery, and eliminates disparities**

1. Individuals receiving services are at the center of care planning, and are **engaged and activated**;
2. Individuals are able to access the health and social service supports **when and where they need** them in a culturally responsive fashion
3. Individuals **achieve improved health and social outcomes** as a result of full integration
4. **Recovery** principles are prominent across the system of care and recovery practices are expected and rewarded
5. Services address a person's health and wellbeing **across the lifespan**
6. Full integration at the clinical and financial levels ensure mechanisms to **treat the whole person and align incentives** as the best way to improve health and social outcomes
7. The system **extends beyond Medicaid** and supports individuals who are low income, or uninsured, including non-Medicaid, immigrants/refugees and undocumented as well as those covered by private insurance and **ensures equity of experience** regardless of payer
8. **Information is shared seamlessly** across providers in order to minimize complexity for the individuals served
9. Payments are based on achieving improved health and social outcomes for individuals because we are **paying for value** rather than volume, allow for the flexibility and capacity at the clinical level to address individual needs and payment models are adjusted to meet the needs of various populations
10. **All funding sources are maximized** and fully leveraged: Medicaid, block grant, philanthropy, local taxes and levies, grants, etc. to ensure a full continuum of health services
11. Payers in the Region (including King County and the Washington State Health Care Authority) are **aligned in how services are contracted and paid for,** including aligning incentives across payers
12. Ongoing **investments in health promotion, prevention, and early intervention** are made to prevent the occurrence of health conditions and achieve improved population health
13. Ongoing **investments** are made to build and maintain necessary system and provider capacity **to provide a full continuum** of health (including behavioral health) services
14. The system is active in **addressing the social determinants of health** including integration of housing, employment, criminal justice diversion and other recovery support services
15. Services are **community-based** and delivered in the least restrictive setting possible

KING COUNTY PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION DESIGN COMMITTEE

July 13, 2016

Navos-Revelle Hall

Burien, WA

Agenda

- Agenda Review and Vote on Principles
- Southwest Washington Update
- Clinical Model Core Elements
- Infrastructure Discussion
- Next Steps

PRINCIPLES

SOUTHWEST WASHINGTON UPDATE

HCA Overview: Whole-Person Care

Isabel Jones
Medicaid Integration Manager
Health Care Authority

Healthier WASHINGTON

Key Milestones to FIMC Implementation

Activity: Mid-Adopter Fully Integrated Contracts	**Key Milestone for Completion**
HCA/Regional Service Area Engagement Begins	Ongoing
Non-Binding Letter of Intent Due	14 months before go-live
Continued County Engagement/Model Discussion/Finalize Model	12 months before go-live and ongoing
Binding Letter of Intent Due	11 months before go-live
Release RFP(s) - *2 months to respond*	10 months before go-live
RFP Responses Due – *1 month to evaluate and score*	8 months before go-live
Announce Apparently Successful Bidders	7 months before go-live
Readiness Review/ Knowledge Transfer & Transition	7 months before go-live
Sign Contracts with Successful Bidders	1-2 months before go-live
Contract Start Date	Go Live

Integrated MCO Contracts for Medicaid Beneficiaries

Medicaid Covered Services (FIMC Contract)

Medical	Mental Health	Substance Use Disorders

Non-Medicaid Services for Medicaid Beneficiaries (Wrap-Around Contract)

Behavioral Health services funded by State General Funds

Two Types of Enrollment

AH-FIMC: Enrollees with managed medical and behavioral health care	BHSO: Enrollees with managed behavioral health care only

Healthier WASHINGTON

MOLINA HEALTHCARE
Your Extended Family.

COMMUNITY HEALTH PLAN of Washington™

Services not included in MCO Contracts

Crisis services for all members of the community

- Includes DMHPs

State-funded services for Non-Medicaid beneficiaries

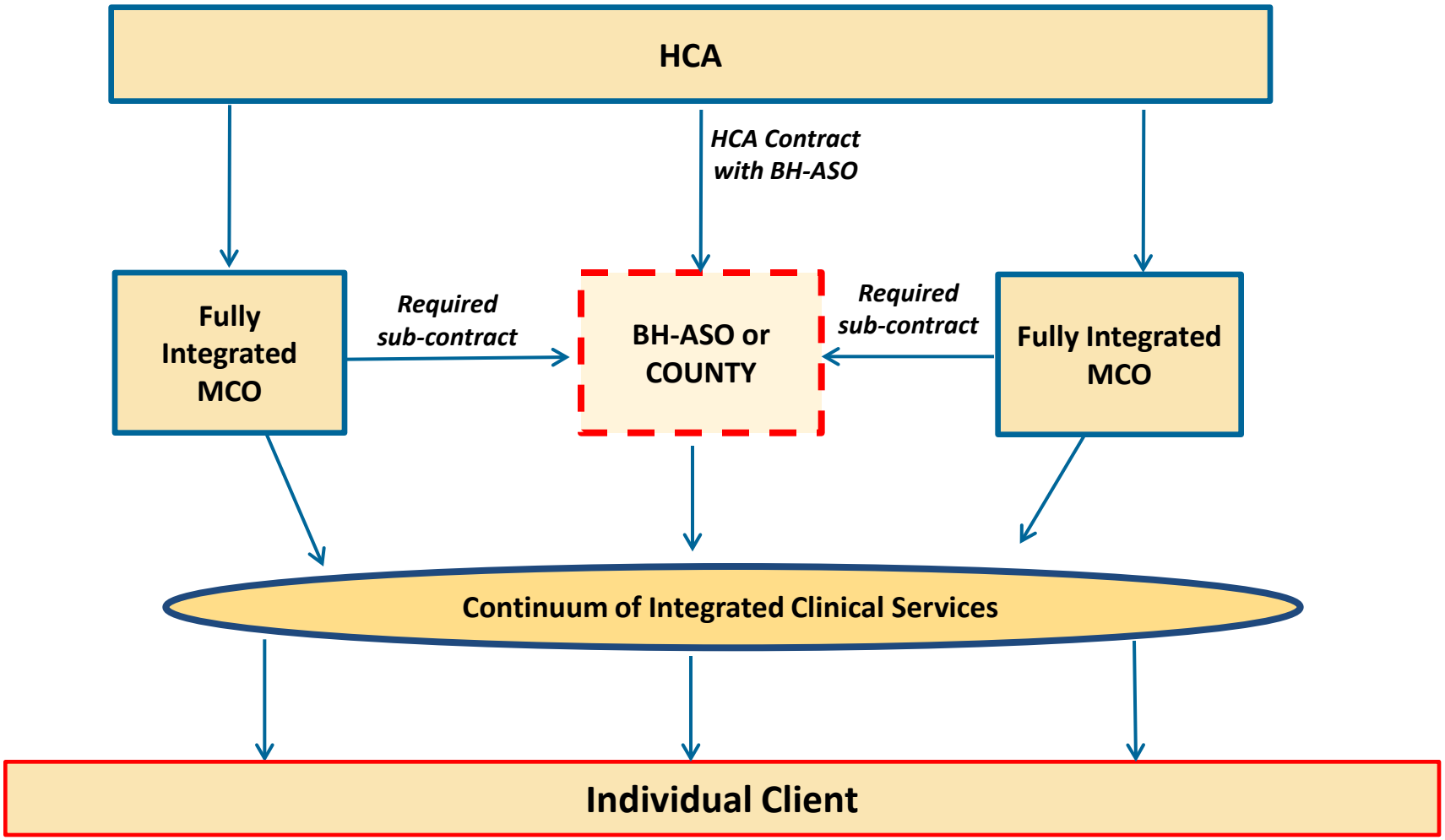
County-funded services for Medicaid and Non-Medicaid

