Behavioral Health and Recovery Division (BHRD)
Provider Manual

For the King County Integrated Care Network (KCICN), Behavioral Health Administrative Services Organization (BH-ASO), and Locally-Funded Programs

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1 Introduction

King County provides behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the Health Care Authority, Washington State Administration Codes (WAC), and Center for Medicare and Medicaid Services (CMS) and contracted Managed Care Organizations (MCOs).

King County provides management and administration of all behavioral health services through the Department of Community and Human Services (DCHS) via the Behavioral Health and Recovery Division (BHRD). Management and/or administration of services is then separated by funding source. Generally, services funded by Medicaid/Apple Health are managed by the King County Integrated Care Network. King County Crisis Services and programs funded by federal and state grants are managed by the Behavioral Health Administrative Services Organization (BH-ASO). All locally-funded behavioral health services including MIDD Behavioral Health Sales Tax initiatives, grants, and city- and county-funded programs are managed directly by BHRD. See attachment *King County Behavioral Health Structure* in this section for a visual guide to the behavioral healthcare system.

When requirements cross between all three programs, the management/administrative entity is referred to as BHRD. When services are specific to a particular funding stream and payer, the entities is referred to by either the specific payer or the administrative bodies identified above.

The Administrative Services Agreement between the MCOs and King County designates King County as the Managed Behavioral Healthcare Organization engaged in the business of arranging for and managing certain mental health and substance abuse services on behalf of MCO members through its network of behavioral health providers (King County Integrated Care Network – KCICN).

Specifically, the MCO members served under the agreements with the MCOs are those that meet medical necessity for high acuity mental health services and substance abuse services. The MCO members are assessed using behavioral health level of care tools: Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS) and/or American Society of Addiction Medicine (ASAM) criteria. MCO members score a minimum of 10 on the LOCUS or CALOCUS and/or at least .5 on ASAM.

Currently, MCO members who score less than 10 on the LOCUS or CALOCUS are not served under the agreements with the MCOs – these services and/or population in Washington have traditionally been referred to as “mild/moderate.”

Attachments in this Section:

- Attachment A: King County Behavioral Health Structure

1.1 Mission

The mission of Behavioral Health and Recovery Division (BHRD) is to provide quality, comprehensive, age and culturally-responsive inpatient and outpatient mental health and/or substance use disorder prevention, treatment, and supportive services to individuals with mental illness or substance use disorders, including those with co-occurring disorders. BHRD is committed to providing a seamless, integrated system of services delivered from a recovery and trauma-informed orientation, which promotes resiliency through a comprehensive array of flexible services that will enable individuals to live, work, learn, and fully participate in our society.

1.2 Goal

The goal of Behavioral Health and Recovery Division (BHRD), in partnership with the King County health community, is to set policy and provide funding to ensure the provision of the highest quality services and supports that promote behavioral health recovery and resiliency.

1.3 Guiding Principles

Behavioral Health and Recovery Division (BHRD) is committed to the development of a comprehensive, recovery-oriented, and trauma-informed system of care, tailored to meet individual needs and goals. The guiding principles of such a system are consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) working definition of recovery:

- Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery:
  - Emerges from hope;
  - Is individual-driven;
  - Occurs via many pathways;
  - Is holistic;
  - Is supported by peers and allies;
  - Is supported through relationship and social networks;
  - Is culturally-based and influenced;
  - Is supported by addressing trauma;
  - Involves individual, family and community strengths and responsibility; and
  - Is based on respect.
- For additional detail: SAMHSA
- BHRD ensures that the service delivery system provides equitable access and competent care to the culturally and ethnically diverse residents of King County.
- BHRD values the strengths and assets of clients, their families, and significant others, and seeks to include their participation in decision-making, policy setting, and the development of services and systems.
- BHRD ensures clinical service quality that is based on scientific research, nationally recognized standards of care for specific behavioral health disorders and is focused on recovery and resiliency.
- BHRD works in partnership with allied system providers to deliver quality-individualized services, supports and outcomes.
- BHRD is accountable to the public, including individuals receiving care, to ensure that resources are carefully managed to provide the highest quality services to a clearly defined eligible population.
- BHRD is committed to establishing and maintaining a network of providers who best meet the needs of the community we serve. Providers and potential providers can access general DCHS Contract Requirements here:

1.4 Behavioral Health and Recovery Division (BHRD) General Requirements

1.4.1 Changes in Capacity

The Provider notifies BHRD of any other changes in capacity that results in the Provider being unable to meet any of the access standards. Events that affect capacity include, but are not limited to: a decrease in the number, frequency, or type of a required service to be provided, employee strike or other work stoppage related to union activities; or any changes that result in the Provider being unable to provide timely, medically necessary services. This includes planned and unplanned closures.

General Requirements

Prior to any public announcement of any site or service changes, the Provider notifies their BHRD Provider Relations/Contract Specialist in writing.

Providers have internal procedures, available for review and approval by BHRD that address minimum requirements for client care in the event of either a planned or an emergency office closure.

Providers ensure the following are available:

- 24-hour crisis response for authorized clients if required by contract;
- Client and network notification procedures including;
    - Answering machine message and website notification regarding the closure;

  and

    - Specific network instructions on procedures related to unplanned closures due to disaster, inclement weather, etc., and how to reach on-call staff (telephone and pager numbers).

The Provider submits additions to the Annual Closure Dates Report and capacity changes to Crisis Connections, BHRD Crisis and Commitment Services (CCS), and Provider Relations/Contract Specialist prior to any closures.

The Provider refers clients to the BHRD client services line as needed and states the following:

> *"If you need assistance with connecting to another behavioral health provider, please call the King County Client Services Line at 206-263-8997, Monday to Friday from 8am to 5 pm."*

Temporary/Unplanned Capacity Changes and Closures:

For temporary unplanned closures due to disaster, inclement weather, etc., the Provider ensures the following:

- At least three agency staff are trained as Command Center Specialists, as defined by Seattle King County Public Health, in the WATrac Resource Management System; and
- Command Center Specialists provide ongoing communications related to the agency's capacities and up-to-date information on the Provider's status is in the WATrac Resource Management System.

In addition to the General Requirements above, for temporary unplanned capacity changes and/or closures less than 14 days:

- The Provider emails their Provider Relations/Contract Specialist on or before the day of the unplanned closure to indicate the date(s) and reason(s) for the closure.
- The Provider updates the agency Vendor Profile Application within 24 hours to reflect this temporary capacity change. Instructions on how to update the Vendor Profile are located in the ISAC Notebook.

In addition to the General Requirements above, for temporary unplanned capacity changes and/or closures more than 14 days:

- The Provider emails their Provider Relations/Contract Specialist before the closure to indicate the date(s) and reason(s) for the closure. The Provider includes additional information as requested.
- The Provider updates the agency Vendor Profile Application within 24 hours to reflect this temporary capacity change. Instructions on how to update the Vendor Profile are located in the ISAC Notebook
- The Provider notifies their Provider Relations/Contract Specialist at least 30 days prior to any change that would significantly affect the delivery of or payment for services provided, including changes in tax identification numbers, billing addresses or practice locations.

Permanent Closures:

In addition to the General Requirements above, the Provider notifies their Provider Relations/Contract Specialist at least 120 days prior to closing a site, or as soon as possible if closing more urgently.

If any of the above events occur, the Provider submits a plan to BHRD and if requested, meet with BHRD to review the plan at least 30 business days prior to the event. The plan should include the following:

- Notification of service/site change;
- Client notification and communication plan;
- Plan for provision of uninterrupted services by client; and
- Plan for provision of uninterrupted services; and
- Any information that will be released to the media.

Adding New Sites:

The Provider notifies their Provider Relations/Contract Specialist 120 days prior to opening any additional site(s) providing services.

The Provider completes the credentialing requirements for the new site.

Attachments in this Section

Attachment B: Changes in Capacity Notification Form

1.4.2 Client Property

The Provider ensures that any adult client receiving services from the Provider has unrestricted access to their personal property, unless otherwise specified. The Provider does not interfere with any adult client's ownership, possession, or use of their property. The Provider provides clients under age 18 with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon discharging from services, the client or client's guardian/custodian promptly receives all of the client's personal property. This does not prohibit the Provider from implementing such lawful and reasonable policies, procedures, and practices as the Provider deems necessary for safe, appropriate, and effective service delivery (e.g., appropriately restricting client access to, or possession or use of, lawful or unlawful weapons and/or drugs).

1.4.3 County Vehicles

The Provider maintains insurance coverage on the vehicle and drivers that will indemnify the County from any and all claims arising from the operation and/or use of the vehicle. A copy of the vehicle registration and proof of insurance must be kept in the vehicle. The Provider's insurance also provides

for the replacement or repair of the vehicle in the event that the vehicle is rendered inoperable or stolen during the course of possession by the Provider.

The Provider ensures that the vehicle is regularly maintained in a manner consistent with the manufacturer's recommendations and that complete maintenance records are kept. All vehicle operation costs, including but not limited to fuel, maintenance, and repair are the responsibility of the Provider. Vehicle maintenance records and County access to the vehicle for inspection are provided within three business days following notification by the County.

The Provider ensures the vehicle is operated by individuals who are trained in its operation, have a valid and current Washington State Driver's License with appropriate endorsements for its use, and that the vehicle is operated in a safe manner at all times in compliance with the laws of the State of Washington.

The Provider ensures the security of the vehicle at all times, even when not in use or in the possession of a Provider employee. In the event the vehicle is stolen, the Provider files a police report and notify BHRD within one business day.

The Provider notifies the County within one business day of any accident involving the vehicle, damage to the vehicle, personal injury or of any repairs to the vehicle in excess of $250.

The Provider is responsible for any fines resulting from violations of State or local laws pertaining to the operation of the vehicle. The County license plate on this vehicle does not authorize illegal parking.

At the request of the County, the Provider returns the vehicle to the County at the end of any Provider contract period in which contract renewal is not intended by the County. In such cases, the vehicle is returned in a condition reasonable to its age and mileage. The registered ownership of the vehicle remains with King County.

1.4.4 Credentialing

Initial Contracting and Credentialing

Providers are subcontractors are credentialed prior to inclusion in the network. Providers or Subcontractors that elect not to participate in the credentialing process are not eligible to contract with BHRD.

A complete application packet includes:

- A copy of appropriate licensure;
- A copy of applicable accreditation certificate from the accrediting organization (i.e. CARF, JACHO, NCQA, etc.).
- Verification of current insurance coverage;
- Current staff roster;
- Current board list;
- Ownership and control disclosure statement;
- Debarment attestation;
- Documentation of any moral objections/restrictions in regard to the care provided, if applicable;
- A copy of the contract or agreement between a Provider and any Subcontractor(s); and

- Any relevant policies and procedures regarding BHRD requirements identified for the specific credentialing period.

Ongoing Contracting and Credentialing

Providers will:

- Hold a current license from the Department of Social and Health Services (DSHS), which covers the services to be provided.
- Notify BHRD of any changes in status for any required licensure or certification; and
- Provide copies of its current professional liability insurance
- Maintain appropriate licensure and board eligibility and certification
- Ensure at hire and, at minimum, annually, that staff credentials for their position are up-to-date.

Credentialing and Re-Credentialing

Contracting and credentialing requirements may be amended over time and currently credentialed Providers and Subcontractors may be required to update their standards or provide additional information.

Providers and subcontractors are credentialed at the following intervals:

- Prior to inclusion in the network
- Monthly: The Provider or Subcontractor are verified monthly by the Office of the Inspector General (OIG)/Federal System for Award Management (SAM)/Washington Medicaid Exclusion List;
- Quarterly: Providers submit quarterly reports to update their credentialing information: Quarterly Update Packet
- Every 36 months.

Review and Site Visit

BHRD conducts periodic reviews with Providers in the following areas:

- Administrative
- Clinical Record
- Facility
- Encounter Data Validation (EDV)

For case-specific follow-up, BHRD may schedule a review. Providers respond to any items where an improvement or correction action plan (IP/CAP) is required within 30 days of receipt of the site visit report.

1.5 Behavioral Health Administrative Services Organization (BH-ASO) Policies and Procedures

As King County maintains a direct contract with the HealthCare Authority (HCA) for all services falling under the Behavioral Health Administrative Services Organization (BH-ASO) management, this body of work has its own policies and procedures. Providers can identify which contracted programs fall under the BH-ASO by *Exhibit 5: KCICN BH-ASO Schedule of Services* in their contract package. BH-ASO Policies and Procedures are located in Appendix A.

1.6 Reporting Requirements Across All Programs

All programs must submit the following reports:

Frequency	Report	Report Requirements	Frequency/ Schedule	Dollars at Risk (Per Each Due Date)	Program
Monthly	Data Certification Letter (Data Attestation)	Provider submits the certification letter.	Monthly	N/A	KCICN
Quarterly	Third Party Payment Report	Third Party Payments collected by category of payment (e.g., private pay, insurance, Medicare). Providers submit Third Party reports for all Medicaid programs (MH & SUD outpatient, MAT, residential). Program payments can be combined, with the exception of MAT which needs to be on a separate report.	• January 31 • April 30 • July 31 • October 31	N/A	KCICN (MH, SUD and MAT outpatient only)
Quarterly	Clinician Roster	All programs providing Medicaid-funded services must submit the following quarterly reports: A Clinician Roster in a report format provided by BHRD to include, but not limited to, a complete list of providing clinicians, licensure information, specialty training, etc.	• March 6 • June 7 • September 6 • December 6	N/A	KCICN
Quarterly	Contractor Profile Update	Provider submits up-to date Contractor profiles and licenses	• January 31 • April 30 • July 31 • October 31	N/A	KCICN, BH-ASO

Frequency	Report	Report Requirements	Frequency/ Schedule	Dollars at Risk (Per Each Due Date)	Program
Annual	Audited Financial Statements	Complete audited financial statements with auditor's opinion, management letter, and A-133 audit where federal funding threshold is met.	30 days after received by Provider no later than 9 months after end of fiscal period.	N/A	KCICN, BH-ASO
Annual	Closure Dates Report	All Providers submit to BHRD an annual planned closure schedule.	January 31	N/A	KCICN, BH-ASO
Annual	Disaster Recovery Business Continuity (DRBC) Attestation	All Providers submit to BHRD a DRBC Attestation of: • Required elements of the agencies DRBC program • Annual test of Information System (IS) system for data back-up and recovery	January 31	N/A	KCIN-BH-ASO
Annual	Disaster Recovery Business Continuity (DRBC) Plan	All Providers submit to BHRD a DRBC Plan that includes the following elements: • Mission or scope statement • IS disaster recovery person(s) • Provisions for back-up of key personnel, emergency procedures, and emergency telephone numbers • Procedures for effective communication, applications inventory and business recovery priorities • Documentation of updated system and	January 31	N/A	KCICN, BH-ASO

Frequency	Report	Report Requirements	Frequency/ Schedule	Dollars at Risk (Per Each Due Date)	Program
		operations, and process for frequent back-up of IS and data • Off-site storage of system and data back-ups, and ability to recover data and systems from back-up files. • Designated recovery options • Evidence that disaster recovery tests or drills have been performed.			
Other	Client Success Stories	One or more brief summaries of sample of client success stories accompanied by a release of information as provided by BHRD. No identifying information should be included. These summaries may be used in various public education venues.	Upon Request	N/A	KCICN, BH-ASO

1.7 Financial Policies, Funding-Specific Requirements, and Invoices

Behavioral Health and Recovery Division (BHRD) staff have provided every agency with a "Funding Overview" to assist agencies in identifying funding sources for each program. If a program receives funding with specialized requirements, an agency follows those funding-specific requirements. Location of the program descriptions within this Provider manual does not indicate the program does not need to follow funding-specific requirements. Additionally, some specific funding instructions are located on the invoices for each program.

Provider invoices and reports templates are located here:

Provider Invoices and Reporting Requirements

1.7.1 Federal Funds

A billing invoice package (BIP) for scopes that use Federal Funds received 30 days or more after the service month may not be accepted for payment.

Per federal block grant requirements, Providers verify income changes and Medicaid status for all clients each day a service is provided. If a client's funding status has changed, the agency will have a process in place on how to address any changes and assist the client to access Medicaid if they are eligible but not currently enrolled.

Coordination of Other Resources

1.7.2 Third Party Benefits

Providers retain any third-party reimbursement (Medicare and private insurance) they collect on authorized clients. For that reason, the case rate includes a coordination of benefits discount.

Providers develop policies and procedures to aggressively pursue collection and documentation of all third-party benefits. Providers utilize separate coding in their accounting system to clearly segregate third-party payments from other payments.

1.7.3 First-Party (Private Pay) Payments by Non-Medicaid Clients

Providers implement a sliding fee scale according to Revised Code of Washington (RCW) 71.24.215. In developing sliding fee schedules, Providers comply with the following:

- Put the sliding fee schedule into writing that is non-discriminatory;
- Include language in the sliding fee schedule that no individual will be denied services due to inability to pay;
- Provide signage and information to clients to educate them on the sliding fee schedule;
- Protect clients' privacy in assessing client fees
- Maintains records to account for each client's visit and any changes incurred;
- Charge clients at or below one hundred percent (100%) of the Federal Poverty Level (FPL), a nominal fee, or no fee at all.
- Develop at least three (3) incremental amounts on the sliding fee scale for clients between one hundred one to two hundred and twenty percent (101%-220%) of the FPL.

Funds collected from a client without Medicaid must be refunded if the client subsequently receives retrospective Medicaid coverage.

Services funded by Behavioral Health Administrative Services Organization (BH-ASO) may not be withheld by a Provider due to the failure of a client without Medicaid to make a first party payment.

1.7.4 First-Party Payments by Medicaid Clients

Providers (and subcontractors) do not collect first-party payments from Medicaid clients for any Medicaid covered services, even if King County Integrated Care Network (KCICN) fails to provide payment. A Medicaid client cannot be held liable for any Medicaid-covered service in the event of:

- The KCICN's insolvency;
- The failure of any state contracted MCO to pay its subcontracted obligation to KCICN;

- KCICN's failure to pay a Provider;
- A Provider's failure to pay a subcontractor;
- The cost of a service provided on referral by KCICN to an out-of-network Provider exceeds what Behavioral Health Administrative Services Organization (BH-ASO) would cover if provided within the KCICN Provider network; or
- A community psychiatric hospital's insolvency.