Miscellaneous

- BH Ombudsman
- Committees formerly led by BHO (RSN) – WISe, CLIP, BH Advisory Board, etc.

Healthier WASHINGTON

How will the crisis system be managed?



Functions of the Crisis Organization

Maintain and Administer Crisis Services

- Maintain 24/7/365 regional crisis hotline
- Provide mental health crisis services, including mobile outreach team
- Administer MH Involuntary Treatment Act
- Administer Chemical Dependency Involuntary Commitment Act
  - Manage case finding, investigation and assessment activities, and legal proceeding for CD ITA cases
- Manage LRA orders for non-Medicaid clients

Manage SUD and Related Benefits

- Provide short-term substance use disorder crisis services to the publically intoxicated
- Administer the Substance Abuse Prevention and Treatment (SAPT) Block Grant Treatment Funds, in accordance with locally approved plans
- Provide SUD + MH services to individuals who are not eligible for Medicaid, within available funds

Provide Administrative and Financial Services and Support

- Operate Behavioral Health Ombudsman
- Manage the administration of the Mental Health Block Grant
- Manage the administration of the Criminal Justice Treatment Account (CJTA) funds and Juvenile Drug Court funds
- Manage the FYSPRT
- Administrative support for the local CLIP Committee

Western State Hospital – Organization in SW

- Southwest Washington bed allocation divided between Beacon, CHPW and Molina
  - Based on historical utilization patters, Beacon was allocated beds for “Non-Medicaid” individuals
  - Remaining beds were divided amongst CHPW/Molina based on proportion of enrollment
- If an organization goes over their bed allocation, they must pay an overage charge – same as BHOs
- SWWA is treated as a region with 40 beds for purposes of waitlist and entry – not divided by Beacon/CHPW/Molina, etc.
- Each entity has a hospital liaison which coordinates placements and discharge planning

Early Warning System and Measurement

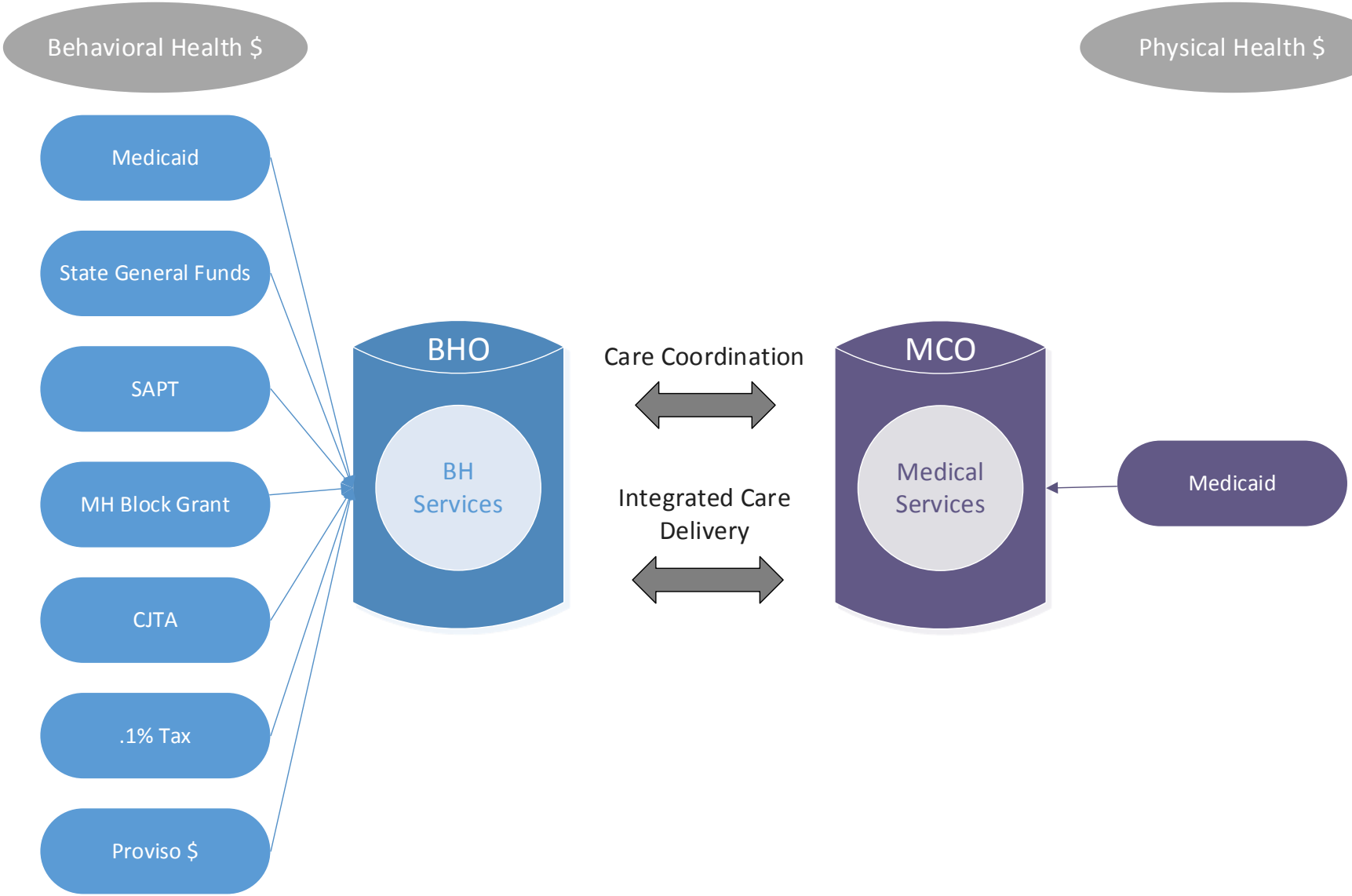
- Early Warning System
  - EWS Steering Committee
    - Accountable Community of Health role
  - Key Performance Indicators: claims payment/denial, WSH hospital beds, ED visits, grievances, crisis calls & detentions, etc.
  - Daily phone calls
- Common Measure Set – 1519/5732
- Commons BHO Measures
  - Alcohol or drug treatment penetration
  - Substance use disorder treatment initiation and engagement (Washington Circle version)
  - Mental Health treatment penetration
  - Psychiatric hospitalization readmission rate

Contact Information

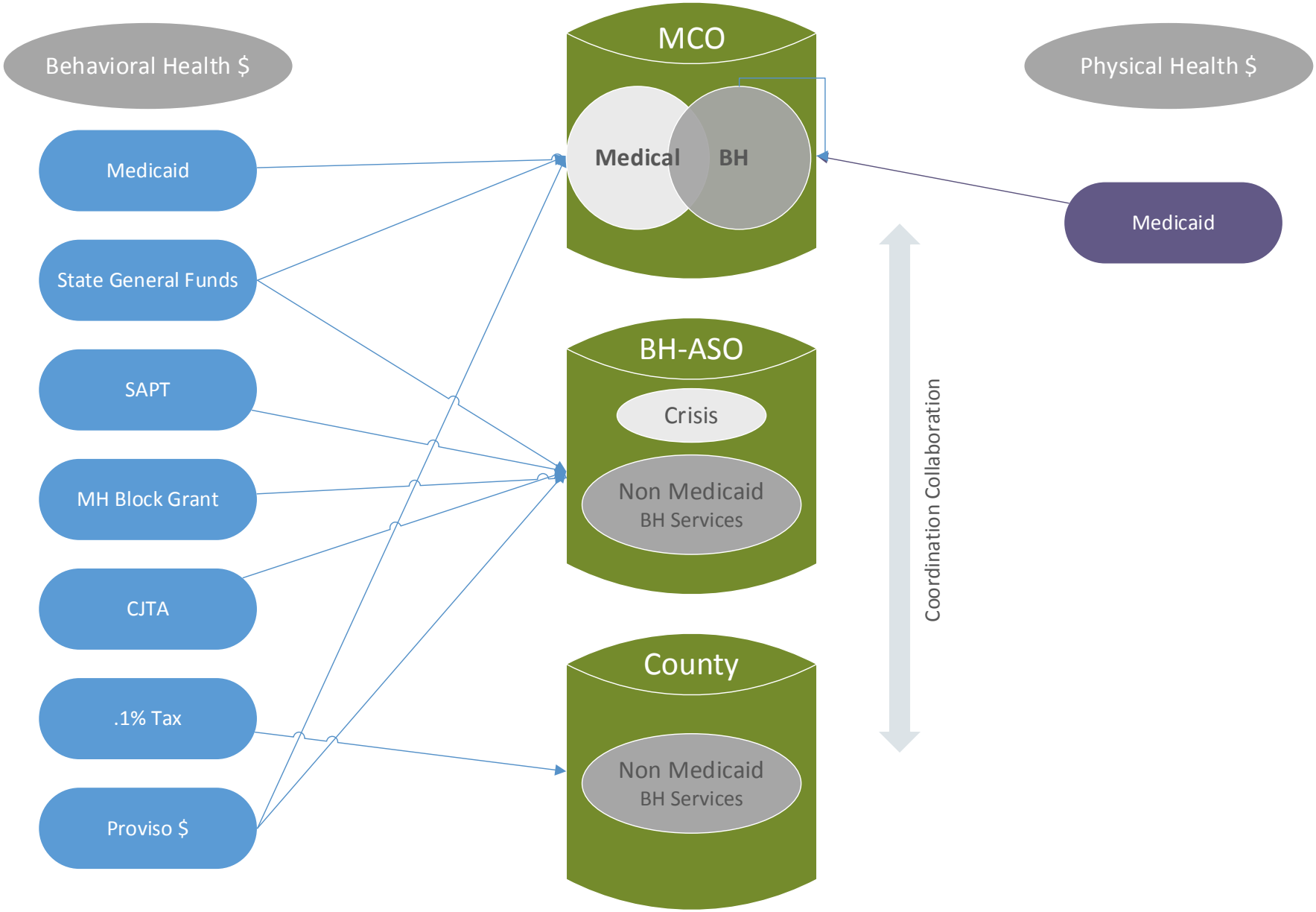
Isabel Jones:
Isabel.Jones@HCA.WA.GOV

Alice Lind:
Alice.Lind@HCA.WA.GOV

King County


Behavioral Health $
Physical Health $
Medicaid
State General Funds
SAPT
MH Block Grant
CJTA
.1% Tax
Proviso $
BHO
BH Services
Care Coordination
Integrated Care Delivery
MCO
Medical Services
Medicaid