Upon approval by KCICN (who has been delegated the responsibility for payment by the Apple Health plan), Providers may collect first-party payment from a Medicaid client:

- For covered services if services are provided pending a client-initiated appeal of an adverse authorization decision and the client loses the appeal; and
- For non-covered services if the requirements of Washington Administrative Code (WAC) 182-502-0160 or its successor are met and, prior to the provision of services, KCICN has made a written determination that KCICN does not cover these services. Inquiries should be directed to the BHRD Fraud, Waste, and Abuse Compliance Officer.

Providers are required, per Medicaid rules, to refund to Medicaid-enrolled clients any first-party payments made by the client to the Provider during any period the client had a KCICN benefit.

Under no circumstances may a publicly funded client be billed for a failure to keep a scheduled appointment.

Providers develop policies and procedures to aggressively pursue collection and documentation of all third-party benefits. Providers utilize separate coding in their accounting system to clearly segregate third-party payments from other payments.

1.7.5 Residential Administrative Daily Bed Rate Requests

The residential administrative bed daily rate is available for a limited time when a client no longer meets medical necessity and is unable to be discharged from the facility to an appropriate placement. This rate applies to all residential programs and includes both Medicaid and non-Medicaid. The residential administrative daily bed rate is 21% of the current bed rate and does not include room and board.

Substance Use Disorder:
To request a Withdrawal Management administrative bed daily rate, submit a "Continued Stay Request for Withdrawal Management" to Resauth@kingcounty.gov or fax to 206-205-1634.

To request a Substance Use Disorder residential administrative bed daily rate, submit a "Continued Stay Request for SUD Residential" to Resauth@kingcounty.gov or fax to 206-205-1634.

MH:
To request a MH residential administrative daily bed rate, submit a Continuing Stay Review request indicating the current level of need to the BHRD Mental Health Residential Utilization Management Supervisor. The Provider is informed within 14 days whether the request is approved or denied.

In addition, the MH residential admin rate is applied when an agency requests a continuing stay for Long Term Residential (LTR) or Intensive Step-Down (ISD) and is denied. These requests are processed by the BHRD Hospital and Mental Health Residential Utilization Management Team.

Once a SUD or MH residential admin request is approved, the Provider documents the admin day on the monthly census report and corresponding invoice.

1.7.6 Spenddown

Provider responsibility regarding spenddown and Medicaid Coverage:

- Providers are expected to actively work with clients on spenddown so that the clients may regain their Medicaid coverage as soon as possible.
- Providers may use their daily rate for services to meet a client's Medicaid spenddown requirements.

1.8 Information System Management

Requirements for collecting, maintaining, and reporting client and service data to support the administrative operation, management decisions, clinical operations, utilization analysis, and system performance of Behavioral Health and Recovery Division (BHRD) can be under Information Management on the Information for Providers page here.

1.9 Program Integrity

Providers that make or receive $5 million or more in Medicaid payments in a preceding federal fiscal year must establish and adopt written policies about the False Claims Act and other provisions named in section 1902(a)(68) of the Social Security Act for all its employees, contractors, and agents (Attachments B-1 and B-2).

Future determinations regarding a Provider's responsibility for this requirement will be made by January 1 of each subsequent year based on payments either received or made in the preceding federal fiscal year.

If the Provider furnishes services at more than a single location or under more than one contract, these provisions apply if the aggregate payments to the Provider meet the $5 million threshold. This applies whether the Provider uses one or more Provider identification or tax identification numbers.

Regardless of Medicaid revenue, all Providers must develop and distribute to employees and subcontractors written standards of conduct and policies and procedures that provide:

- Detailed provisions for detecting and preventing fraud, waste, and abuse that include the following elements:
  - A statement of the Provider's commitment to comply with all applicable federal and state standards.
  - Designation of a compliance officer and a compliance committee that is accountable to senior management.
  - Provision of effective ongoing training and education for the compliance officer and staff of the Provider.
  - Facilitation of effective communication between the compliance officer and the Provider's employees.
  - A process to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation.
  - Enforcement of standards through well-publicized disciplinary guidelines.
  - Provision for internal monitoring and auditing.
  - Provision for prompt response to detected offenses and for development of corrective action initiatives.

  - Reporting of fraud, waste, or abuse information to Behavioral Health and Recovery Division (BHRD) as soon as it is discovered, to include the source of the complaint, the involved employee or subcontractor, the nature of the fraud, waste, or abuse complaint, the approximate dollars involved, and the legal and administrative disposition of the case.
- Detailed information about the False Claims Act established under sections 3729 through 3722 of title 31 United States Code (USC) (Attachment B-1).
- Detailed information about administrative remedies for false claims and statements established under chapter 38 of title 31 USC (Attachment B-2).
- State laws pertaining to civil or criminal penalties for false claims and statements (Attachment B-4).
- Whistleblower protections under such laws with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (Attachment B-4).

The Provider is prohibited from using Medicaid funds to pay for goods and services furnished, ordered, or prescribed by excluded individuals and/or entities.

The Provider must include in any employee handbook for the Provider, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. The Provider need not create an employee handbook if none already exists.

1.10 Client Rights

Providers ensure clients and individuals:

- Are fully informed about available services;
- Are made aware of their rights and that these rights are protected;
- Are provided an opportunity to complete or modify an advance directive at any time;
- Can access information, referral, and advocacy services from Behavioral Health and Recovery Division (BHRD) Client Assistance Services;
- Can access assistance from an independent Advocacy Service;
- Can file a grievance and receive assistance during the resolution process;
- Are aware of their right to file an appeal in the event of an adverse action and receive assistance during the resolution process.

At the time of the intake evaluation, and as needed thereafter, inform of the availability on-line and offer a copy of the following information in the client's language of choice:

	Medicaid Enrollee	Client or Individual served by BH-ASO or Locally funded services
Medicaid Client Rights See: Apple Health Client Booklets	✓	
Notice of Privacy Practices See: Chapter 1 Attachment B	✓	✓
BH-ASO Individual and Client Rights See Chapter 1 Attachment C		✓
The BH-ASO Grievance and Appeal Process See Chapter 1 Attachment D		✓

Providers ensure clients are able to understand the information provided to them, including clients with communication barriers or sensory impairments. This includes the following:

- Providers post a multilingual notice in each of the DSHS prevalent languages that advises clients that information is available in other languages and how to access this information.
- Information in an individual or client's primary language, when interpretation is needed for adequate understanding between the client and the Provider for interactions including but not limited to:
  - Customer Service
  - All appointments for any covered service,
  - Crisis services, and
  - All steps necessary to file a grievance or appeal.
- Access free of charge for:
  - Interpreters who are qualified and objective and not family members or friends, and
  - Persons who are proficient in the use of Text Telephone (TTY)/Telecommunication Device for the Deaf (TDD) or alternate communication devices or languages (e.g. American Sign Language) to serve persons who are deaf or hard of hearing.
  - Information in language that is appropriate for the client's level of education (for written documents, no more than a 6th grade reading level whenever possible).
  - Written notifications and BHRD publications. These are available in alternative formats, such as audiotape, Braille, large print or audio files and may be accessed upon request.

- Providers ensure availability of translated materials for applications for services and consent forms, as well as all other publications or information in the following languages established by the HCA:
  - Chinese
  - Korean
  - Somali
  - Russian
  - Spanish
  - Vietnamese
- If the client's primary language is other than English, but the client can understand English and prefers to receive the materials in English, Providers provide the materials in English.
- Document in the client record when:
  - The client's preference for English when their primary language is not English
  - Information provided through alternate methods such as Audio or video recording in the client's primary language or having an interpreter read the materials in the client's primary language, or
  - Materials in any other alternative format that is acceptable to the client.
- Providers maintain a log of all client requests for interpreter services, translated written materials, or alternative formats.
- If a client is unable to understand the information provided due to cognitive impairment, the information is provided to the client's family and/or representative, if available, or re-offered to the client when capacity is regained, should that occur.
- Informing Clients of their rights:
  - Client rights are posted at facility locations where clients will most likely be able to view them.
  - Client rights are available on BHRD's website here.
  - For Medicaid funded clients, client rights are available in 15 languages in the Washington Apple Health: Integrated Managed Care (HCA 19-046) Booklet.
  - Rights are posted in each of the DSHS prevalent languages as made available by BHRD.
  - Providers give clients a copy of their rights and explain them at the time of their assessment or admission for outpatient or residential services, and review as needed thereafter.
  - The understanding of rights, including the notice of privacy practices are documented in the clinical record by client signature.

Individual Rights – How to Promote and Protect Each Right	
People receiving public behavioral health services in the community have the right to:	Staff members should:

Individual Rights – How to Promote and Protect Each Right	
Be treated with respect and dignity	• See clients as individuals, not cases or diagnoses. • Treat clients with the courtesy, fairness, and kindness staff themselves would want to receive, inclusive of providing a complete introduction (e.g. name, title, and organization) when initiating or returning a phone call. • Recognize the talents and capabilities of the client. • Listen to and support the client. This right is most frequently the subject of a grievance – it is based on how a client perceives they have been treated.
Have their privacy protected	• Conduct confidential conversations in areas where they can't be overheard: Waiting rooms, intake desks, offices • Keep personal information out of public site: Computer monitors, charts, data entry documents are not visible • Provide the client your Notice of Privacy Practices • Comply with HIPAA and other confidentiality requirements related to the: Release, exchange, transmission, and storage of client information
Help develop a plan of care with services to meet their needs	Develop an Individual Service Plan (ISP) collaboratively with the authorized client that: • Meets the client's unique needs • Is client-driven and strength-based • Include the client in updates to his or her plan
Participate in decisions regarding their behavioral healthcare	Encourage client to express preferences about future treatment decisions. Review and update the ISP in consultation with the client: • More often at the request of the client
Receive services in a barrier-free location (accessible)	Ensure clients can participate in behavioral health services: • Regardless of disability, e.g., limited mobility or sensory impairment • Facilities are compliant with the Americans with Disabilities Act • TTY communication devices available • Interpreters are provided for hearing impaired or limited English proficient clients • Bring services to clients or service sites where there is limited transportation
Receive the amount and duration of services they need	Assist clients to achieve the goals stated in their individual service plans Provide access or referral to medically necessary services Applies to: • All Medicaid clients who meet access to care criteria • Non-Medicaid clients who meet access to care criteria and for whom funding is available

Individual Rights – How to Promote and Protect Each Right	
Request information about the structure and operation of the King County BH-ASO	Inform clients if they want to make this request to call: **BHRD Client Services** 206-263-8997 1-800-790-8049 TTY 206-205-0569
Services within 2 hours for emergent care and 24 hours for urgent care	Inform authorized clients of: • Crisis services available from community behavioral health agency, including after-hours crisis support • When and how to use designated crisis number • Provide client with a wallet card with crisis information People not currently receiving services should call: **24-hour Crisis Line** 206-461-3222 1-866-427-4747 TTY 206-461-3219

Be free from use of seclusion or restraints	Seclusion and restraint:
	• Cannot be used as a means of coercion, discipline, convenience, or retaliation
	• Includes:
	  • Chemical restraint
	  • Anything that keeps a client from moving about on his or her own
	• May only be used in a facility certified to do so (hospital, E&T, nursing home, Residential Treatment Facility):
	  • To protect the client or others when all other interventions have been determined ineffective
	  • For the shortest time possible

Receive age and culturally appropriate services	• Inquire of client with which cultures they identify • Ensure clinical consultation with appropriate behavioral health specialist(s)

Individual Rights – How to Promote and Protect Each Right	

Be provided at no cost a certified interpreter and translated material	• Provide an interpreter in the language the client prefers to communicate
	• Provide translated materials in DSHS prevalent languages for:
	• BHRD Brochure, Client Rights, and Notice of Privacy Practices
	  • HCA Booklets for Medicaid Enrollees
	  • Application for services
	  • Consent forms
	• DSHS prevalent languages include: English, Spanish, Chinese, Russian, Korean, Somali, and Vietnamese
	• Providers maintain a log of all client requests for interpreter services, translated written materials, or alternative formats.

Understand available treatment options and alternatives	Provide information to the client:
	• About other commonly available treatment options, whether or not they are available from the agency:
	  • Alternative treatments: Dialectical Behavior Therapy; Transcranial Magnetic Stimulation
	  • Other treatments that may be self-administered: Alcoholics Anonymous; self-help and/or support groups
	• To assist client in choosing among relevant treatment options, including: Risks, benefits, and consequences of treatment and non-treatment

Refuse any proposed treatment	• Ask clients if they want to: get treatment; take medication • Provide information about how treatment or medications may help • Provide information about adverse effects • Answer questions the client may have • Honor the client's decision to refuse
Receive care that does not discriminate against them	Ensure clients are not discriminated against due to their: • Race • Color • Sex • Religion • National origin • Sexual orientation • Age • Disability (sensory, mental, or physical) • Type of illness • Willingness to provide information about these personal characteristic
Be free of any sexual exploitation or harassment	• Let clients know sexual exploitation or harassment by staff or other clients will not be tolerated by the agency • Provide client information about and assistance in reporting such an event

Individual Rights – How to Promote and Protect Each Right	
Receive an explanation of all medications prescribed and possible side effects	• Inform clients they can ask their prescriber about their medications and possible side effects • Ask the client if they are experiencing any side effects • Advocate for the client if necessary
Make an advance directive that states their choices and preferences for medical and behavioral health care	Give each adult, emancipated minor, and youth age 13 or older written information about: • Their right under state law to participate in decisions concerning their care; including behavioral health care • Their right to give someone else legal authority to make physical health and behavioral health care decisions if the client is unable to do so; • The agency's policy regarding advanced directives; • How to execute an advance directive; and • Their right to cancel or revoke an advance directive at any time. For additional information on mental health advance directives, see the HCA's Mental Health Advance Directives Brochure here
Receive quality services that are medically necessary	• Ask clinically relevant questions of the client to determine if the services requested are medically necessary • Review the ISP periodically with the client to determine if services are assisting the client to achieve his or her goals
Have a second opinion from a behavioral health professional	Assist the client to obtain a second opinion from another mental health professional within your agency Ensure a second opinion: • Occurs within 30 days of request • Is provided at no cost to the client Submit any requests to obtain a second opinion from a different mental health agency to BHRD Client Services

<table>
<tr><th colspan="2">Individual Rights – How to Promote and Protect Each Right</th></tr>
<tr><td>File a grievance about your agency or the behavioral health services you are receiving</td><td>

For services for clients covered by Medicaid, ensure they are aware they may file a grievance at any time with their MCO.
For services for clients covered by the BH-ASO, ensure they are aware they may file a grievance at any time with BHRD.

<table>
<tr><th>Payer of Service</th><th>Contact Information</th></tr>
<tr><td>BH-ASO</td><td>(800) 790-8049
BHRDComplaintsGrievances@kingcounty.gov</td></tr>
<tr><td>Amerigroup</td><td>(800) 600-4441
WA-Grievance@amerigroup.com</td></tr>
<tr><td>Community Health Plan of WA</td><td>(800) 440-1561
AppealsGrievances@chpw.org</td></tr>
<tr><td>Coordinated Care</td><td>(877) 644-4613
WAGrievances@centene.com</td></tr>
<tr><td>Molina Healthcare</td><td>(800) 869-7165
WAMemberServices@MolinaHealthcare.com</td></tr>
<tr><td>UnitedHealthcare</td><td>(877) 542-8997
WACS_Appeals@uhc.com</td></tr>
</table>
</td></tr>
<tr><td>File an appeal based on a BHRD written Notice of Action for an ASO-funded service</td><td>

To file an appeal, call the BHRD Client Services Line at 1-800-790-8049.
For assistance in filing an appeal, call the Office of Behavioral Health Advocacy at 800-366-3103.
The agency may file an appeal on behalf of a client with the client's written consent.
Services can be continued during the appeal process if time frames on the notice are followed.

</td></tr>
</table>

<table>
<tr><th colspan="2">Individual Rights – How to Promote and Protect Each Right</th></tr>
<tr><td>File an appeal based on a written Notice of Adverse Benefit Determination (NOABD) for a Medicaid funded service</td><td>If a client receives a NOABD for a Medicaid funded service, and they would like to appeal, the client's MCO should be contacted.
<table>
<tr><th>Payer of Service</th><th>Contact Information</th></tr>
<tr><td>Amerigroup Healthcare</td><td>1800-600-4441 (TTY 711)</td></tr>
<tr><td>Community Health Plan of Washington</td><td>1800-440-1561 (TTY 711)
customercare@chpw.org</td></tr>
<tr><td>Coordinated Care</td><td>1877-644-4613 (TTY 711)
WAQualityDept@centene.com</td></tr>
<tr><td>UnitedHealthcare</td><td>1-877-542-8997 (TTY 711)
WACS_Appeals@uhc.com</td></tr>
<tr><td>Molina Healthcare</td><td>1800-869-7165 (TTY 711)
wamemberservices@molinahealthcare.com</td></tr>
</table></td></tr>
<tr><td>For Medicaid clients, choose a behavioral health care provider or choose one for their child who is under 13 years of age</td><td>Offer clients who request services:
A choice of behavioral health care providers (care coordinator/ care manager/therapist) from available staff within the agency
If services are requested for a child under age 13, the choice should be offered to the child's parents
Respect the client's choice
If the client does not make a choice, the behavioral health agency must assign a behavioral health care provider within 14 days from when the client requested services.</td></tr>
<tr><td>Request and receive a copy of their medical records and ask for changes</td><td>Provide privacy for clients to read their chart
Explain things in the chart the client doesn't understand
Inform client if any portion of the record could not be released (harmful to the client or others)
Incorporate changes requested by the client into the chart.
If the client requests copies, the fee is no more than 15 cents a page.</td></tr>
<tr><td>Be free from retaliation</td><td>Ensure clients know:
They are free to exercise their rights without fear of retaliation
How to recognize retaliation if it happens, e.g.:
Threatening to or actually terminating services
Discouraging or depriving clients from exercising their rights
Intimidating, threatening, or coercing the client in any way</td></tr>
</table>

Individual Rights – How to Promote and Protect Each Right	

Be informed that research concerning clients whose cost of care is publicly funded must be done in accordance with all applicable laws, including State rules on the protection of human research subjects	Inform clients if they are asked to participate in a research project:
	• They may refuse – participation is voluntary
	• If they refuse it will not impact their regular services
	• If they agree to participate:
	  • They will be asked to sign a consent that has information about the research
	  • They can stop their participation at any time
	  • Personal information will not be release without their consent except in emergencies

Discuss a concern with the Office of Behavioral Health Advocacy (formerly known as Behavioral Health Ombuds),BHRD, or Provider if they believe their rights have been violated. If they discuss a concern or file a grievance or appeal, they must be free of any act of retaliation. The Office of Behavioral Health Advocacy may, at their request, assist them in resolving their concerns.	• Make clients feel it's safe to express concerns that their rights may have been violated • Provide client assistance in contacting: **Office of Behavioral Health Advocacy (OBHA)** Toll-free: (800) 366-3103 kingcounty@obhadvocacy.org https://www.obhadvocacy.org/ **BHRD Client Services** 206-263-8997 or 1-800-790-8049 • Monitor that no retaliation occurs

1.11 Client Rights Materials and Consent Forms

Consent Processes for Clients Receiving Substance Use Disorder (SUD) Treatment

All clients receiving any publicly-funded substance use assessment or substance use disorder treatment in King County should be presented two client consent forms -- one is required for payment and operations ("SUD Authorization for Disclosure-Required"), and one is voluntary and is used for Health Information Exchange - HIE ("SUD Health Information Exchange Consent-Voluntary"). While the HIE consent is not required, it is encouraged as it allows for crucial treatment information to be shared for the purpose of care coordination.

SUD program codes for which these consent forms should be presented are listed in the Behavioral Health and Recovery Division (BHRD) Data Dictionary SUD Release of Information transaction and include: SUD assessment-only, SUD outpatient, SUD residential, co-occurring disorders (COD), detox, medication-assisted treatment (MAT) and jail/Community Center for Alternative Programs (CCAP)-based SUD treatment.

Attachments in this Section:

- Attachment C: BHRD Notice of Privacy Practices
- Attachment D: BH-ASO Grievance and Appeal Template
- Attachment E: BH-ASO and Locally Funded Client Rights
- Attachment F: SUD Authorization for Disclosure - Required
- Attachment G: SUD Health Information Exchange Consent - Voluntary

1.12 Crisis Plans and Advance Directives

Crisis Plans

Providers create Crisis Plans, in partnership with clients when possible, for a majority of clients in the Behavioral Health and Recovery Division (BHRD) system. Ideally, the individual in care fills out this form with agency staff. Crisis Plans are to be shared with Crisis Connections via the Collective Medical Technologies (CMT) platform, which is accessible to all providers.

The CMT platform allows for the following:

- Supports Emergency Department Utilization Management (EDUM).
- Lets other health care facilities know that individuals are receiving BH services.
- Facilitates care coordination between hospitals and behavioral health agencies.
- Promotes integrated physical-behavioral healthcare.

Not every individual enrolled in care requires a Crisis Plan. Crisis Plans should be updated when clinically indicated. Crisis Plans are developed with all clients who fall into one or more of the following categories:

- Clients authorized to a Mental Health high outpatient level of care.
- Clients authorized for residential level of care.
- Any client released within the past 12 months from:
- A voluntary or involuntary inpatient setting (including WSH and CLIP facilities);
- A jail or DOC facility; or
- A juvenile detention or JRA.
- Clients with co-occurring mental health and substance use disorders.
- Clients with current suicide or violent ideation, or who have a history of suicide attempts or violence toward others, or have other clinical indicators that a risk of suicide or harm to others exists.
- Children and youth involved with two or more systems.
  Regular school attendance is not considered involvement with another system unless there are other special behavioral health problem indicators present in school.
- Clients who were served by any hospital emergency department (ED) due to a behavioral health crisis at least once in the preceding 12 months.
- Clients who have a mental health advance directive.
- All other clients identified by clinicians as being at risk or likely to access crisis services in the next two weeks.

All Crisis Plans are in the standardized format provided in Attachment H. If desired, providers can utilize other formats; other formats must include all data elements found in Attachment H and be approved by King County.

When developing a Crisis Plan, the following is considered as related to Advance Directives:

- A client's Crisis Plan contains documentation on whether or not the client has executed a mental health or physical health care advance directive.
- DCRs and hospital staff can access Crisis Plans in CMT 24/7 in order to review Advance Directive(s) if applicable.

Advance Directives

By law, Providers providing services paid for by Medicare or Medicaid meet certain advance directive requirements. Providers will:

- Maintain written policies and follow procedures that ensure compliance with State and federal law on advanced directives, including 42 CFR 438, 42 CFR 102, RCW 71.32, RCW 70.97.020, and WAC 182-501-0125;
- Document in the client's record whether or not the client has executed an advance directive (including a mental health advance directive);
- Educate staff and the community on issues concerning advance directives;
- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; and
- Inform the individual that they may file complaints concerning implementation of these advance directive requirements and where they need to file the complaint.

Providers uphold and utilize advance directives for adults, emancipated minors, and youth age 13 or older who have completed a mental health or medical advance directive in the provision of services. Mental health advance directives are applicable to individuals participating in behavioral health services. For individuals participating in substance abuse services, Providers ask about, uphold, and utilize advance directives as applicable.

- At intake, Providers ask all adults age 18 and over, emancipated minors, and youth 13 and older if they have a mental health or medical advance directive.
- A client's clinical record contains prominent documentation on whether or not the client has executed a mental health or medical advance directive, or if the client prefers not to disclose that information.
- If a client at the time of intake is unable to articulate whether or not they have completed an advance directive, the Provider makes an inquiry about advance directives as soon as the person is able to provide a response. The information is documented in the client's clinical record.
- If a client indicates they have a mental health or medical advance directive, Providers request a copy of the most recent version for the clinical record. A client's refusal to provide a copy is documented in the clinical record.
- At time of intake, Providers give each adult, emancipated minor, and youth age 13 and older written information on advance directives which includes at a minimum a brief description of State law and information on how to execute an advance directive.
- No Provider may limit the implementation of an advance directive because of a conscientious objection by the agency or an individual employee or subcontractor of the Provider. Implementation may be limited only as allowed in RCW 71.32.150 or its successor.
- If a client has a mental health advance directive, the Provider is expected to develop a crisis plan with the client.

Additional information on medical advance directives can be found on at the Washington State Medical Associations website here.

Attachments in this Section:

- Attachment H: Crisis Plan Form
- Attachment I: Mental Health Advance Directives

1.13 Faith-Based Organizations (FBO)

A Faith Based Organization (FBO), contracted under this agreement to provide Behavioral Health Administrative Services Organization (BH-ASO) services meets the requirements of 42 C.F.R. Part 54 as follows:

- Clients requesting or receiving Substance Use Disorder (SUD) services are provided with a choice of SUD treatment Providers.
- The FBO facilitates a referral to an alternative Provider within a reasonable time frame when requested by the recipient of services.
- The FBO reports to the Contractor all referrals made to alternative Providers.
- The FBO provides clients with a notice of their rights.
- The FBO provides clients with a summary of services that includes any religious activities.
- Funds received from the FBO must be segregated in a manner consistent with federal regulations.
- No funds may be expended for religious activities.

1.14 Disaster Recovery and Business Continuity

Disaster Recovery and Business Continuity Plan

Provider agencies maintain a DRBC Plan that outlines timely reinstitution of information systems following the loss of the primary system or substantial loss of functionality (45 CFR §164.308). At a minimum, the DRBC Plan includes the following elements:

- A mission or scope statement.
- Information services disaster recovery person(s).
- Provisions for back up of key personnel, emergency procedures, and emergency telephone numbers.
- Procedures for effective communication, applications inventory and business recovery priorities, and hardware and software vendor lists.
- Documentation of updated system and operations and a process for frequent back up of systems and data.
- Off-site storage of system and data backups and ability to recover data and systems from back-up files.
- Designated recovery options.
- Evidence that disaster recovery tests or drills have been performed.

System Back-Up

Provider agencies have a primary and back-up system for electronic submission of data (45 CFR §164.308; 45 CFR §164.310). The system includes the use of Inter-Governmental Network (IGN) Information Systems Services Division (ISSD) approved secured virtual private network (VPN) or another ISSD-approved dial-up. At least annually, BHRD and its provider network conduct a disaster recovery test or drill of their information system and back-up.

Reporting of DRBC Plan and System Back-Up

As required by contracts with the Health Care Authority (HCA) and/or Medicaid Managed Care Organizations (MCO), Provider agencies annually report on DRBC program requirements, including:

1. Attestation of DRBC Plan elements according to those described above;
2. Attestation of annual systems check according to requirements described above; and
3. A copy of the most current DRBC Plan a provider agency has developed.

1.15 Waiver Requests

Providers can request waivers for Behavioral Health and Recovery Division (BHRD) contract requirements by submitting requests in writing to their BHRD Provider relations/Contract Specialist. Requests should include:

- The contract requirement the Provider requests to waive;
- Context and the specific reason for the waiver request;
- Proposed timeline necessary for waiver approval & implementation;
- Contact information (name, agency, title, phone and email) for Provider point-of-contact for additional information;
- Any additional information the Provider deems necessary for BHRD in evaluating the waiver request.

Waivers are reviewed by the Provider Relations/Contract Specialist and are subject to approval by the Provider Relations/Contract Specialist. Depending on the scope and impact of the waiver request, waivers may be subject to additional review and approval by BHRD executive leadership.

1.16 BRHD Sponsored Training Opportunities

BHRD is committed to advancing the delivery of recovery-oriented, culturally-responsive, and trauma-informed behavioral health services in an integrated care environment through workforce training and development. For current training opportunities are available on BHRD's website here.

1.17 Updates to this Provider Manual

The Behavioral Health and Recovery Division (BHRD) Provider Manual has frequent updates on an ongoing basis. BHRD provides opportunity for Provider feedback prior to official release of updated versions. Providers receive a 30-day formal notice of any substantial changes unless the changes are deemed emergent due to legal change to Revised Code of Washington (RCWs), Washington State Administrative Codes (WACS), or other regulatory changes that must be made more immediately.

2 Outpatient Services

Behavioral Health Outpatient services provide a continuum of crisis and outpatient care, including inpatient discharge planning services, designed from a recovery and resiliency perspective and available to eligible individuals in King County. Services provided to eligible individuals ensure that individuals receive easily accessible, culturally responsive, coordinated, comprehensive, and quality behavioral health services. Services should be provided in such a way as to reduce the incidence and severity of behavioral health disorders and reduce the number of people with behavioral health issues using costly interventions like jail, emergency rooms, and hospitals.

Outpatient Providers ensure continuity of care with the participation of clients, the community behavioral health system, the physical health system, inpatient facilities, advocates, families, housing services, employment services, education services, and other community supports as clinically indicated. Providers also collaborate with the staff at the courts, probation, correctional facilities, and juvenile detention facilities, in arranging for services to individuals referred by the local justice system and State Department of Corrections.

Providers create an Individual Service Plan (ISP) for each client, their family or their support system pursuant to relevant Washington Administrative Codes (WACs) or evidence-based, research-based, or state-mandated program requirements as appropriate.

Providers ensure services and interventions are community-based rather than facility-based when this best meets the individual's needs or improves the quality of care. Services are provided in the least restrictive setting whenever possible, include assertive engagement, and discharge planning to accomplish the most efficient and appropriate use of resources.

Providers make arrangements to assure the availability of services to clients on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of client visits after hours. Providers meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services. The following Appointment Wait Time Standards follow accessibility and appointment wait time requirements set forth by the Health Care Authority and applicable regulatory (42 CFR § 438.206) and oversight agencies (CMS).

Type of Care	Appointment Standard
Emergent, life-threatening emergency	Immediately
Urgent, non-life-threatening emergency	Within 6 hours
Urgent Care Office Visit	Within 24 hours
Routine Care Office Visit	Within 10 calendar days of request
Routine Care Follow-up Office Visit	Within 7 calendar days of discharge
Preventative Care Office Visit	Within 30 calendar days of request

- Agencies are responsible for responding to all crises which occur for their enrolled clients during the business day.
- Crisis Connections is scheduled to cover telephonic after hour crisis response for all agencies. After hours is considered 5:00PM to 8:00AM.
- If Crisis Connections is unable to provide stabilization of the crisis over the phone and believes a client needs an urgent or emergent response, this will be referred back to the agency who holds the benefit to provide the necessary response.

- Agencies will need to work with Crisis Connections to determine how this “loop back” will work.
- Agency is responsible for responding to clients in emergency departments and hospitals 24 hours a day, 7 days a week.

  When serving out of county clients, agencies should be familiar with the crisis systems where the client lives and be prepared to coordinate care if one of their clients utilizes a particular county’s crisis system.

2.0.1 Access to Outpatient Services for Non-Medicaid Individuals

Behavioral Health and Recovery Division (BHRD) maintains funding for Non-Medicaid Individuals who otherwise meet eligibility requirements for outpatient services and who would benefit from treatment. Funding allocations for mental health outpatient services are managed at the agency level. There is a request process through BHRD to access substance use disorder outpatient benefits. Priority populations are identified in *Appendix A: BH-ASO Policies and Procedures.*

2.0.2 Eligibility and Identification of Payor

Providers check an individual’s Medicaid status using the Extended Client Look-up System (ECLS) as their primary source (ProviderOne is a secondary source) once a day before the initial billable service. Through the client’s main page in ECLS, Providers can identify if the individual has already been indicated as having a Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) and whether the individual’s Medicaid is active. If yes, then the individual is eligible for Behavioral Health and Recovery Division (BHRD) outpatient services. If the individual does not have a SED/SMI indicator in ECLS, the Provider completes a brief screening called the *KCICN Behavioral Health Risk Stratification Screening Tool* (attached below).

Attachments in this Section:

- ***Attachment A***: KCICN Behavioral Health Risk Stratification Screening Tool

2.0.3 Non-Medicaid Eligibility

A person not covered by Medicaid, who is a resident of King County, may be eligible for Behavioral Health Administrative Services Organization (BH-ASO) services if:

- The following individuals meet financial eligibility criteria at every non-crisis encounter:
- Eligible children are those persons younger than 18 who have a family income of less than 300 percent of the federal poverty level;
- Eligible adults are those persons age 18 or older who have a family income of less than 220 percent of federal poverty level; and

The person meets clinical eligibility criteria and priorities.

Providers convert all non-Medicaid clients who are eligible for Medicaid within 30 days of Medicaid eligibility. Providers document activities undertaken to evaluate eligibility and efforts made to effect conversion.

In order to maximize the appropriate utilization of the limited non-Medicaid resources, Providers update the clients funding source in Behavioral Health Recovery Division Information System (BHRD IS) upon change as specified in the Data Dictionary.

Individuals who meet financial eligibility for Medicaid, but are not currently enrolled, will have documentation in their clinical file as to the reason they have not been enrolled. This documentation will

include what the Provider is currently doing to assist in the enrollment process and be completed on a monthly basis.

King County BH-ASO low-income eligibility tables are located in the ISAC Notebook under “Income Transaction.” For access to the ISAC Notebook, please contact your agency’s ISAC representative

2.0.4 Transitional Services

Transitional Services are required when an individual transfers from one care setting to another or one level of care to another.* Providers should work with appropriate staff at any hospital, including a Certified Public Expenditure (CPE) facility, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which supports the individual’s recovery and prevent readmission. This care coordination activity includes scheduling a face-to-face meeting within 7 days of discharge. Outpatient Providers should work with the clients to support discharge care needs, including:

- Follow-up appointments for behavioral health issues (as clinically indicated);
- Care planning with the client, to include assessment of support network needs and assess any changing needs;
- Updating Releases of Information as needed to share information with clinical and non-clinical providers to facilitate needed linkages; and
- Assistance with follow-up for self-management of the individual’s chronic or acute conditions, including information on when to seek medical care and emergency care.

Outpatient providers should work with the individual to ensure timely access to needed follow-up care post discharge, and to identify and re-engage clients who do not receive post discharge care. When clients are at a high risk of re-hospitalization, outpatient providers should ensure linkage to a Primary Care Provider, if not already in place.

*Transitional Care services to clients who participate in Health Home services should continue to follow Health Homes program requirements.

2.0.5 KCICN Outreach and Engagement Initiative

The KCICN Outreach and Engagement (O&E) Initiative is a pilot project effective October 1, 2021 through November 30, 2022. The purpose of the pilot is to provide reimbursement to providers for traditionally non-billable O&E services that help re-engage clients back into an active Medicaid-funded mental health (MH) outpatient, substance use disorder (SUD) outpatient or Medication-Assisted Treatment benefit. Information from this initiative will inform future considerations for O&E activity funding and design.

No services should be billed to O&E Initiative that can be billed through Medicaid.

O&E services include, but are not limited to the following:

- Outreach to re-engage the client in treatment including:
    - In-person outreach attempt to client or collateral contact
    - Telephone call attempt to client or collateral contact
    - Remote communication attempt (telephone, text, e-mail) when allowable by privacy rules.
        - Collateral contacts could include friends, relatives, shelters, jails or other community-based organizations/institutional settings, primary care clinics, schools, etc.
    - The following may be eligible for O&E:
        - Refusal to share information
        - No answer (voicemail)

- Travel time necessary to conduct in-person outreach & engagement without client contact
- Assisting the client with scheduling appointments to engage or re-engage the client into services if only activity is scheduling appointment

Eligibility:

- Client must have an open MH, SUD or MAT Medicaid-funded outpatient benefit during the date of O&E service, and;
  - MH or SUD client has not received a direct service in more than 30-days; or
  - MAT client has missed 3 consecutive days of dosing.