Southwest Washington



CLINICAL MODEL CORE ELEMENTS

Tying the Core Clinical Elements to the Principles

Principles Categories	Core Elements	Implementation Examples (How we might do it) - subpopulations color coded	As Measured By….	When/Where/Why
The System is Client Centered and Promotes Equity				
The System Addresses Whole Person Needs Across the Continuum from Prevention to				
The System Promotes Value-Based Purchasing and Maximizing Resources				
The System Invests in the Infrastructure Necessary to Support the System				

INFRASTRUCTURE MODEL DISCUSSION

Proposed options for Fully Integrated Managed Care (FIMC) in the King County Region

MCO Lead Model	Public-Private Partnership Model	County Lead Model
General Concept: Designated MCOs have full risk and responsibility for continuum of physicl and behavioral health	**General Concept:** Collaborative partnership with governance structure and contractual arrangements that allow for risk and gain sharing	**General Concept:** King County has full risk and responsibility for continuum of physical and behavioral health care
County BHO goes away – King County government role is monitoring and assurance/oversight only (TAC Option 7)	**New entity is created in collaborative partnership between King County and MCO who co-lead and share risk/gain (TAC Option 5)**	**State contracts with King County for full physical and behavioral health for a specialty populations as one of multiple plans available in region (TAC Option 3)**
	New Option: County/MCO Partnership where money flows to one entity with shared governance and contractual mechanisms to support risk and gain sharing	

SWWA Early Adopter Progress Report for April 2016

By Vanessa Gaston, Director Clark County Community Services

Overall, implementation went fairly well with the exception of Provider One going down on April 1st but HCA had it up and running by the end of the day. HCA held daily calls to do check in with representatives from MCOs, Beacon Health Options, behavioral health providers and Counties. The calls even took place over the first weekend in April and then moved to week-days only. The MCOs and Beacon Health meet regularly with providers to work out issues for data collection and to problem solve client issues. The biggest system issues that needed to be addressed in April are listed below:

1. Communicating and working with CD residential providers outside of SWWA to accept people from Clark and Skamania Counties. HCA is working on setting up meetings with CD residential providers and will include the MCOs and Beacon Health to go over the Early Adopter process.
2. WSH admissions. HCA has met with DSHS, WSH staff, MCOs and Beacon Health however due to issues at WSH this remains an ongoing issue.
3. Interpreter services. HCA has a contract with CTS for statewide interpretation services. There were challenges with CTS having the capacity to provide interpreters for certain languages in SWWA. Outpatient providers are required to use CTS but HCA made an exception for crisis services and the Evaluation and Treatment Center. Recently, HCA worked with CTS to come up with a resolution. If CTS is not able to provide an interpreter, providers can schedule with another interpreter service and HCA will reimburse them.
4. State agencies such as Department of Corrections and DSHS not clear on SWWA model but HCA was able to quickly step in and clear up communication.
5. Changing of addresses in Provider One for people in CLIP, CD Residential, WSH, etc. causing problems for people returning to SWWA trying to access care because system shows they belong to another region. HCA and DSHS created a work group to work on this issue.
6. Protected Address issue. Clients enrolled in the statewide domestic violence program are responsible to "opt in" to FIMC by contacting HCA. This issue has caused a disruption in services for some people so it's important to establish good working relationships early on with the MCO Provider Contract Manager to get this particular issue resolved quickly for enrolled consumers.

Learning Lessons from County perspective:

1. Must educate and update County Boards about this process numerous times.
2. Must choose knowledgeable staff and allow time for them to participate in the planning.
3. Must include the providers and consumer representatives in the planning process.
4. BH-ASO must know behavioral health more specifically how crisis services operate.
5. Understand and address the differences in rural versus urban counties.
6. MCOs and BH-ASO must be strong collaborators and be flexible.
7. Spend the time upfront educating the community and other allied systems about the change.
8. Educate and communicate with State Legislators, HCA, DSHS and Governor's office regarding specific ideas for how to spend RSN/BHO reserves. Clear communication and specific detail is critical.

9. Must educate MCOs and BH-ASO about mental health and CD programs and payment models.
10. Must advocate for consumers and providers in this process.
11. MUST BE PATIENT – takes time to develop levels of care missing in community. Change takes time to implement.
12. Extremely helpful to have an implementation team with a "point person". This facilitates communication, completion of tasks and a streamlining of work.