Encounter Submission Requirements:

- Encounters must be submitted by the end of the following calendar month from date of service. Encounters not submitted by then will not receive payment.

Payment Methodology and Allocation:

- An agency's monthly allocation is calculated by:
  - *Agency monthly allocation = Base allocation + # of units to provide at least 3 O&E services to 15% of agency's total Medicaid client population*
  - Note, it is provider's discretion how they choose to allocate and prioritize units for providing O&E services
- Monthly allocation is fixed. Unused units will not rollover into the following month.
- Payment will only be provided based on an agency's available units within a month of service.

2.0.6 Capacity to Intake New Clients and Support Linkage to Care

In an effort to support clients in navigating the continuum of ICN behavioral health services, BHRD is available as a point of contact for any individuals interested in connecting to behavioral health services within the ICN.

Providers are asked to support this linkage to care by reporting their weekly capacity to receive new individuals and schedule intake appointments (see Attachment B). BHRD will use the Weekly Provider Capacity Reporting Form to maintain a current inventory of intake appointments that may be used to connect individuals to services. Having the most accurate and up-to-date provider capacity information will support BHRD and ensure our Client Services Line staff can promptly connect individuals to an available ICN provider.

In the event a provider agency is unable to receive a new intake request, they are encouraged to redirect these inquiries to the BHRD Client Services Line at 206-263-8997, Monday to Friday from 8am to 5pm. Any messages left on voicemail will be answered within one business day.

The BHRD Client Services Line is staffed with behavioral health professionals who are trained to receive calls and provide care coordination for individuals and caregivers of individuals interested in behavioral health or community-based services. Using the most current provider capacity-reported information, Client Services Line staff will provide intake appointment options to callers, and when needed a warm handoff to an ICN provider agency.

Attachments in this Section:

- Attachment B: Weekly Provider Capacity Reporting Form

2.1 Mental Health Outpatient Benefit

Mental Health Outpatient Benefits are comprehensive outpatient mental health programs, which allow Providers to work long-term with clients to create an individualized approach to their wellness and recovery. Services are included in the Mental Health Outpatient Benefit are described in the Medicaid State Plan and may include:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and
- Therapeutic psychoeducation.

A Provider must be licensed as a Least Restrictive Alternative (LRA) Provider in order to monitor a client on a LRA per WAC 246-341-0805.

2.1.1 Mental Health Outpatient Level of Care System after July 1, 2020

Mental Health Outpatient Benefits are assigned a Level of Care (LOC) based on the Population Health Stratification (PHS) model which uses data. Clients are assigned LOC service intensity based on data points at Low, Medium and High service intensities. A client's assigned LOC is automatically reassessed quarterly using the PHS, so client's LOC can change throughout the year. PHS is different based on Adults versus Child/Youth population.

- 0 – 17 years old: Child/Youth LOC
- 18 - 20 years old: Provider requests age benefit LOC that matches client's developmental status
- 21+ years old: Adult LOC

Expected utilization hours, called Service Delivery Adherence (SDA), are determined by assigned LOC per client, and benefits are open-ended as long as the client continues to receive services.

2.1.2 Service Delivery Adherence (SDA) Calculation

The SDA aligns Medicaid-directed payments with the clinical model level of care and utilization. Case rate payments are adjusted based on the service utilization provided during the lookback period per Table 1.

Table 1: SDA Payment Adjustments	
0.0 - 24.9%	25%
25.0 - 29.9%	30%
30.0 - 34.9%	45%
35.0 - 39.9%	50%
40.0 - 44.9%	55%
45.0 - 49.9%	60%
50.0 - 54.9%	65%
55.0 - 59.9%	70%
60.0 - 64.9%	75%
65.0 - 69.9%	80%
70.0 - 74.9%	85%
75.0 - 79.9%	90%
80.0 - 84.9%	95%
85.0 – 99.9%	100%
100.0 – 104.9%	105%
105.0 – 109.9%	110%
110.0 – 114.9%	115%
115.0 – 119.9%	120%
> 120.0%	125%
No SDA available	100%

Initial Calculation**:**

Active benefits receive an SDA calculation when the Population Health Stratification (PHS) score is determined. SDA percentages are the ratio of the amount of services a client received relative to the amount requested for all clients at a certain benefit level during a period. Or:

$$SDA\ \% = \frac{Prorated\ monthly\ service\ hours}{Number\ of\ monthly\ hours\ expected}$$

Where:

$$Prorated\ monthly\ service\ hours = 30 * \frac{Total\ billable\ service\ hours}{Total\ days\ the\ benefit\ was\ active}$$

Providers receive an SDA calculation based on the amount of services a client received during the lookback period relative to the level of care service hour expectations. If clients received less than 85% of the expected service hours, a certain percent of payment is deducted from the case rate.

Recalculation**:**

Providers may request SDA recalculation when the following requirements have been met:

- Provider notifies the BHRD Functional Analysts at (BHRDfunctionalanalyst@kingcounty.gov) of the anticipated encounter submission.
- Provider works with BHRD Functional Analysts and Information System staff to address anticipated challenges with electronic health record conversions.
- Provider requests recalculation during the quarter that the payment is made (e.g., request must come in during Q1 for a recalculation of SDA that affects Q1 payments, as illustrated in Table 2 below).
  - SDA recalculations will have SDA recalculated from the three-month period prior to the month before the current quarter. For example, Quarter 1 SDA calculation will be based on service delivery adherence over the period September-November. Additional guidelines for SDA calculation for different benefit business rule scenarios (e.g., client level of care changes between quarters, new clients, etc.) can be referenced in the PHS Business Rules and Technical Document. This document can be made available by your agency's ISAC representative.

Table 2: Example Timeframe for Recalculation Request

Q1 SDA Look Back Period				**Q1 Payment (SDA Applied based on Q1 Look Back Period)**		
Sept	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**

- Missing data is transmitted to the Behavioral Health and Recovery Division Information System (BHRD IS) during the quarter that the recalculated SDA is to be applied.
- A request for SDA recalculation is intended for use when there has been an unforeseen data transmission failure due to technical problems during the Look Back Period for the quarter in question that is impacting the agency's whole outpatient Medicaid population (e.g., super majority—at least 65% of encounters).

SDA Recalculation Exclusions:

- Workflow, workforce, or vendor challenges (e.g., untimely submission of progress notes, authorization requests or benefit renewal information).

2.1.3 Level of Care

Adult Level of Care (LOC) based on* Population Health Stratification (*PHS) as follows:

- Acute Care Utilization (in last 12 months);
  - Hospitalization or Emergency Department (ED) visits
  - SUD withdrawal management
  - Involuntary Treatment Act (ITA)
  - Substance Use Disorder (SUD) residential

- Social Determinants of Health;
  - Housing stability
  - Jail utilization
  - Jail length of stay
- Chronic Conditions; and
  - Presence of diabetes, cardiovascular disease, asthma, and/or Chronic Obstructive Pulmonary Disease (COPD)
- Clinical Assessment/LOCUS).

LOC	PHS Point Range	SDA per Month
Mental Health Assessment Only	Mental Health Assessment completed but individual did not meet medical necessity standards.	N/A
Adult: Low	0 – 4 total points	1.5 hours
Adult: Medium	5 – 10 total points	2.5 hours
Adult: High	11 + total points	7.0 hours

Child/Youth LOC based on PHS as follows:

- Acute Care Utilization;
  - Hospitalization
  - ED visits
  - SUD Withdrawal Management
  - ITA
  - SUD residential
- Social Determinants of Health;
  - Foster care
- Chronic Conditions; and
  - Presence of Diabetes, cardiovascular disease, asthma, and/or COPD
- Clinical Assessment/CALOCUS.

**All youth under the age of 6 automatically assigned to High LOC.*

LOC	PHS Point Range	SDA per month
Mental Health Assessment Only	Mental Health Assessment completed but individual did not meet medical necessity standards.	N/A
Child/Youth: Low	0 – 4 total points	1.5 hours
Child/Youth: Medium	5 – 10 total points	2.5 hours
Child/Youth: High	11 + total points	7.0 hours

Timeline for Benefits Ending:

While individual benefits for clients are open ended, the benefits are automatically closed after a period of no services. If a client is not seen at all for two "look-back" periods, then a client's benefit is terminated and payment to the Provider is stopped.

MH Outpatient Benefit Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available for priority populations as described in the BH-ASO policy and procedures
Age Range	Full Life Span
Authorization Needed	No
Additional Criteria	Additional Criteria only necessary when utilizing non-Medicaid funding for benefit
MH Outpatient Benefit Reporting Requirements	
Monthly Reports	Submission of encounters into the BHRD Information System

2.1.4 Outpatient Benefit and WISe Services*:* This section is only for youth pre-approved prior to 3/1/2020 to be in the Split Wise Model.

Clinicians and case managers providing outpatient clinical services to a client enrolled in WISe ensures:

- Outpatient clinical services are provided at a level of intensity and frequency commensurate to the client's level of need and as indicated by their inclusion into the WISe program.
- Services are provided at times and locations that ensure meaningful participation of youth, family members which may include in the home, in the school, and in community. Wise clinicians attend and participate in WISe team meetings (otherwise known as Child and Family Team meetings) and other relevant planning activities. In collaboration with the Wraparound Delivery Team, an average of 10.5 services hours per month of Medicaid billable services are provided from the services array outlined in the WISe manual, including but not limited to:
  - Individual treatment services
  - Family therapy services
  - Case management services
  - Psychiatric medication services
  - 24/7 Crisis Intervention and Stabilization Services
- Tier and supplemental payment for any particular WISe-enrolled client for any particular month will only be remitted if meaningful service is provided for that client for that month and is accurately submitted to the King County system.

2.2 Substance Use Disorder Outpatient Benefit

Substance Use Disorder (SUD) Outpatient Benefits are comprehensive outpatient substance use disorder programs, which allow Providers to work long-term with clients to create an individualized approach to their wellness and recovery. Services are included in the Substance Use Disorder Outpatient Benefit are described in the Medicaid State Plan and may include:

- Alcohol/Drug Screening and Assessment;
- Individual rehabilitative counseling;

- Group counseling;
- Laboratory services (drug and alcohol screens); and
- Case Management services.

Providers assess and assign separate American Society of Addiction Medicine (ASAM) level of care for each of the six dimensions and an overall level-of-care placement recommendation at the following treatment points:

- Assessment;
- ISP reviews; and
- Discharge.

A Provider must be licensed as a Least Restrictive Alternative (LRA) Provider in order to monitor a client on a LRA per WAC 246-341-0805.

SUD Outpatient Benefits are based on level of functioning, degree of psychiatric impairment, expected service intensity, and expected outcomes and benefit period. Benefit levels are as follows:

Benefit	Description	Treatment Goals	Benefit Period	Admission Criteria
Adult/Youth 500: Medicaid 501: MIDD ***Outpatient*** ***Adult/Youth*** 500: Medicaid *501: MIDD* ***Intensive Outpatient***	Treatment to assist an adult to establish, improve, or stabilize their level of functioning.	• Recovery and resiliency • Maintenance/stabilization in Substance Use Disorder (SUD) symptoms • Maintenance/stabilization in level of functioning • Restoration of normative life • Prevention of incarceration • Prevention of homelessness • Linkage with medical system • Engagement in structured activities outside the substance use disorder treatment center • Prevention of homelessness • Linkage with medical system • Engagement in structured activities outside the substance use disorder treatment center	N/A	ASAM Level of Care of 1.0 ASAM Level of Care 2.1

Benefit	Description	Treatment Goals	Benefit Period	Admission Criteria
Adult MAT: *Medication-Assisted Treatment (MAT)*	Treatment to assist an adult to establish, improve, or stabilize their level of functioning combined with continuous MAT treatment.	• Recovery and resiliency • Improvement/stabilization of SUD symptoms • Improvement/stabilization in level of functioning • Prevention of Opioid Overdose • Prevention of medical or psychiatric hospitalization due to opiate use • Prevention of incarceration • Prevention of homelessness • Linkage with medical system • Engagement in structured activities outside the substance use disorder treatment center	N/A	ASAM Level of Care of 1 or 2.1
SA0: *Assessment-Only*	SUD Assessment completed but individual did not meet medical necessity standards, or individual met medical necessity standards but declined admission into treatment.	N/A	N/A	N/A
SA1: *Assessment Only - MN Met - Referred elsewhere*	SUD Assessment completed wherein individual met medical necessity standards but was referred to another Provider.	N/A	N/A	N/A

Substance Use Disorder Outpatient is a modified fee for service (FFS) payment model. On the 7th day of each month, the King County system finds encounters submitted between the first and last day of the previous month. For example, for February's payment the process will look for encounters submitted between 1/1-1/31 of that year, regardless of service dates. Those are the encounters that will be paid in February. If an agency submits a January (or earlier) encounter on Feb. 2nd it wouldn't get included until the next month. In addition, the authorization must be in Authorized Approved/Outcome Data Set Complete (AA/OC) status, all data in, before encounters are paid. If the payment process picks up the encounters, but determines the authorization is not Authorization Approved/Unauthorized (AA/UA), it won't get paid on the next cycle (or the authorization will cancel if the agency doesn't get it to (OC status). See ISAC Notebook for details.

Fee schedule located here:

Reimbursement will be made for up to six drug screens or urinalysis samples (UA) per client, per month. UAs that are not medically necessary are not reimbursable.

Provider establishes medical necessity and determines level of care by ASAM.

SUD Outpatient Benefit Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available for priority populations as described in the BH-AS0 policy and procedures with BHRD approval
Age Range	Full Life Span
Authorization Needed	No
Additional Criteria	Additional Criteria only necessary when seeking non-Medicaid funding for benefit
SUD Outpatient Benefit Reporting Requirements	
Submission of encounters into the BHRD Management Information System	

2.3 Assisted Outpatient Services Program (AOSP)

The Assisted Outpatient Services Program (AOSP) provides management and oversight of the care of individuals ordered to a Least Restrictive alternative court order (also referred to as “LROs” or “LRAs”; hereinafter referred to as “LROs”). AOSP provides support to individuals in the community to increase engagement and participation in recovery and reduce hospitalizations. Individuals receiving AOSP services must see their Provider face-to-face a minimum of one time per week and receive a minimum of three clinical encounters per week.

Since AOSP is a court-ordered treatment, LROs should be determined in conjunction with the treatment team at the Provider Agency, and treatment plans and services must align with the LRO, and any subsequent modifications required by court.

Treatment is individualized and client centered and includes the services defined in WAC 246-341-0805.

Crisis Housing Voucher

Crisis Housing Vouchers provide short-term housing to eligible individuals. These residential supports target individuals who are assessed to need more intensive support and stability immediately following a behavioral health crisis and are intended to increase the opportunity for stability while awaiting more permanent housing solutions. Providers administering Crisis Housing Vouchers will find a short-term housing placement, pay for the placement, and refer individuals to community-based supportive housing programs. Follow-up supports will be coordinated and provided by the community-based supportive housing program.

Individuals are eligible for Crisis Housing Vouchers if they are clinically assessed to be experiencing a behavioral health crisis, need supportive housing services, and are experiencing homelessness or are unstably housed. An individual is clinically assessed to be experiencing a behavioral health crisis if they are being referred from a crisis facility or if they have experienced a Crisis Event. A Crisis Event is defined as a period of time of engagement by crisis hourly staff with a person who is experiencing symptoms of a behavioral health disorder which currently outweigh their abilities to tolerate, minimize,

or attend to those symptoms or other current circumstances, the person does not appear to meet involuntary detainment criteria under RCW 71.05, and the person is at a higher risk for victimization in the current situation or circumstance if they remain in the current situation or circumstance without respite. Individuals may experience more than one stay at a crisis facility or Crisis Event, therefore, their eligibility if based on the stay or event.

Crisis Housing Vouchers will be dispersed based on the need of the eligible individual. They initially cover a maximum of 14 days, but can be extended an additional 14 days at the discretion of the provider.

Crisis Housing Vouchers are intended to be utilized at:

- **Hotel**- An establishment that provides paid lodging on a short-term basis.
- **Motel**- An establishment that provides lodging and parking and in which the rooms are usually accessible from an outdoor parking area.
- **Family Member or Friend**- A verified family member or friend of the eligible individual that agrees to temporarily house them.
- **Other Housing Related Expenses**- On a case-by-case basis and with prior-approval, Crisis Housing Vouchers may be approved for other housing related expenses. Prior approval must be requested through the Crisis Housing Voucher Exception Request Form.

When a provider utilizes a Crisis Housing Voucher, a referral to a community-based supportive housing program also must occur.

- A referral to the community-based supportive housing program Forensic HARPS must occur for individuals who meet the following criteria:
    - Have had at least two contacts with the forensic mental system in the past 24 months, or were brought to a crisis diversion facility or brought to the attention of a mobile crisis responder team via arrest diversion in accordance with RCW 10.31.110;
    - Need assistance accessing independent living options and would benefit from short-term housing assistance beyond the 14-day vouchers;
    - Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Housing Voucher;
    - Are unstably housed;
    - Are not currently in the community outpatient competency restoration program; and
    - Do not meet Involuntary Treatment Act commitment criteria (RCW 71.05).
- If an individual is not eligible for Forensic HARPS, a referral must be made to another community-based supportive housing program. This can include, but is not limited to, Foundational Community Supports Supportive Housing, traditional HARPS programs, local coordinated entry systems, or other community-based supportive housing programs.
- Referrals must be made by or within the same day as Crisis Housing Voucher utilization.

- Referrals must be made via secure email, phone call, or fax.