Learning Lessons from Behavioral Health Provider perspective:

1. Depending on how the behavioral health network is set up for EHR and billing/data functionality the work is massive-even if providers have talented knowledgeable staff.
2. A proactive, humble, collaborative health plan really makes a difference-because providers have a choice to sign with more than one.
3. The process of changing is a ton of information (fire hydrant) and takes a lot of time at the administrative level.
4. MCOs are not interested in micro managing the network-if behavioral health providers have this dynamic now.
5. Treat the transition period very differently (minimal disruption/change/not a lot of new projects) than the aspirational goals which will come in the years after implementation. Bandwidth will be consumed too much to do both at the same time.
6. Develop healthy communication/feedback loops that are more network focused rather than individual provider agency focused so that big system problems are identified quickly and get in front of the right audience (HCA, MCOs, etc.)
7. Providers and MCO's should get clarity early on about fields needed on the 837 that are non-standard.
8. Providers and MCO's should get clarity early on regarding which services are state funded and would therefore require the non-encounter data set transmission. This makes a huge difference in terms of administrative burden for a provider that does not receive state funding. In the RSN system, the state funds were intertwined with some services unbeknownst to the provider and it continues to be a challenge to sort this out.
9. Address early on setting up non-encounter data transmission. This could potentially increase the administrative burden as compared to the RSN/BHO system.
10. Address issues with interpreter services early on to ensure that access to services is not disrupted due to interpreter access lacking for certain languages.
11. Given the amount of new information and unanticipated outcomes for everyone (MCO's, providers, consumers), a process similar to what SWWA developed is critical to address issues early on i.e. identifying who to contact for various issues, daily phone calls with all involved parties, consistent meetings with involved parties to address network-wide concerns, etc.
12. Finally, it's important to remember to celebrate minor victories as providers/MCOs work through the daily challenges.

beacon
health options

CRISIS SYSTEM
SWWA FIMC

June 2016

Who We Are

- A health improvement company that specializes in mental and emotional wellbeing and recovery
- A mission-driven company singularly focused on behavioral health
- Largest privately-held behavioral health company in the nation

beacon health options

We help people live their lives to the fullest potential.

Beacon – A National Company with a Local Presence

Role of the BH-ASO in Southwest Washington

1. Maintain the Crisis System

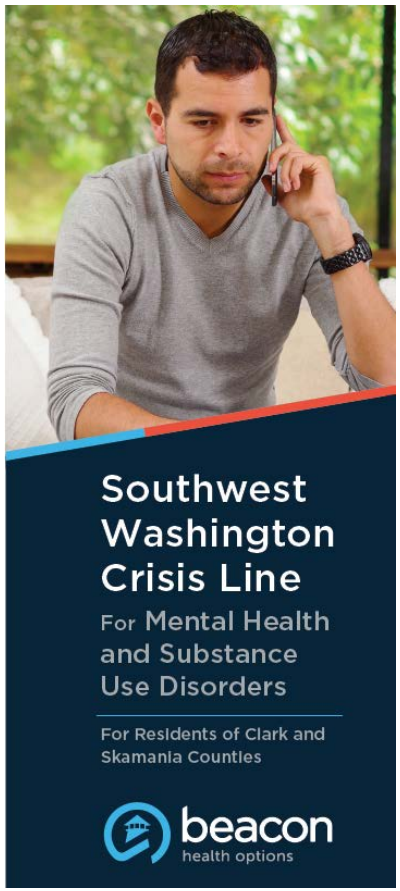
- Maintain 24/7/365 regional crisis hotline
- Provide mental health crisis services, including mobile outreach team
- Administer Involuntary Treatment Act for MH + SUD

2. SUD + MH services to the non-Medicaid population

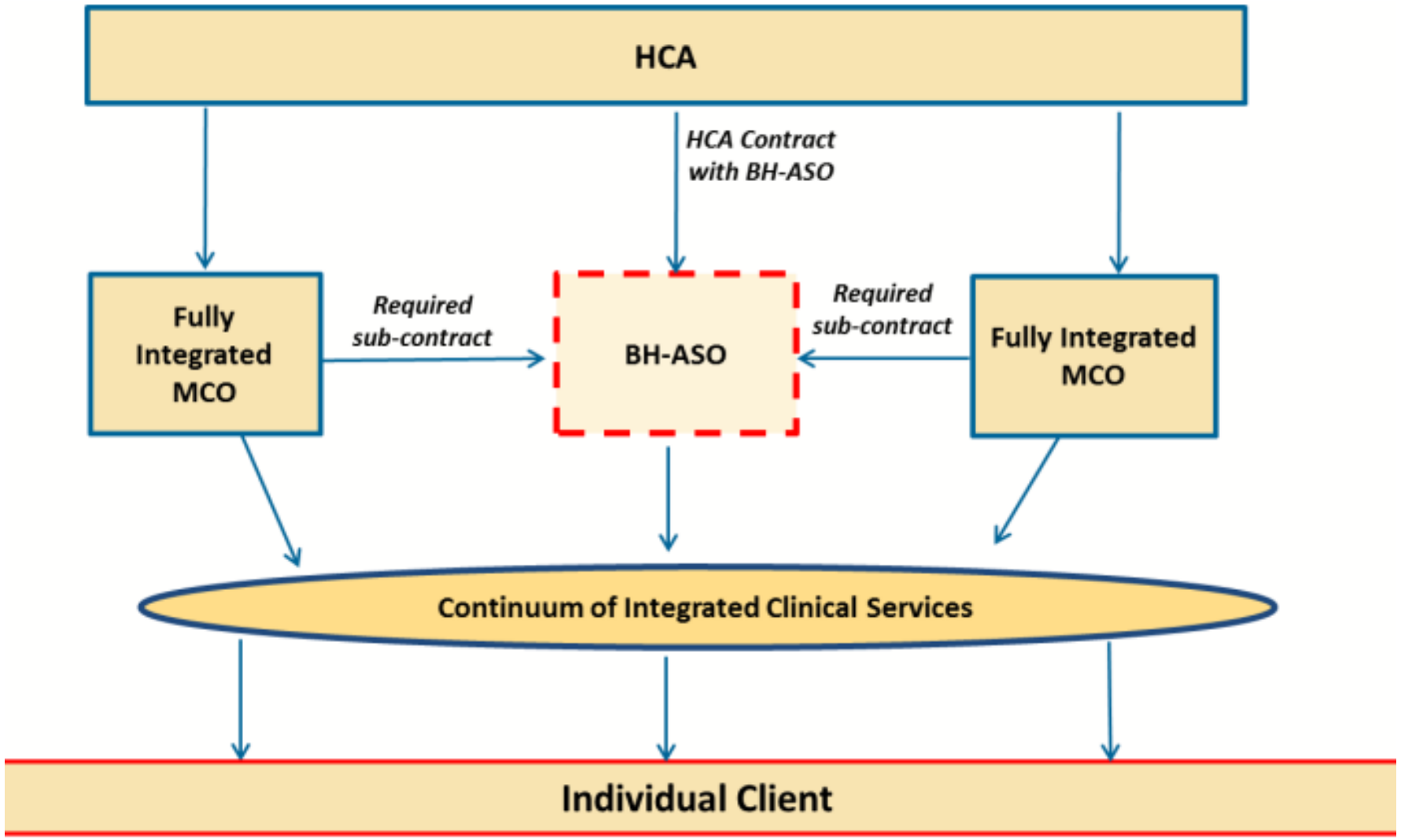
- Pay for inpatient and other discretionary OP services to non-Medicaid individuals with incomes less than 220% FPL
- Target these services to individuals who may be frequent users of the crisis system
- Provide care coordination to assist individuals in enrolling in Medicaid, when possible