AOSP Eligibility Criteria	
Medicaid Status	Yes, with limited capacity to serve those who are Non-Medicaid
Age Range	18 years or older
Authorization Needed	Yes
Additional Criteria	• Already enrolled in KCICN services; • Conditionally released from the hospital and who have been issued a less restrictive alternative (LRO) order for treatment; • Referred by King County AOT Coordinator; and • Not enrolled in an intensive community support or residential program including but not limited to Program for Assertive Community Treatment (PACT), Standard Supportive Housing (SSH), Long Term Rehabilitative Services (LTR), and Supervised Living (SL).
AOSP Reporting Requirements	
Monthly Reports	• AOSP Provider Tracking Form • **For AOSP providers utilizing Crisis Housing Vouchers:** Crisis Housing Voucher Log-due the 5th of the month following the reporting period

Attachments in this Section

- Attachment C: Crisis Housing Voucher Exception Request Form

2.4 Intensive Community Support and Recovery Program (ICSRP)

Intensive Community Support and Recovery Program is designed for Expanded Community Services (ECS) project participants and other identified clients hospitalized in the adult units at Western State Hospital (WSH). Services include pre-engagement, transition planning, intensive behavioral health treatment, linkages to needed services, case management, nursing services to ensure continuity of care for acute and chronic medical conditions, and discharge planning and community and residential supports that promote recovery and successful community integration. Clients referred by King County Integrated Care Network (KCICN) to this program generally have lengthy hospitalizations at WSH, are on the WSH waiting list, or at risk of referral to WSH, and this program provides them with comprehensive, flexible, and individualized services that increase their chances of remaining in the community.

This program is limited to 48 clients annually, and the contracting agency must provide 10,950 days-of-service for program clients annually (days-of-service does not include days when a client is residing in a state hospital, in jail, or in a DOC facility). The Community Planning Team at the contracted agency works collaboratively with King County Hospital and Community Liaisons (KCHCL) and treatment teams during the engagement and transition phases of service. The Community Planning Team assesses strengths, preferences and needs, arranges safe, clinically appropriate and stable places to live for each client, and ensures that other needed medical, behavioral health, and social services are in place.

This program maintains a staff to client ratio of 1 case manager for every 10 clients. Staff maintain availability 24 hours a day, 7 days a week for psychiatric assessment and medication prescription and

monitoring when needed by clients and to provide supervised health care when needed by clients (e.g., nutrition management, chronic health condition management). The program supports individual subsidized apartments and supported living homes dedicated to clients with 24 hours a day, 7 days a week staff availability to provide intensive support services as needed. Additionally, 24 hours a day, 7 days a week crisis and stabilization services are stationed in close proximity to clients' houses and apartments.

Requesting Exceptions

Program staff can request an exception from BHRD if it is anticipated that a client will need an extension of days-of-service when in a local medical or psychiatric bed at a hospital, residing in a local jail or DOC facility (non-ECS clients only), or is on unauthorized leave while the Consortium is working to locate and/or transition the client back into the program. Program staff are expected to provide the frequency of service indicated above while a client is out of the facility in order to be considered for an exception.

- Exceptions are requested using the protocol developed by BHRD in collaboration with ECS program staff.
- In cases where a client is not expected to return to ECS, program staff work toward transition within 60 days.

ICSRP Eligibility Criteria	
Medicaid Status	Yes
Age Range	All Ages
Authorization Needed	Yes
Additional Criteria	• Determined eligible for the ECS Project through ECS screening process and referred for services by the KCHCLs; • No longer require active psychiatric treatment at an inpatient hospital level of care; • Have experienced multiple treatment failures and/or have been unable to maintain community tenure for a significant period of time; • Have significant barriers to community placement (e.g. criminal history, refusal of admission by other behavioral health Providers, etc.); • Can complete all activities of daily living (ADLs) tasks without hands on assistance; and • Are ready for engagement toward transition to the community; and • Currently in a long-term placement (15 months or more) at WSH; or • Currently in local hospital and on the WSH waiting list or at risk for referral to WSH and has been approved in consultation with KCHCL; or • Eligible for Medicaid upon discharge from WSH. • Referred by the Clinical Specialist and/or the Hospital and Mental Health Residential Coordinator.
ICSRP Reporting Requirements	
Monthly Reports	• ICSRP Engagement Log • ICSRP Census Log

2.5 Medication-Assisted Treatment (MAT)

Medication-Assisted Treatment (MAT) in an Opioid Treatment Program (OTP) is offered seven days a week to provide a continuum of treatment and recovery support services. Contracting agencies secure and maintain licensure with pertinent regulations including Washington Administrative Code (WAC) 247-341 and/or its successors; the Food and Drug Administration—21 Code of Federal Regulations (CFR) 291.505 and/or its successors; and the Drug Enforcement Administration –21 CFR 1301, 1304, 1305, and 1306 and/or its successors; as such regulations now exist or are hereafter amended. MAT services include:

- Prescribing and dispensing methadone or buprenorphine;
- Withdrawal management and maintenance on MAT medications;
- Physical exams;
- Clinical evaluations;
- Early intervention, education, and prevention services for Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS);
- Education and prevention of Hepatitis B and C;
- Referral for HIV or Tuberculosis treatment services if necessary; and
- Individual face-to-face treatment sessions and group treatment sessions as determined necessary using American Society of Addiction Medicine (ASAM) Criteria to assist the individual with Opiate Use Disorder (OUD) in reaching mutually agreed upon goals and objectives toward stability and/or recovery from drug and nicotine addiction including assessment; Individual Service Plans (ISP); individual sessions; family treatment and support; group treatment; and referral to and coordination with employment or education services or other meaningful activities based on client preferences for adults who are unemployed.

A Provider must be licensed as a Least Restrictive Alternative (LRA) Provider in order to monitor a client on a LRA per WAC 246-341-0805.

MAT peer support services that are provided by a state certified peer counselor and are part of the client's individual services plan are reimbursable outside of the dose day rate on a fee for service basis.

MAT Eligibility Criteria	
Medicaid Status	• Yes, with limited capacity to serve people who are non-Medicaid. • Non-Medicaid clients must meet income criteria (220% of federal poverty line) and priority population guidelines.
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	• Adults who meet Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5) criteria for a moderate to severe Opiate Use Disorder; • In need of MAT services as determined by an assessment instrument that incorporates the American Society of Addiction Medicine (ASAM) Criteria • The individual's needs cannot be more appropriately met by any other formal or informal system of support; and • Individuals must reside in King County or be assigned by a King County Regional Managed Care Organization. Individuals receive priority services as described in this Manual.
MAT Reporting Requirements	
Monthly Reports	• MAT Client Census Count

The Provider ensures the maximum number of clients enrolled at each site does not exceed the numbers cited below. Should the Provider need to enroll more clients the Provider submits a waiver request to their BHRD Provider Relations/Contract Specialist.

Evergreen Treatment Services

Unit 1	700
Unit 2	700
Unit 3	200
Renton Site	550

Therapeutic Health Services

Seneca Branch	385
Seneca Branch	385
Shoreline Branch	700
Eastside Branch	495

WCHS

Kent Treatment Solutions	600

The Provider maintains policies and procedures for courtesy dosing for Medicaid individuals.

When MAT services are determined to be appropriate, but not immediately available, individuals receive Interim Services via the King County Needle Exchange.

Interim Services: A centralized waiting list for the BHRD MAT services is kept by the Public Health – Seattle & King County (PHSKC) Needle Exchange. The Needle Exchange provides case management, overdose prevention, and admission support services while the client is on the waitlist.

Pregnant women are provided with comprehensive assessment services within 48 hours of referral and treatment services no later than seven days after the assessment has been completed. Waiting List Interim Services must commence upon request for services when comprehensive services are not immediately available.

Individuals who are injecting drugs are provided comprehensive assessment and treatment services no later than 10 business days after the service has been requested. Waiting List Interim Services must commence upon request for services.

MAT Vans

Evergreen Treatment Services maintains two publicly funded vans as part of MAT treatment:

- Van 1: (Mobile OTP Van) This is a customized van that is a fully functional OTP dispensary staffed by a dispensary nurse (Licensed Practical Nurse-LPN or Registered Nurse-RN), a dispensary technician who assists the nurse, and staff who collects urine samples. This van is stationed and operates in the greater Seattle area in areas known for illicit opioid use.
- Van 2: This van is stationed and operates in coordination with Van-1.

2.5.1 Jail-Based MAT (Therapeutic Health Services Only)

In addition to the MAT requirements described above, Jail dosing services are provided to eligible adults who are incarcerated at the King County Correctional Facility (KCCF) in Seattle and the Maleng Regional Justice Center (MRJC) in Kent. Verification of active enrollment in MAT services in the community immediately prior to incarceration must be documented. Nursing staff providing MAT services in the jail must obtain jail clearance and identification badges through the King County Department of Adult and Juvenile Detention (DAJD) before accessing the KCCF or the MRJC. Case coordination is required for those individuals who will continue receiving MAT services upon release from custody to the community.

If a client receiving jail dosing is released from jail on a Friday or Saturday, the Provider provides sufficient dose carries for the individual to make it to their next appointment at a MAT agency.

The Provider sets-up an appointment with a MAT Provider for clients who are receiving jail dosing prior to their release from custody.

MAT Jail Dosing Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Actively enrolled in MAT services in the community immediately prior to incarceration; and • Incarcerated at the KCCF-Seattle or the MRJC-Kent, or a municipal jail.

2.5.2 Medication for Opioid Use Disorder (MOUD) in a Residential Setting (Pioneer Human Services and Triumph Treatment Services Only)

MOUD dosing is provided in the residential treatment facility by an approved third-party Provider (for non-Medicaid clients or other cases as approved by the Provider Relations/Contract Specialist. In addition, the Residential Provider has policies and procedures for MOUD dosing.

MOUD Dosing in a Residential Setting Reporting Requirements	
Monthly Reports	SUD Census Report and MAT Log

2.6 Program for Assertive Community Treatment (PACT)

PACT is a service delivery model for providing robust and comprehensive community-based treatment to adults with severe and persistent mental illness per the Assertive Community Treatment (ACT) evidence-based practice model of care. The eligibility criteria, array of PACT services, and Provider requirements are documented in the Washington State PACT (WA PACT) Program Standards

The Program for Assertive Community Treatment (PACT) is an individualized treatment approach that offers intensive services in the community utilizing a multi-disciplinary team to provide a single point of accountable care. PACT services are mobile, flexible, and can deliver tailored mental health and co-occurring disorder treatment to support individuals in community tenure and their pursuit of recovery. Service components of PACT include:

- Treatment, support, and psychiatric rehabilitation services provided directly by the PACT team as a unit;
- Assistance in acquiring and maintaining housing for participants who are experiencing homelessness or are at risk of becoming homeless according to a Permanent Supportive Housing (PSH) model;
- Co-occurring disorder services based on an Integrated Dual Diagnosis Treatment (IDDT) treatment model that is non-confrontational, focused on Harm Reduction, and considers interactions of mental illness and substance abuse;
- Assistance in pursuing participant education and employment goals;
- Wellness and recovery promotion including peer support services, recovery planning, and development of social supports;
- Assistance in meeting basic needs and developing independent living skills;

- Low staff to participant ratios;
- Comprehensive and flexible range of treatment and services;
- Interventions occurring primarily in community settings rather than in clinical settings;
- 24 hour a day availability of services including crisis response; and
- Engagement of individuals in treatment and recovery.

Community Behavioral Health Rental Assistance (CBRA)

CBRA provides long-term or bridge rental subsidies for high-risk individuals with behavioral health conditions and their households. When partnered with programs offering supportive housing services, highly-vulnerable persons with complex behavioral health needs have opportunities to live independently in the communities of their choice.

PACT Providers administering CBRA should follow the CBRA program guidelines and requirements found within the Program Guidelines document for the current fiscal year, which is published on the following Washington State Department of Commerce webpage: Permanent Housing Subsidy Programs - Washington State Department of Commerce.

HARPS Housing Bridge Subsidy Funds for PACT Consumers

PACT Providers administering HARPS Housing Bridge Subsidy are encouraged to have housing subsidy policies in place to address appeals, denials, and the following guidelines. PACT Providers administering HARPS Housing Bridge Subsidy apply internal controls that are aligned with generally accepted accounting principles to ensure that invoiced costs are accurate, allowable, and reasonable.

The HARPS Housing Bridge Subsidy provides short-term funding to help reduce barriers and increase access to housing. Individuals exiting detox, 30, 60, and 90-day inpatient SUD treatment facilities, residential treatment facilities, state hospitals, E&T's, local psychiatric hospitals, and other inpatient behavioral healthcare settings could receive up to 3 months of HARPS Housing Bridge Subsidy.

HARPS Housing Bridge Subsidies are temporary in nature and should be combined with other funding streams, whenever possible, to leverage resources to assist individuals with obtaining and maintaining a permanent residence.

HARPS Housing Bridge Subsidies are estimated at $2,500 per person, but can be adjusted as needed to meet Fair Market Rental Housing rates as long as the total is within the contracted amount.

A PACT participant is eligible for HARPS Housing Bridge Subsidy if they meet the following eligibility criteria:

- The individual is a King County PACT participant with an open authorization for either PACT Engagement or PACT Enrollment; and
- Is 18 years of age or older; and
- Is experiencing a behavioral health disorder; and
- Is being released from or at risk of entering a psychiatric inpatient setting and/or SUD residential treatment program; and

- Is homeless or at risk of homelessness; and

- Is not eligible for Medicaid through Foundational Community Supports Supportive Housing Services.

Allowable expenses for HARPS Housing Bridge Subsidy include:

- Monthly rent and utilities, and any combination of first and last months' rent for up to three months. Rent may only be paid one month at a time, although rental arrears, pro-rated rent, and last month's may be included with the first month's payment. Payments beyond three months may be provided with King County pre-approval;
- Rental and/or utility arrears for up to three months if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit. The HARPS Housing Bridge Subsidy may be used to bring the program participant out of default for the debt and the PACT Provider will assist the participant to make payment arrangements to pay off the remaining balances. Payments beyond three months may be provided with King County pre-approval;
- Security deposits and utility deposits for a household moving into a new unit;
- Rent assistance for move-in costs including but not limited to deposits and first month's rent associated with housing, including project- or tenant-based housing;
- Application fees, background and credit check fees for rental housing;
- Lot rent for RV or manufactured home;
- Costs of parking spaces when connected to a unit;
- Landlord incentives (provided there are written policies and/or procedures explaining what constitutes landlord incentives, how they are determined, and who has approval and review responsibilities);
- Reasonable storage costs;
- Reasonable moving costs such as truck rental and hiring a moving company;
- Hotel/motel expenses for up to 30 days per year per household if unsheltered households are actively engaged in housing search and no other shelter option is available. Payments beyond 30 days may be provided with county pre-approval; and
- Temporary absences. If a household must be temporarily away from unit, but is expected to return (e.g., client violates conditions of their Department of Corrections (DOC) supervision and is placed in confinement for 30 days or re-hospitalized), HARPS Housing Bridge Subsidy may pay for the household's rent for up to 60 days per year. Payments beyond 60 days may be provided with King County pre-approval.

- Rental payments to Oxford houses or other Recovery Residences on the Recovery Residence Registry located here: Workbook: Residence/Oxford House Locations (wa.gov)

PACT Eligibility Criteria	
Medicaid Status	Yes, limited funding available for Medicare only and unfunded individuals
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Refer to Washington State PACT Program Standards Section III.A. Admission Criteria
PACT Reporting Requirements	
Monthly Reports	• PACT Monthly Report • HARPS Participant Log-due the 10th of the month following the reporting period • **For PACT Providers administering CBRA:** CBRA Monthly Log-due the 10th of the month following the reporting period. Final reports for the biennium may be due sooner.
Semi-annual Reports	• PACT Transition Scale
Annual/Other Reports	• **For PACT Providers administering CBRA:** Upon request, Providers will submit accurate and complete information for the Annual County Expenditure Report to the Consolidated Homeless Grant Lead Contractor in the communities in which they serve. • **For PACT Providers administering CBRA:** Upon request, Providers will respond to requests for information by Department of Commerce.

2.7 Recovery Navigator Program

The Recovery Navigator Program (RNP) was developed in response to the endorsed Senate Bill 5476 addressing the State versus Blake decision. This program is a community-based outreach/engagement program that seeks to engage individuals who may benefit from behavioral health treatment and facilitate connections to the behavioral health treatment system. RNP serves Individuals who are at risk of arrest, or already have been involved in the criminal legal system. The focus population for the RNP is to serve individuals who intersect with law enforcement because of simple drug possession and/or have frequent contact with the criminal legal system because of unmet behavioral healthcare needs. The goal of the RNP is to make these services available across our region in areas that are currently not served or underserved, to remove barriers, and create a seamless approach to recovery.
This program assists individuals with a Substance Use Disorder (SUD), or substance use concerns in accessing outreach, treatment, and recovery support services that are low barrier, person centered, informed by people with lived experience, and culturally and linguistically appropriate.

RNP provides:

- Rapid response outreach to referrals
- Outreach services as long as needed to engage individual in other services
- Intake and referral services
- Biopsychosocial assessments
- Intensive case management
- Light case management

- Coordination with law enforcement, prosecutors, program staff, medical providers, and community partners
- Warm handoffs to treatment along the continuum of care
- Warm handoffs to recovery support as needed

Program Specific Requirements:

- Provide rapid response outreach/engagement services 30-45 minutes within urban and suburban areas and one hour to 1.5 hours in rural areas between the hours of 9am and 5pm, 7 days a week.
- Provide outreach and engagements services, case management services, recovery services, and to help navigate individuals to other behavioral health services that may be needed.
- RNP includes staff members who spend most of their time in the field. This will include spending time visiting community-based organizations and settings.
- The outreach and referral staff will be available to respond and engage upon referral.
- Outreach staff will connect with individuals who might need case management or ongoing referrals to external services.
- RNP staff prioritizes responses to law enforcement calls in the early stages of this program with the long-term goal of being able to respond to any community-based and emergency response referral and coordinate with case management staff to meet the individual needs of new and existing program participants.
- Provide ongoing recovery support through RNP outreach workers and, when agreed upon with the individual, longer-term light and intensive case management services which may include, a biopsychosocial assessment, referrals and linkage to access services across the continuum of care.
- Coordinate communication between law enforcement, prosecutors, program staff, medical providers, and community partners.
- Provide behavioral health information and resources to staff and volunteers at local community-based organizations and to individuals living in rural unincorporated areas about the availability of behavioral health services.
- RNP maintains a sufficient number of appropriate personnel, including people with lived-experience in SUD to the extent possible, to provide outreach/engagement services, case management services, and supervision/management for all program staff.
- Each zone has staff designated to work on the rural enhancement project to provide services within the rural Community Service Areas (CSAs).
- Outreach services will begin at first referral and case management services will begin when the individual agrees to services by signing the program Release of Information Form
- The program provides funds for client direct service expense.
- Participating RNPs collect and provide data points related to the individuals referred into the program, and service date(s) on participant they serve within the RNP program.

Other support services may include, but is not limited to the following:

- Outreach and engagement to meet with harder to serve populations
- To help individuals who need assistance learning how to use technology and telehealth
- Paying for staff's mileage
- Establishing extra office space to allow for proper social distancing
- Other expenses as approved by your BHRD RNP Program Manager

Reimbursement is contingent on available funding. Reimbursement is available for activities conducted and expenses incurred between April 1, 2022 and December 30, 2023.

Method of Payment:

- Reimbursement is made based on actual costs for eligible expenses outlined above.
- Receipts and payment documents must be submitted with the invoice.
- The amount requested for outreach/coordination should be equal to the staff time spent on that activity multiplied by their hourly salary.

Additional Requirements:

- The Provider attests that by submission of this invoice, they have not been reimbursed by any other fund source.

Crisis Housing Voucher

Crisis Housing Vouchers provide short-term housing to eligible individuals. These residential supports target individuals who are assessed to need more intensive support and stability immediately following a behavioral health crisis and are intended to increase the opportunity for stability while awaiting more permanent housing solutions. Providers administering Crisis Housing Vouchers will find a short-term housing placement, pay for the placement, and refer individuals to community-based supportive housing programs. Follow-up supports will be coordinated and provided by the community-based supportive housing program.

Individuals are eligible for Crisis Housing Vouchers if they are clinically assessed to be experiencing a behavioral health crisis, need supportive housing services, and are experiencing homelessness or are unstably housed. An individual is clinically assessed to be experiencing a behavioral health crisis if they are being referred from a crisis facility or if they have experienced a Crisis Event. A Crisis Event is defined as a period of time of engagement by crisis hourly staff with a person who is experiencing symptoms of a behavioral health disorder which currently outweigh their abilities to tolerate, minimize, or attend to those symptoms or other current circumstances, the person does not appear to meet involuntary detainment criteria under RCW 71.05, and the person is at a higher risk for victimization in the current situation or circumstance if they remain in the current situation or circumstance without respite. Individuals may experience more than one stay at a crisis facility or Crisis Event, therefore, their eligibility if based on the stay or event.

Crisis Housing Vouchers will be dispersed based on the need of the eligible individual. They initially cover a maximum of 14 days, but can be extended an additional 14 days at the discretion of the provider.

Crisis Housing Vouchers are intended to be utilized at:

- **Hotel**- An establishment that provides paid lodging on a short-term basis.
- **Motel**- An establishment that provides lodging and parking and in which the rooms are usually accessible from an outdoor parking area.
- **Family Member or Friend**- A verified family member or friend of the eligible individual that agrees to temporarily house them.

- **Other Housing Related Expenses**- On a case-by-case basis and with prior-approval, Crisis Housing Vouchers may be approved for other housing related expenses. Prior approval must be requested through the Crisis Housing Voucher Exception Request Form.

When a provider utilizes a Crisis Housing Voucher, a referral to a community-based supportive housing program also must occur.

- A referral to the community-based supportive housing program Forensic HARPS must occur for individuals who meet the following criteria:
    - Have had at least two contacts with the forensic mental system in the past 24 months, or were brought to a crisis diversion facility or brought to the attention of a mobile crisis responder team via arrest diversion in accordance with RCW 10.31.110;
    - Need assistance accessing independent living options and would benefit from short-term housing assistance beyond the 14-day vouchers;
    - Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Housing Voucher;
    - Are unstably housed;
    - Are not currently in the community outpatient competency restoration program; and
    - Do not meet Involuntary Treatment Act commitment criteria (RCW 71.05).

- If an individual is not eligible for Forensic HARPS, a referral must be made to another community-based supportive housing program. This can include, but is not limited to, Foundational Community Supports Supportive Housing, traditional HARPS programs, local coordinated entry systems, or other community-based supportive housing programs.

- Referrals must be made by or within the same day as Crisis Housing Voucher utilization.

- Referrals must be made via secure email, phone call, or fax.

Recovery Navigator Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth and Adult
Authorization Needed	No
Additional Criteria	N/A
Monthly Reports	• RNP Data Collection Tool • RNP Monthly Report • RNP FTE Report and time sheets (as need for ARPA funds) • Crisis Housing Voucher Log-due the 5th of the month following the reporting period
Annual/Other Reports	• Other information as requested by SAMHSA, HCA and/or BHRD

Attachments in this Section

- Attachment A: Crisis Housing Voucher Exception Request Form

2.8 Transitional Recovery Program (TRP) at the Maleng Regional Justice Center

TRP is a Washington State licensed and certified outpatient substance use disorder (SUD) treatment program sited at the Maleng Regional Justice Center (MRJC) in Kent. TRP was developed as a 60-day, in-custody treatment program, with a capacity of 36 adult participants, for King County Adult Drug Diversion Court (ADDC) participants who are rebooked into the King County Jail as a result of a drug-related arrest. TRP was subsequently expanded to include referrals from King County Juvenile Drug Court (JDC) and King County Regional Mental Health Court (RMHC) with the addition of a licensed mental health professional, effectively transforming TRP into a co-occurring disorders treatment program. The expanded maximum capacity of the TRP is 42 adult participants (24-30 men and 6-12 women). Referrals from ADDC have priority access to TRP. The program consists of the following validated tools and evidence-based practices:

- Global Appraisal of Individual Needs—Individual (GAIN-I) Lite assessment instrument;
- Moral Resonation Therapy (MRT);
- SUD treatment curriculum is based on the Transtheoretical Model of Change (1) using the following recovery tools: *Straight Ahead: Transition Skills for Recovery*; *Downward Spiral*; *Mapping New Roads to Recovery*: *Cognitive Enhancements to Counseling*; *Preparation for Change*: *The Tower of Strengths and The Weekly Planner;* and *Thinking for a Change*: *Integrated Cognitive Behavior Change Program*.

Transitional Recovery Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes

Additional Criteria	• Adult men and women participants of ADDC who are incarcerated in the King County Jail and who:
	  • Are referred to TRP and will serve 60 consecutive jail days;
	  • Meet established Classifications criteria approved by the Department of Adult and Juvenile Detention;
	  • Are assessed as having an SUD or having a substance abuse problem that, if not treated, would result in a SUD; and
	  • Meet American Society of Addiction Medicine (ASAM) Criteria, or its successors, for outpatient or intensive outpatient substance use disorder treatment.
	• Men and women participants (maximum of three) of JDC who are incarcerated in the King County Jail and who:
	  • Are aged 18 years or older;
	  • Are referred to TRP and will serve 60 consecutive jail days;
	  • Meet established Classifications criteria approved by DAJD;

[1] **The research efforts primarily of Prochaska, J., Norcross, J., & DiClemente, C. led to the identification and development of the Transtheoretical Model of Change. This model, as it pertains to substance use disorder treatment, is profiled in: Connors, G., Donovan, D., DiClemente, C., (2002). *Substance Abuse Treatment and the Stages of Change*. New York: Guilford Press.**

	• Are assessed as chemically dependent or having a substance abuse problem that, if not treated, would result in addiction; and • Meet ASAM Criteria for outpatient or intensive outpatient substance use disorder treatment. • Adult men and women participants (maximum of three) of RMHC who are incarcerated in the King County Jail and who: • Are referred to TRP and will serve 60 consecutive jail days; • Meet established Classifications criteria approved by DAJD; • Are screened by JHS staff for medical and psychiatric housing needs, if requested by DAJD Classifications; • Are medically stable, including medications management; and • Meet ASAM Criteria for outpatient or intensive outpatient substance use disorder treatment.
Transitional Recovery Program Reporting Requirements	
Monthly Reports	TRP Staffing Report
Quarterly Reports	Criminal Justice Treatment Account (CJTA) Project Plan Report
Annual/Other Reports	CJTA Project Plan Annual Report (for In-custody Projects that Exceed 8-Session Limit)

2.9 Corrections-based Substance Use Disorder Treatment Services at the Maleng Regional Justice Center (MRJC)

In-custody substance use disorder (SUD) treatment services are provided to adult men with varying lengths of stay at the MRJC in Kent. The program has a maximum capacity of 36 participants on any given day.

Evidence-based tools and a curriculum adapted to serve people of color are applied utilizing a trauma-informed, modified Therapeutic Community (TC) approach; cognitive behavioral interventions are applied to address criminogenic risk factors. The program is funded by the MIDD Behavioral Health Sales Tax Initiative RR-12 – Jail-based Substance Abuse Treatment.

Corrections-Based SUD Treatment Services at the MRJC Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Adult men demonstrating medium to high risk for substance abuse via a validated Risk-Need-Responsivity (RNR) tool who are incarcerated at, or transferred to, the MRJC for a projected period of 14 days or longer, and who: • Meet the established classifications criteria approved by the King County Department of Adult and Juvenile Detention; and • Meet medical necessity for outpatient or intensive outpatient SUD treatment.
Corrections-Based SUD Treatment Services at the MRJC Reporting Requirements	

Monthly Reports	• Corrections-based SUD Treatment Services at MRJC Staffing Report. • Corrections-based SUD Treatment Services at MRJC Flex Fund Expenditures Report.

Annual/Other Reports	• Upon request from the County, an Annual Outcomes Report is submitted to include:
	  • A description of the activities, successes and challenges of the program; and
	  • A summary of the accomplishment of outcomes/goals of the program.

2.10 Substance Use Disorder Mobile Medical Van Outreach Services

Substance Use Disorder Mobile Medical Van Outreach Services provide substance use disorder (SUD) outreach and intervention services for homeless individuals who are accessing services at the Public Health – Seattle & King County (Public Health) mobile medical van in an effort to engage them in SUD treatment services. This program strives to lower barriers to SUD treatment for homeless individuals and individuals with chronic behavioral health issues. It also aims to increase collaboration between SUD treatment Providers, Public Health, and prevention and health service treatment Providers. The Provider provides the following array of support services: SUD screenings, assessment, face-to-face sessions, case management, and outreach services.

The Provider establishes and maintains a record for each individual served under this program who receives SUD outreach and intervention services and/or assessment. The record includes, but is not limited to:

- SUD screenings and/or assessments;
- Financial eligibility screens;
- Outreach, case-management, care coordination progress notes; and
- Confidentiality agreements.

The Provider has a Health Information System (IS) that complies with the requirements of 42 CFR Part 438.242. The Provider maintains records in a secured room, locked file cabinets, safe, or other similar container, to meet requirements to protect client confidentiality. Electronic records are maintained on a password protected computer. The Provider establishes and maintain a written interagency protocol or Memorandum of Agreement (MOA) with Public Health available for review at the request of the County. The protocol or MOA covers the following areas of administration and coordination:

- Collaboration on the selection and/or hiring of a Substance Use Disorder Professional (SUDP) who will provide services under this scope of work;
- Day-to-day oversight and coordination of a SUDP is provided by Public Health;
- Provision of supervision specific to SUD expertise by the Provider;
- Amount of time the SUDP will be physically located at the mobile medical van;
- Coordination with Public Health regarding leave time and release time to maintain SUDP certification;
- Attendance at required meetings including, but not limited to:
- Mobile Medical Program Meetings; and
- Evergreen/REACH meetings;

- Compliance with the internal Mobile Medical Program documentation requirements;
- Creating a SUDP work schedule that matches the medical van's clinic schedule;
- Location of the SUDP's workstation;
- Ensuring the SUDP is not used by Public Health to meet the staffing requirements of other contracts; and
- Collaboration with Public Health to ensure that MOA requirements are met

SUD Mobile Medical Van Outreach Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years and older
Authorization Needed	No
Additional Criteria	Individuals meet the standards for low-income client eligibility as described in the King County BH-ASO low-income eligibility tables, located in the ISAC Notebook under "Income Transaction." For access to the ISAC Notebook, please contact your agency's ISAC representative

SUD Mobile Medical Van Outreach Services Reporting Requirements	
Monthly Reports	SUD Mobile Medical Van Outreach Report
Quarterly Reports	SUD Mobile Medical Van Evaluation Report Deadlines for submitting quarterly reports to the County are as follows: • January through March due April 10 • April through June due July 10 • July through September due October 10; and • October through December due January 10.

2.11 Wraparound with Intensive Services (WISe)

WISe is a range of Medicaid-funded service components that are individualized, intensive, coordinated, comprehensive, culturally relevant, and home and community based. The delivery of these services will be by a WISe approved agency, and referred to as the triad model. Beginning March 1, 2020, the Managed Care Organizations (MCOs) operating in King County assumed direct contracting with the WISe Providers in King County to manage and oversee these WISe services, in accordance with the Health Care Authority (HCA) WISe Program, Policy and Procedure Manual, 2019 edition and its successors.

The MCO's have delegated back to King County the monitoring of youth remaining in the split model. These are youth receiving mental health services at an agency different from the agency providing the facilitation and peer supports. King County will track service intensity and monitor service plans until these youth attrition out of this service.

Each ICN Mental Health Provider in the split model has agreed to maintain an average of 7 service hours per youth per month while continuing with WISe. The WISe Providers offering the facilitation and peer support will maintain a minimum of 3-4 service hours per youth per month. The total average number of services hours per youth per month is 10.5 in accordance with the standards set forth by HCA in the WISe manual.

WISe Eligibility Criteria (Medicaid)	
Medicaid Status	Yes
Age Range	0-21
Authorization Needed	Yes
Additional Criteria	Pre-approved by MCO prior to 3/1/2020
WISe Reporting Requirements	
Monthly Reports	WISe Discharge Report

3 Inpatient Psychiatric Services

3.1 Involuntary Treatment Triage Program

The Involuntary Treatment Triage Program consists of psychiatric evaluation services for up to 90 days for individuals who have been charged with serious misdemeanor offenses and suffer with a serious mental health condition, and who are found by the court to be not legally competent to stand trial. The criminal case is then dismissed, and the court orders the individuals to be psychiatrically evaluated in accordance with Revised Code of Washington (RCW) 10.77.088 (1) (b) (ii) ("Dismiss and Refer" case). Evaluations are conducted for individuals charged in Seattle Municipal Court and/or King County District Court who are incarcerated in the King County Jail. Petitions are filed for a 90-day more restrictive order for individuals who are found to meet the threshold for civil commitment. The program is funded by the MIDD Behavioral Health Sales Tax Plan Initiative CD-14 – *Involuntary Treatment Triage Pilot*.

Involuntary Treatment Triage Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals eligible for this service must be 18 years of age or older and who: • Are incarcerated, having been charged with a serious misdemeanor offense as determined by the Prosecuting Attorney; • Have a mental disorder or a mental disorder cannot be ruled out; and • Are referred by the court after an order for evaluation for a 90-day psychiatric hospitalization.
Involuntary Treatment Triage Program Reporting Requirements	
Monthly Reports	• Involuntary Treatment Triage Report
Annual/Other Reports	• An annual report providing a description and analysis of program activities, successes, challenges, and additional funding sources (including in-kind contributions) identified to support program activity.

3.2 Sixteen Bed Evaluation and Treatment Facility Services

Evaluation and Treatment (E&T) Facilities provide psychiatric inpatient services to individuals who exhibit acute psychiatric symptoms to the level of meeting criteria for risk of harm and are detained according to the Involuntary Treatment Act as described in RCW 71.05. Facilities provide evaluation and treatment services under the Adult Residential Rehabilitation state licensure as described in WAC 246-322 and/or Behavioral Health Services Administrative Requirements as described in WAC 246-341.

All individuals are eligible for crisis services in the Behavioral Health-Administrative Services Organization (BH-ASO). E&T Facilities provide evidence-based treatment and recovery services in the inpatient setting that meet compliance criteria for patient rights while they are involuntarily detained. E&T facilities are expected to adhere to treatment guidelines for timely evaluation, discharge planning, safety, and ITA laws and regulations as outlined in WAC 246-322 and RCW 71.05 for adults (RCW 71.34 for youth if applicable).