3. Admin & Financial Services and Support

- Operate Behavioral Health Ombudsman
- Manage the administration of the Mental Health Block Grant (MHBG) and Substance use Prevention & Treatment (SAPT) BG
- Manage the administration of the Criminal Justice Treatment Account (CJTA) funds and Juvenile Drug Court funds



Role of the Behavioral Health ASO



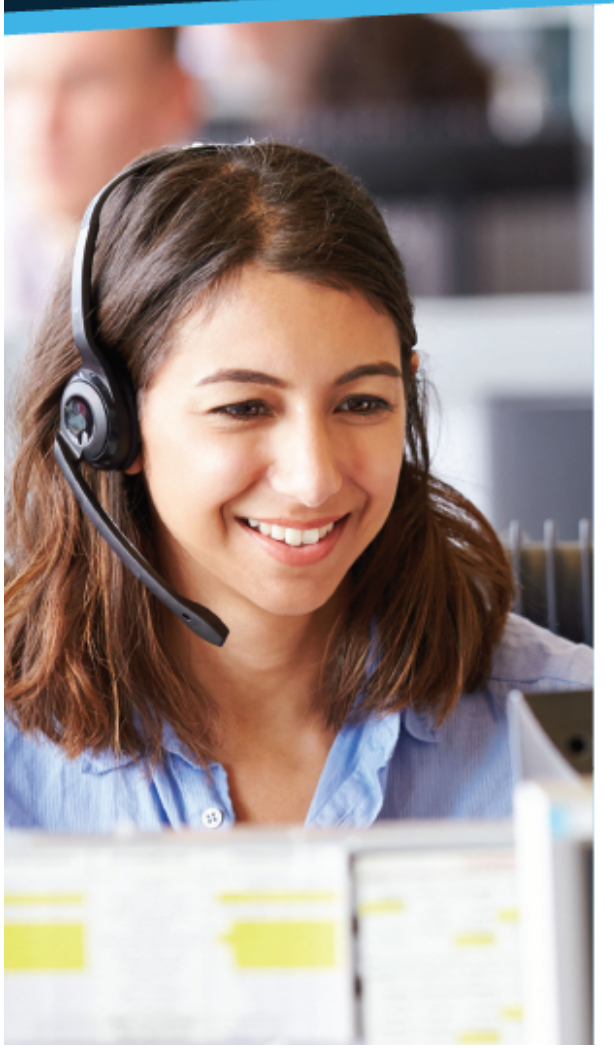
Design Considerations behind the BH-ASO

- Ensure equal and adequate access to crisis services for all individuals, regardless of insurance status
- Centralize certain functions, to ensure 1 hotline, 1 payer for DMHPS, 1 entity working with courts, FYSPRT, CLIP Committee, etc.
- Maximize MCO responsibility for Medicaid enrollees
- Formalized contractual relationship between MCOs/BH-ASO
- Maintain mechanism for continued provision of limited services to individuals who are not eligible for Medicaid
- Establish an entity that is responsible for non-Medicaid individuals who are in Western State Hospital, on the SW census
- Ensure local influence over block grant and CJTA funds is maintained
- Maximize independence of the ombudsman and centralize employment of ombuds
- Financial solvency of crisis organization

CRISES CAN HAPPEN AT ANY TIME.

If you or a loved one are having a mental health or substance use crisis, you can call and speak to a counselor.

The Southwest Washington Crisis Line is free. You can call 24 hours a day, 7 days a week.
(800) 626-8137 | TTY (866) 835-2755



The Crisis Line can help when you or a loved one is:

- Talking or thinking about harming or killing oneself or others
- Seeking access to firearms, pills, or other ways to kill oneself
- Talking or writing about death, dying, or killing oneself
- Feeling hopeless
- Very angry or looking for revenge
- Acting recklessly or doing risky activities
- Feeling trapped, like there's no way out
- Increasing alcohol or drug use
- Pulling away from friends and family
- Feeling worried or irritated
- Having trouble sleeping or sleeping all the time

Crisis Services Available to All Residents in Clark and Skamania County

- Professional counselors are available 24 hours a day, 7 days a week at **(800) 626-8137** to answer calls and connect you with behavioral health services.
- Mobile crisis outreach teams staffed by mental health professionals and certified peer counselors are also available 24-7.
- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public.

Beacon supports whole-person wellness. If you are an Apple Health (Medicaid) member, we will work with you and your provider to coordinate your behavioral health care with your physical health care. If you do not have health care insurance, Beacon will evaluate the services you are eligible to receive.

beacon health options

The Southwest Washington Crisis Line is free.