Program Specific Requirements

For each individual, E&T facilities provide:

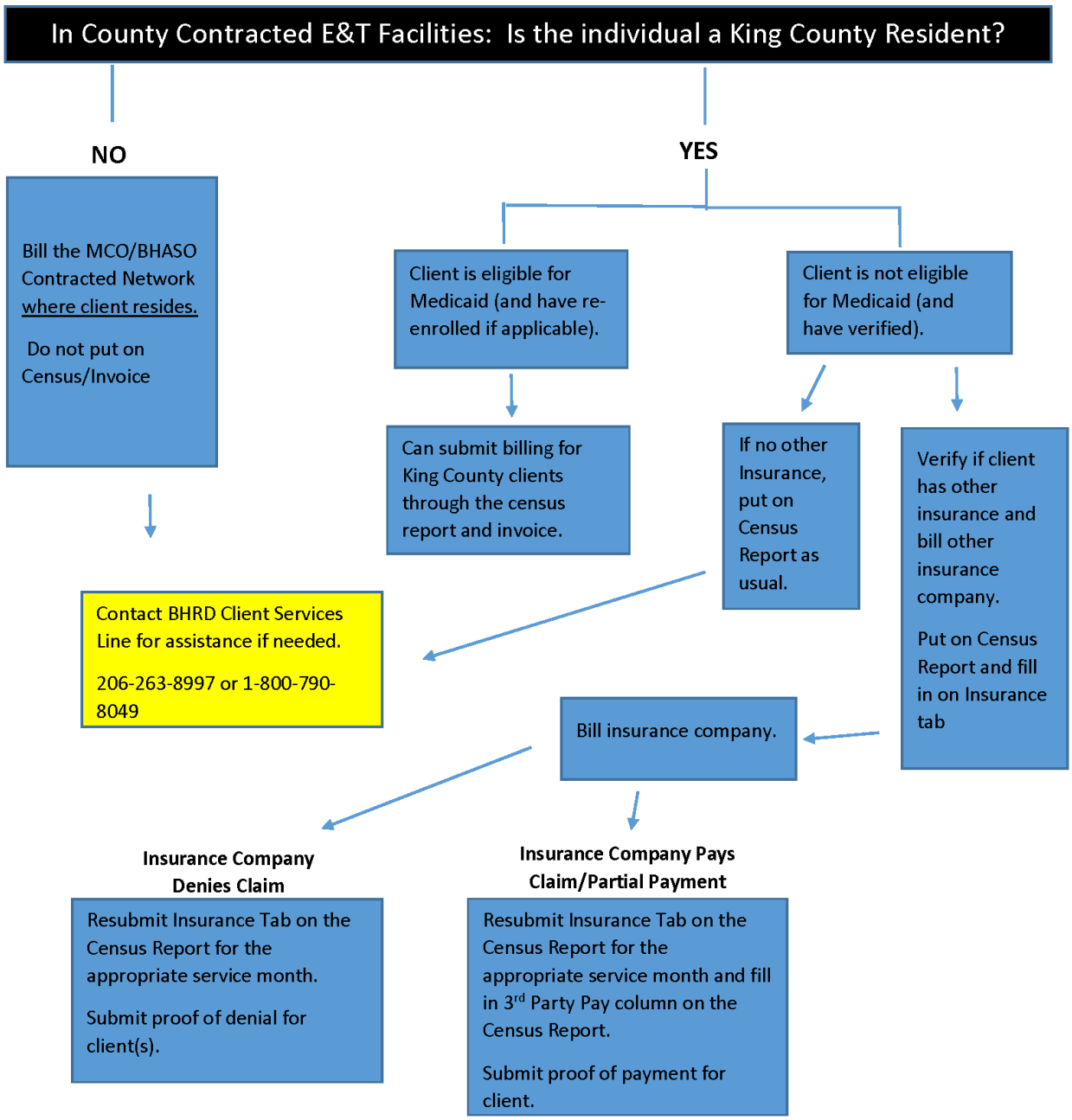
- Admissions of an individual twenty-four hours a day, seven days a week, per WAC 246.341-0810(4) or its successor.
- A comprehensive diagnostic psychiatric evaluation and an initial treatment plan completed by MD/ARNP within 24 hours of admission as described in RCW 71.05.210.
- This evaluation includes a review of any applicable Mental Health Advanced Directives as described in RCW 71.32.
- A comprehensive History and Physical examination completed by MD/ARNP/RN within 24 hours of admission as described in WAC 246.322.170 or its successor.
- A daily evaluation including current progress towards treatment plan goals, medication management and justification of continued detainment based on imminence criteria as described in RCW 71.05.
- Clinical documentation includes a description of current status and clinical acuity, current diagnosis or changes in diagnosis, symptoms that support diagnostic criteria, current medications and any changes, interventions used to address symptoms, relevant lab results, and any other relevant medical data.
- Daily coordinated efforts to evaluate an individual's readiness to move towards a lower level of care including coordination with outpatient behavioral health providers, social service providers or individual's natural supports.
- Services and treatment that aligns with Individual Rights as outlined in this manual in Section 1.9. In addition, individuals who have been involuntarily detained have additional rights as described in RCW 71.05.360.
- Use of multidisciplinary team for the development of a comprehensive treatment plan to ensure patient care services as outlined in WAC 246.322.170 or its successor. Services ideally include, but are not limited to:
  - Person centered treatment with a recovery focus, utilizing trauma informed care principles, and demonstrating cultural competence;
  - Daily services and therapeutic strategies to promote safety and healing;
  - Medication management services;
  - Psychotherapeutic interventions – individual and group;
  - Address any presenting co-occurring disorders;
  - Peer Support Services;
  - Engaging the individual in discussing treatment options and partnering in treatment planning. Daily review of the individual's willingness to engage in a less restrictive treatment option and/or voluntary treatment options including outpatient behavioral health services;
  - Address care of co-morbid physical health conditions and any needed coordinated care efforts; and
  - Safety planning.
  - Discharge planning is completed by a designated discharge planner. Responsibilities include, but are not limited to:
  - Involvement of the individual, family, and natural supports throughout the discharge planning process;

  - Providing linkage to outpatient behavioral health services, coordination with existing outpatient resources and ensure the individual leaves with medications in hand (if an individual does not have ongoing outpatient behavioral health services in place, the discharge planner facilitates linkage to these services prior to discharge);
  - Review of the individual's insurance coverage status upon intake;
  - Assisting all individuals who are not enrolled, but eligible for Medicaid, to apply for coverage;
  - Scheduling follow-up visits with outpatient behavioral health providers for continuity of care and medication management no later than 7 days from time of discharge;
  - Use of Collective Medical to improve system wide coordinated care efforts;
  - Coordination with community resources, including discharge to stable, safe, and secure housing with a specific transportation plan at the time of discharge, whenever possible; and
  - Contacting the individual's county of residence outside King County for purposes of discharge planning. This applies to individuals who were detained by King County Designated Crisis Responders (DCRs) and reside outside of King County.
- There must be an Attending MD/ARNP available 24-7 for emergent consultation (WAC 246-322-170).
- The following requirements for safety, seclusion care and restraints according to WAC 246-322-180 and WAC 246-377-110 include, but are not limited to:
  - E & T facilities having a minimum of one seclusion room for seclusion or temporary holding of individuals
  - E&T facilities having a minimum of one seclusion room for seclusion or temporary holding of individuals;
- Individuals have the right to be free of all forms of seclusion and physical and chemical restraints;
  - Seclusion and restraints will not be used as a means of coercion, discipline, convenience, or retaliation;
  - Seclusion and restraints may only be used for the purpose of protecting the individual or others and only if less restrictive de-escalation interventions have been determined to be ineffective; and
  - If seclusion and restraints are used, the duration will be as brief as possible.
- E&T facilities provide court evaluation and testimony services including, but not limited to, preparation, documentation and timely filing of legal documents and pre-court planning pertaining to the involuntary detention of individuals at the facility as required by RCW 71.05 (71.34 for youth), applicable WAC's and the King County Superior Court Systems.
- For clients that elope from facilities:
  - When a client on a 14 or 90-day order elopes from a certified E&T, a facility representative immediately calls 911 to report the elopement.
  - As soon as possible, the facility representative notifies Crisis and Commitment Services (CCS) about the elopement so that the DCR can respond appropriately if the client is apprehended.
  - Complete a Critical Incident Report as instructed in the Critical Incidents Program and Reporting Requirements Section of this Provider Manual.
  - During normal ITA Court hours, the facility representative should contact the ITA Prosecuting Attorney to determine if the Court will issue a bench warrant for the eloped client.
  - E&Ts will re-admit eloped clients unless the intent is to release the client from the court order.

Additional Program Specific Requirements

- E&T facilities provide services for a 16-bed treatment facility.
- E&T facilities ensure documentation of services occur per licensing, certification, and accreditation requirements.
- E&T facilities ensure each individual has at least one service encounter entered daily and submitted to King County Behavioral Health and Recovery Division (BHRD) Information System (IS) System.

Please see process walk below for information on billing guidelines.


In County Contracted E&T Facilities: Is the individual a King County Resident?
NO
YES
Bill the MCO/BHASO Contracted Network where client resides.
Do not put on Census/Invoice
Client is eligible for Medicaid (and have re-enrolled if applicable).
Client is not eligible for Medicaid (and have verified).
Can submit billing for King County clients through the census report and invoice.
If no other Insurance, put on Census Report as usual.
Verify if client has other insurance and bill other insurance company.
Put on Census Report and fill in on Insurance tab
Contact BHRD Client Services Line for assistance if needed.
206-263-8997 or 1-800-790-8049
Bill insurance company.
Insurance Company Denies Claim
Resubmit Insurance Tab on the Census Report for the appropriate service month.
Submit proof of denial for client(s).
Insurance Company Pays Claim/Partial Payment
Resubmit Insurance Tab on the Census Report for the appropriate service month and fill in 3rd Party Pay column on the Census Report.
Submit proof of payment for client.

OTHER CIRCUMSTANCES

Is this an AI/AN client?

Claims need to be submitted directly to the State for payment.

https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-

If the client has Medicare: Document in client's record that E&T is not covered by Medicare and bill King County as the primary payer.

Does the client have a spenddown?

If Spenddown HAS BEEN MET:

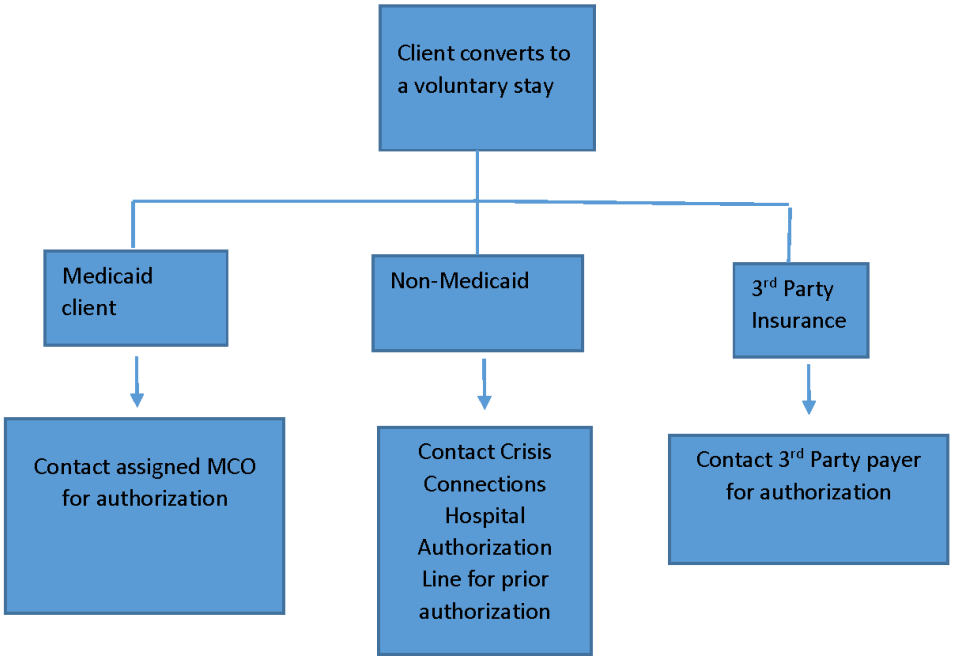
Can bill the King County client through King County ICN via Census report.

If Spenddown has NOT BEEN MET:

Place the spenddown amount in the appropriate column in the Census spreadsheet. BHRD will pay the spenddown only.

Submit information to DSHS to meet Spenddown, more information can be found here:
https://www.dshs.wa.gov/esa/community-services-offices/spenddown

Voluntary Stays for King County Residents

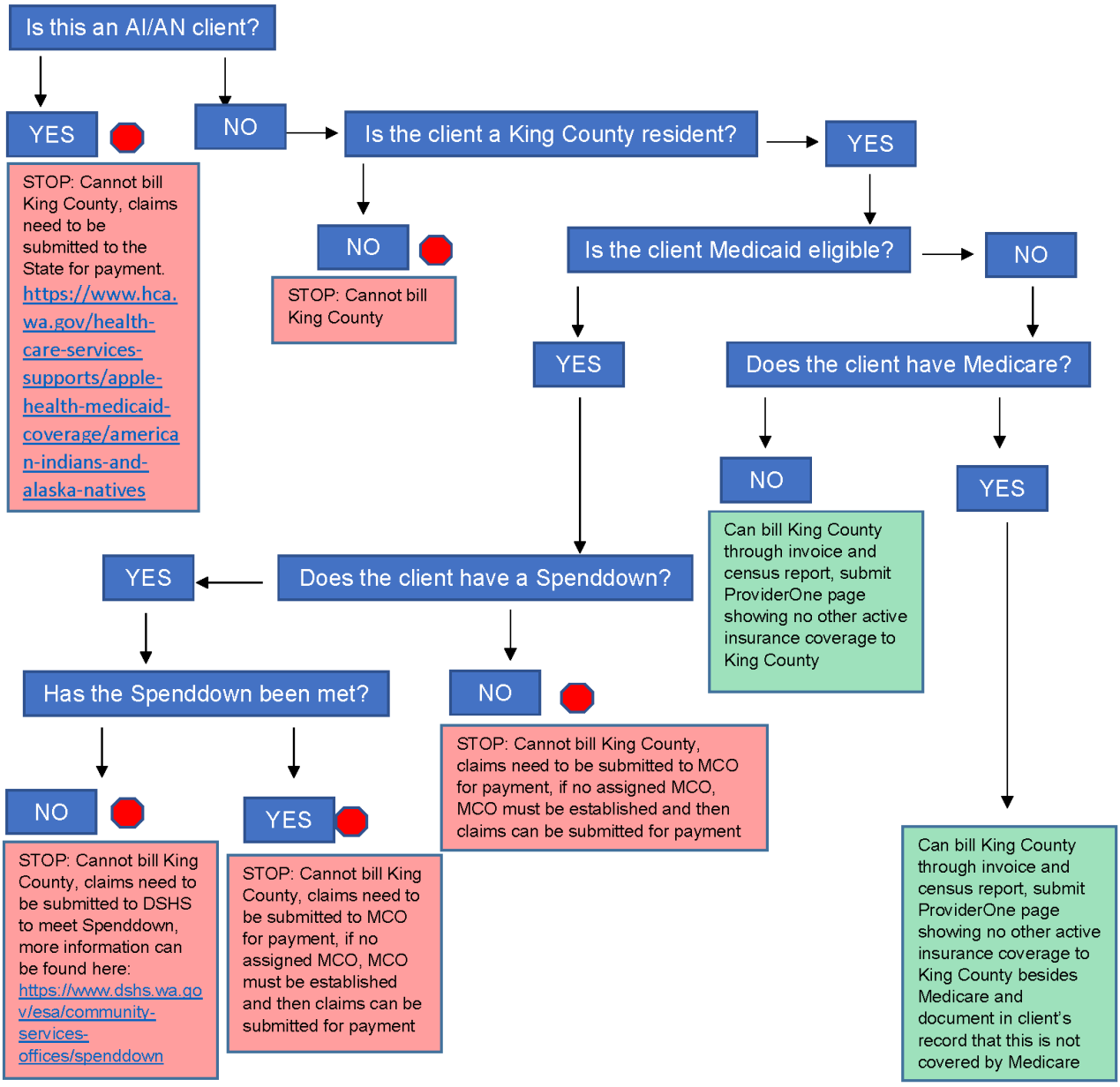


Sixteen-Bed Evaluation and Treatment Facility Services Eligibility Criteria	
Medicaid Status	No
Age Range	Adults: Age 18 years and older (If applicable, Youth: 17 years and younger)
Authorization Needed	Services to eligible persons for Involuntary Treatment must be authorized by the DCRs. For Voluntary Hospitalizations, prior authorization must be approved by MCOs (Medicaid eligible individuals) or Care Authorizers at Crisis Connections (Non-Medicaid eligible individuals)
Additional Criteria	Individuals eligible for this service must: • Have been involuntarily detained by a Designated Crisis Responder (DCR) for a 120 hour evaluation and treatment period; or • Committed by the King County Superior Court for a 14-day period of evaluation and treatment under Revised Code of Washington (RCW) 71.05 and 71.34; or • Referred by the DCR's through the revocation process provided in RCW 71.05 and 71.34.
Sixteen-Bed Evaluation and Treatment Facility Services Reporting Requirements	
Monthly	• E&T Census Report • E&T Admission/Denial Log • E&T Discharge Planner Report • E&T Seclusion and Restraint Report

E&T for Non-Medicaid Clients (For Out-of-County Providers Only)

Starting January 1, 2020, out-of-county E&T Providers must submit billing directly to King County for King County clients that do not have Medicaid. A contract with King County Behavioral Health and Recovery Division must be in place for E&T's to receive payment. E&T Providers are referred to 3.1 Sixteen Bed Evaluation and Treatment Facility Services for an explanation for program requirements. A Process Flow document is included to guide out-of-county Providers on billing submission process. Please note King County BH-ASO is payment of last resort, and all other avenues must be exhausted first, i.e. private insurance. Please see process flow below.

E+T Out of County Providers with KC Contract and Non-Medicaid Clients Process Flow



3.3 Voluntary and Involuntary Treatment Act (ITA) Inpatient Psychiatric Services for Non-Medicaid Individuals

This scope of work provides acute psychiatric hospital services for individuals needing inpatient psychiatric services who are not eligible for Medicaid. Hospitals can also contract to provide capacity for individuals who require involuntary treatment in accordance with the Involuntary Treatment Act and 71.05, 71.34 RCW.

Services are provided in a licensed facility that is qualified to provide mental health inpatient services as outlined in all applicable WAC's.

Program Specific Requirements

Providers of this scope of work are licensed and certified to provide inpatient psychiatric services as described in all applicable WAC's governing inpatient psychiatric services.

Services are intended to provide timely inpatient psychiatric intervention, resolution, referral, and follow-up services for eligible individuals with the goal of stabilizing individuals' symptoms as quickly as possible and assisting them in returning to a level of functioning that no longer requires inpatient psychiatric services.