You can call 24 hours a day, 7 days a week

(800) 626-8137

TTY: (866) 835-2755

wa.beaconhealthoptions.com

Crisis System Mission and Purpose

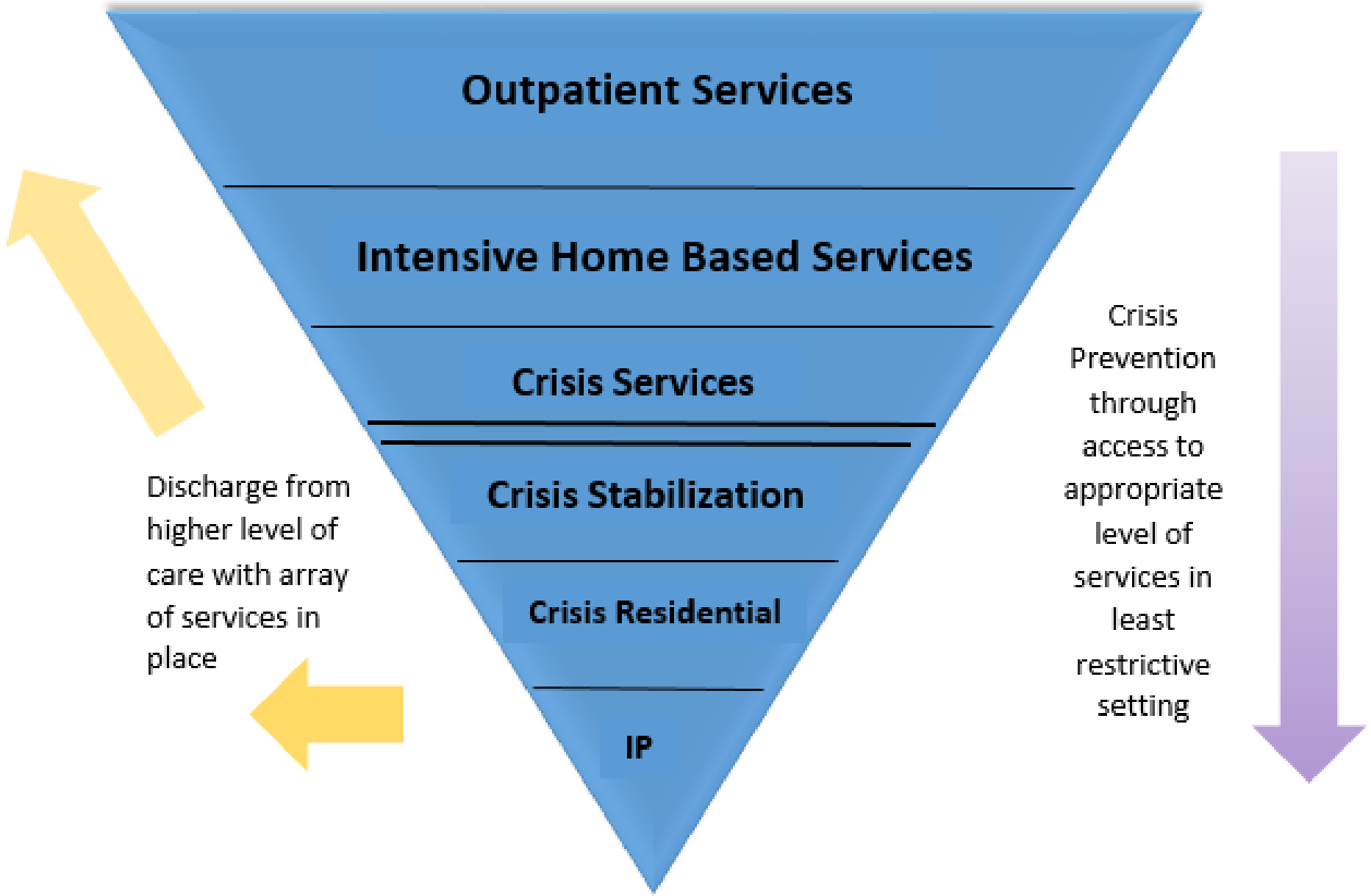
The Mission of Crisis System is to:

- Deliver high-quality, culturally competent, clinically and cost-effective, integrated community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, rehabilitation, and recovery.

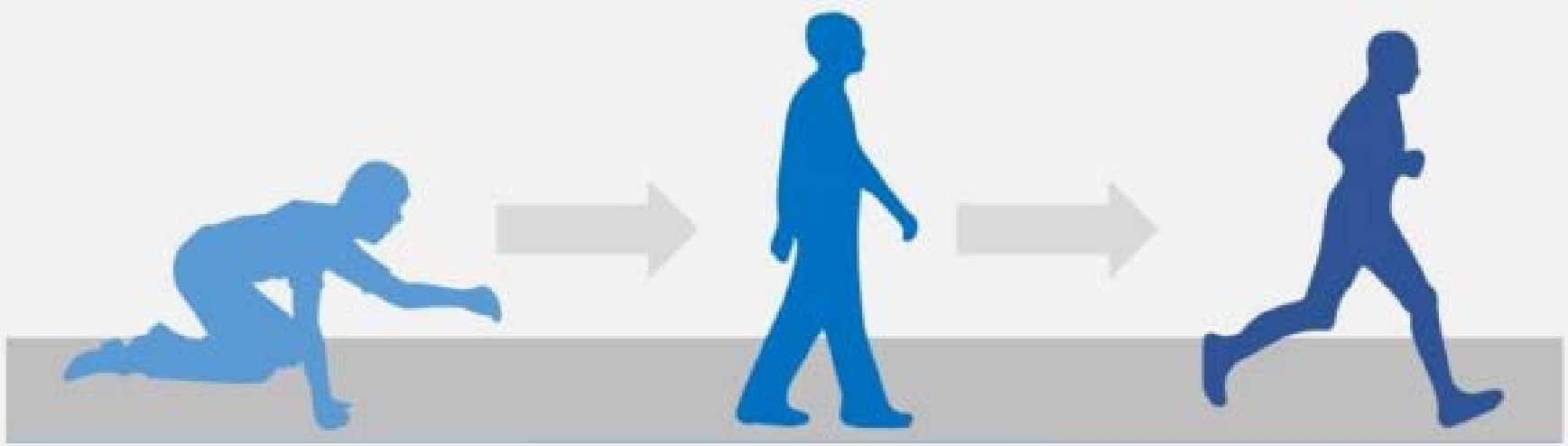
The Purpose of the Crisis System is to:

- Respond rapidly, Assess effectively, Deliver a course of treatment
- Promote recovery, ensure safety, and stabilize the crisis
- Facilitate access to other levels of care
- Offer community-based behavioral health emergency services in order to bring treatment to individuals in crisis, allow for individual choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery

Crisis Continuum of Care



System Development Approach: Crawl, Walk Run



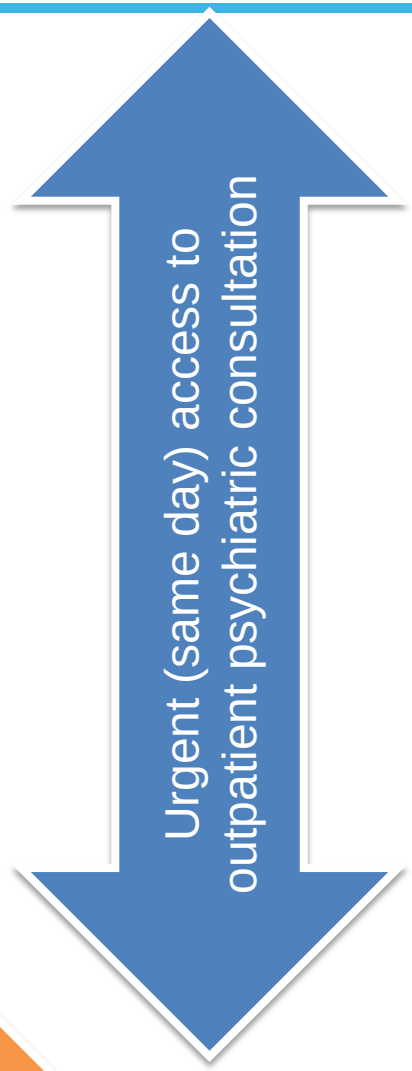
Phase 1: Go Live; ensure continuity

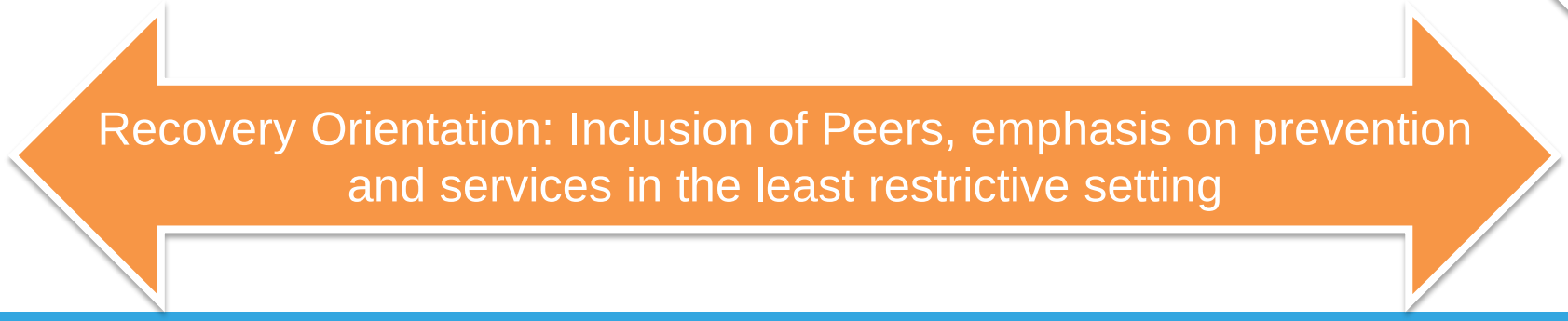
Phase 2: Short-term improvements

Phase 3: Long-term Improvements

Array of Crisis Services

- 24/7/265 Crisis hotline for telephonic counseling to prevent escalation and need for escalated services
- 24/7/265 Community-Based Hub to provide an alternative to hospital EDs for individuals seeking BH services
- Involuntary Treatment Act (ITA) Investigation & support (MH & SUD)
- Adult Mobile Crisis Intervention
- Child Mobile Crisis Intervention
- Adult Community Crisis Stabilization
- Respite services for consumers and/or family





Key metrics to be tracked

- **Proactive crisis planning**. Quarter over Quarter increase in number of crisis alerts created for SWWA residents with an emphasis on provider coordination for individuals who have a crisis episode.
- **Reductions in involuntary inpatient recidivism**. Track repeat users of the crisis system who end up inpatient and track diversion.
- Estimated **percentage of calls to the crisis hotline successfully diverted** from Emergency Rooms and/or ITA commitments.
- Outcome measures for mobile crisis that reflects the expectation for % of alerts they respond to in the community and the success diverting them away from the ED

Working Together

- The is a time of very exciting change across the Region
- **This Goal** is to increase access to community-based BH crisis encounters by developing community-based alternatives to hospital EDs and county crisis teams by changing referral pathways to and activation of alternative resources for crisis planning, intervention and stabilization
- To reach this goal, requires everyone working together

Lesson Learned so far in SWWA

1. Must include the providers in the planning process
2. Understand and address the differences in rural versus urban counties
3. BH-ASO must be a strong collaborator
4. Spend the time upfront and ongoing educating the community and other allied systems about the change
5. Health care is local: having local staff is important
6. Ongoing HCA involvement and responsiveness, willingness to be at the table as concerns came up
7. Education and iteration as understanding of behavioral health and crisis system evolves
8. MUST BE PATIENT – takes time to develop levels of care missing in community