Services within this scope of work include:

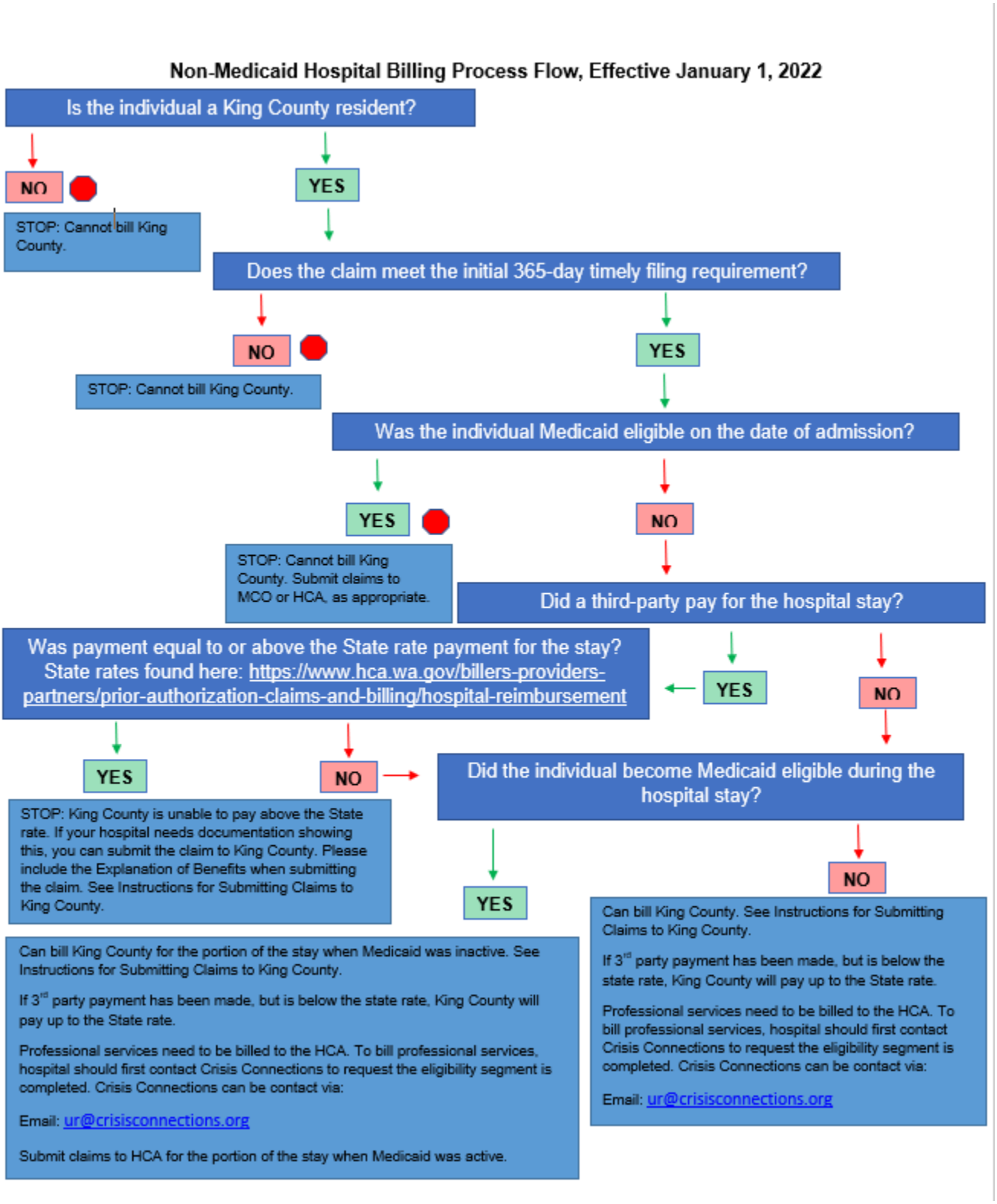
- Admissions (when there is bed availability)
  - Admit eligible individuals for a voluntary stay who have been authorized by Crisis Connections for the inpatient level of care; and
  - Admit individuals who are involuntarily detained by Designated Crisis Responders (DCRs).
- Treatment Services
  - Diagnostic and evidenced-based therapeutic services;
  - Inclusion of family, significant others, and natural supports, with the consent of the individual being served and as clinically appropriate;
  - Medication evaluation, management, and monitoring by qualified staff members;
  - For involuntary treatment, a mental health professional or substance use disorder professional, as appropriate, must have daily contact with each individual and provide supporting documentation for the purpose of determining the need for continued involuntary treatment; and
  - Documentation of services occur per licensing, certification, and accreditation requirements.
- Coordination of Care
  - Coordination with existing outpatient provider; or
  - Linkage to an outpatient provider prior to discharge; and
  - Assisting individuals who are not enrolled, but eligible for Medicaid to apply for coverage;
  - Ensure that prescriber and other provider appointments are scheduled to occur within seven (7) calendar days of the individual's discharge from the hospital.
- Discharge Planning
  - Develop and implement an appropriate, timely, and individualized discharge plan for each individual; Integration of discharge planning within the Individual Service Plan (ISP);
  - Linkage to outpatient behavioral health treatment services for individuals without a service connection in place and coordination with appropriate ongoing outpatient behavioral health treatment providers for individuals with a service connection in place;
  - Inclusion of family, significant others, and natural supports, with the consent of the individual being served and as clinically appropriate;

    - Developing a plan to continue the use of the individual's psychiatric medication, including assisting those individuals that do not have the means to pay for medication in developing a plan for accessing needed medication(s);
  - Assist individuals who do not qualify for Medicaid in accessing a non-Medicaid benefit or other resources (i.e. insurance coverage) where possible, to ensure continuity of care;
    - Coordination with community resources, including discharge to stable, safe, and secure housing with a specific transportation plan at the time of discharge, whenever possible; and
    - For residents of other counties detained in King County by King County DCRs, the Provider must contact the county of residence for purposes of discharge planning.
  - Involuntary Treatment Supports
    - Provide court evaluation and testimony services for individuals detained under the Involuntary Treatment Act.

- For clients that elope from facilities:
  - When a client on a 14 or 90-day order elopes from a certified E&T, a facility representative immediately calls 911 to report the elopement.
  - As soon as possible, the facility representative notifies Crisis and Commitment Services (CCS) about the elopement so that the DCR can respond appropriately if the client is apprehended.
  - Complete a Critical Incident Report as instructed in the Critical Incidents Program and Reporting Requirements Section of this Provider Manual.
  - During normal ITA Court hours, the facility representative should contact the ITA Prosecuting Attorney to determine if the Court will issue a bench warrant for the eloped client.
  - E&Ts will re-admit eloped clients unless the intent is to release the client from the court order.

Compensation and Method of Payment

- Payment of claims are based on verification of authorization for the length of stay.
- The Provider submits an inpatient claim for each authorized individual served in a format approved by the County, no later than 365-days after the individual's discharge date.
- The BH-ASO will not reimburse for emergency room, pharmacy and/or professional services.
- Maximum daily bed rates do not exceed the published rates for State payment rates for Inpatient Psychiatric Services Per Diem:: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/hospital-reimbursement
- Reimbursement is made according to the following formula: Number of bed days (actual occupancy minus day of discharge) x daily bed rate.
- The Provider has a written policy regarding third party payments.
- The Provider provides notice to clients with a full written disclosure of Provider's intent to directly bill the client for any non-covered services.
- King County is always the payer of last resort. King County will not initially pay claims as primary if there is another payer such as Medicare or commercial insurance.
- For additional information on the processing of claims, please see the **Hospital Billing Process Walk** below.


Non-Medicaid Hospital Billing Process Flow, Effective January 1, 2022
Is the individual a King County resident?
NO
STOP: Cannot bill King County.
YES
Does the claim meet the initial 365-day timely filing requirement?
NO
STOP: Cannot bill King County.
YES
Was the individual Medicaid eligible on the date of admission?
YES
STOP: Cannot bill King County. Submit claims to MCO or HCA, as appropriate.
NO
Did a third-party pay for the hospital stay?
YES
NO
Was payment equal to or above the State rate payment for the stay? State rates found here: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/hospital-reimbursement
YES
STOP: King County is unable to pay above the State rate. If your hospital needs documentation showing this, you can submit the claim to King County. Please include the Explanation of Benefits when submitting the claim. See Instructions for Submitting Claims to King County.
NO
Did the individual become Medicaid eligible during the hospital stay?
YES
Can bill King County for the portion of the stay when Medicaid was inactive. See Instructions for Submitting Claims to King County.
If 3rd party payment has been made, but is below the state rate, King County will pay up to the State rate.
Professional services need to be billed to the HCA. To bill professional services, hospital should first contact Crisis Connections to request the eligibility segment is completed. Crisis Connections can be contact via:
Email: ur@crisisconnections.org
Submit claims to HCA for the portion of the stay when Medicaid was active.
NO
Can bill King County. See Instructions for Submitting Claims to King County.
If 3rd party payment has been made, but is below the state rate, King County will pay up to the State rate.
Professional services need to be billed to the HCA. To bill professional services, hospital should first contact Crisis Connections to request the eligibility segment is completed. Crisis Connections can be contact via:
Email: ur@crisisconnections.org

Additional Information

Out-of-State Residents

If an individual is an out-of-state resident who was detained by King County Designated Crisis Responders and does not have any other active insurance coverage, you can submit these claims to King County. When you submit the claim, please include documentation showing your efforts to determine that there is no other active insurance coverage for the dates of service.

Alien Emergency Medical Status (AEM)

If you believe an individual qualifies for this program because ProviderOne shows ERSO as the benefit or for other reasons, contact Crisis Connections. Crisis Connections will confirm if the individual is AEM eligible. Crisis Connections will provide a pre-authorization number that can be used to bill HCA directly. Crisis Connections can be contacted via:

Email: ur@crisisconnections.org

J. Doe (Unidentified Client)

- When hospitals have a J. Doe admit: In keeping with providing excellent clinical care and being able to provide continuing care, follow up plans, etc., it is vital to have an accurate identity for the person being admitted. If a client has Medicaid, hospitals can submit the claim to MCO/HCA for higher payment.
- When a client enters the hospital and the client's identify is undetermined, then the hospital will complete due diligence to find out the client's identity. For example: use of fingerprint, ID in belongings, follow up with family for photo ID, some way to confirm the identity of the client. This will also allow hospitals to confirm insurance. Once the hospital has the correct information, contact DCR's so they can update legal information. DCR's will want to know HOW the client has been identified before they will change the ITA record.
- If the hospital is unable to determine the client's identity; complete discharge grid for client with J. Doe moniker that matches ITA and DOB; submit discharge grid to Crisis Connections to ensure official record of Days of Stay (DOS). Hospitals can submit claim to King County hospital billing claim email or fax with evidence of due diligence and on-going effort to obtain actual identity.

Instructions for Submitting Claims to King County

Submit claims to King County.

- Options for claim submission include paper claims or electronic encounter submission. For electronic encounter submission instructions, contact your King County Provider Relations Specialist. For instructions for submitting paper claims, see below.

Verify residency.
The county listed on ProviderOne and claim address should both be King County.

- If this is the case, no additional information is required to verify King County residency.
- If this is not the case, but you still believe that King County is the county of residence, provide a total of 2 sources of documentation which verify King County residency. In addition to ProviderOne or the address on the claim, examples of documents that can be used to verify King County residency include the following:
    - ITA paperwork showing King County as the county of residence
    - Current identification or driver's license showing King County as the county of residence
    - Intake paperwork that clearly indicates the individual's living situation is located in King County

If you are unable to determine residency, contact the county that detained the individual with this information, so that the county that detained can partner with other involved counties to determine which county is responsible for payment.

If required, submit admission, discharge, and ITA documentation.

- For ITA and voluntary stays that went through King County ITA court or Crisis Connections, no supporting documentation is needed, unless requested. For voluntary stays, submit the discharge grid to Crisis Connections when the client discharges.

- For ITA stays that went through a non-King County ITA court, contact Crisis Connections to inform them of this individual's hospital stay. When the client discharges, submit the discharge grid to Crisis Connections.

Submit third-party payment documentation

- If a third-party payment was made or if a third-party denied payment, provide documentation of the third-party payment or denial.

Paper claims and supporting documentation can be submitted by:

Email: KCASOHospitalBilling@kingcounty.gov Please include Attn: Your Hospital's King County Provider Relations/Contract Specialist's Name
Fax: 206-788-8506 Please include Attn: Your Hospital's King County Provider Relations/Contract Specialist's Name

Voluntary and Involuntary Treatment Act (ITA) Inpatient Psychiatric Services for Non-Medicaid Individuals Eligibility Criteria	
Medicaid Status	N/A
Age Range	Children, youth, adults, older adults as contracted
Authorization Needed	Yes, for voluntary hospitalizations
Additional Criteria	Individuals must be residents of King County
Voluntary and Involuntary Treatment Act (ITA) Inpatient Psychiatric Services for Non-Medicaid Individuals Reporting Requirements	
Semi-annual Reports	Attestation of Good Standing is due on July and January 31st of each year.

4 Crisis Services

Crisis Services in King County are managed by a subsection of Behavioral Health and Recovery Division (BHRD) called the Behavioral Health Administrative Services Organization (BH-ASO). Crisis services are designed to respond to urgent and emergent behavioral health needs of individuals in the community. The goal of crisis services is to stabilize the individual and family in the least restrictive setting appropriate to their needs, considering the strengths of the individual, resources, and choice. Interventions are age and developmentally appropriate and contribute to and support the individual's innate resiliency. For individuals with a previously identified behavioral health issue, crisis services are delivered in a manner that supports the individual's recovery. All crisis services are delivered in accordance with applicable Washington Administrative Codes. All agencies delivering crisis services will, at a minimum, comply with *WAC 246-341-0900 - Crisis mental health services—General*.

Eligibility

Crisis services are available to any individual at no cost, regardless of income, age, or residency, who is experiencing a behavioral health crisis in King County. Additional eligibility requirements for certain programs that may target minority or at-risk populations are identified in the program scopes in this chapter.

Medical Necessity Criteria

Crisis services are available for any individual for whom a mental health, substance use, or emotional distress issue may be present.

Authorization

Authorization cannot be required for this level of care.

Continuing Stay Criteria

Crisis services are continued until the client no longer meets the eligibility and/or medical necessity criteria or until the client is transitions to another source and/or level of care.

Notices

There are no Notice of Action or Notice of Determination requirements for the Crisis Services Level of Care.

Provider Appeals

There is no appeal process for the Crisis Services Level of Care.

Time Frames

Client need determines response time.

- Emergent care are those services that, if not provided, would likely result in the need for crisis intervention or hospitalization due to imminent concerns about potential danger to self, others, or grave disability. Emergency crisis services must be initiated within two hours of the initial request from any source. Examples include phone crisis services, CCS services, CCORS services, inpatient diversion beds, and crisis stabilization services.
- Urgent care services are those services that, if not provided, would result in decompensating to the point that emergency care is necessary. Urgent crisis services must be initiated within 24 hours of the initial request from any source. Examples include CCS services, CCORS services, inpatient diversion beds, and crisis stabilization services.

Documentation Requirements

All crisis services provided by the agency are documented in the individual's clinical record in accordance with appropriate Washington Administrative Codes (WACs).

Attachments in this Section:

- Attachment A: Sobering Services—Short-term Emergency Shelter, Screening, and Recovery Referral Services to Adults under the Effects of Acute Intoxication

4.1 Adult Crisis Services

Crisis Services for adults in King County who are not enrolled in Behavioral Health and Recovery Division (BHRD) Contracted treatment services. A portion of the services provided under the scope of this work are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative *CD-10 – Next Day Crisis Appointments (NDAs).* The Provider ensures at least ten (10) mental health NDAs are available per week. Provider agencies provide geographic access to crisis services at its sites, and the following services must be provided Monday through Friday, 8 a.m. to 5 p.m., excluding holidays:

- Crisis intervention and stabilization services provided by professional staff trained in crisis management;
- Consultation with an appropriate clinical specialist when such services are necessary to ensure
- Culturally appropriate crisis response; and
- Referral to long-term (behavioral health or other) care as appropriate.

Providers have the capacity to make available the following services for clients presenting for NDAs:

- Benefits counseling to work with clients to gain entitlements that will enable clients to qualify for ongoing behavioral health and medical services;
- Psychiatric evaluation and medication management services, when Clinically Indicated, that include access to medications via prescription or direct provision of medications, or provides access to medication through collaboration with the individual's primary care provider and
- Referrals to ongoing care.

Follow-up visits include:

- The attempt to provide a minimum of one follow-up visit with the client within the first 10 days of treatment, unless an appropriate transfer to another Provider has occurred. Follow-up is provided by a crisis services clinician;
- Providing follow-up for clients who fail to show for an NDA. If Clinically Indicated, same day face-to-face outreach will be undertaken; and
- Documenting all follow-up contacts. The Provider documents clinical justification for NDA no-shows that do not result in face-to-face outreach.

Adult Crisis services are guided by the following minimum regulatory requirements:

- WAC 246-341-0900 – Crisis mental health services—General

Crisis Housing Voucher

Crisis Housing Vouchers provide short-term housing to eligible individuals. These residential supports target individuals who are assessed to need more intensive support and stability immediately following a behavioral health crisis and are intended to increase the opportunity for stability while awaiting more permanent housing solutions. Providers administering Crisis Housing Vouchers will find a short-term

housing placement, pay for the placement, and refer individuals to community-based supportive housing programs. Follow-up supports will be coordinated and provided by the community-based supportive housing program.

Individuals are eligible for Crisis Housing Vouchers if they are clinically assessed to be experiencing a behavioral health crisis, need supportive housing services, and are experiencing homelessness or are unstably housed. An individual is clinically assessed to be experiencing a behavioral health crisis if they are being referred from a crisis facility or if they have experienced a Crisis Event. A Crisis Event is defined as a period of time of engagement by crisis hourly staff with a person who is experiencing symptoms of a behavioral health disorder which currently outweigh their abilities to tolerate, minimize, or attend to those symptoms or other current circumstances, the person does not appear to meet involuntary detainment criteria under RCW 71.05, and the person is at a higher risk for victimization in the current situation or circumstance if they remain in the current situation or circumstance without respite. Individuals may experience more than one stay at a crisis facility or Crisis Event, therefore, their eligibility if based on the stay or event.

Crisis Housing Vouchers will be dispersed based on the need of the eligible individual. They initially cover a maximum of 14 days, but can be extended an additional 14 days at the discretion of the provider.

Crisis Housing Vouchers are intended to be utilized at:

- **Hotel**- An establishment that provides paid lodging on a short-term basis.
- **Motel**- An establishment that provides lodging and parking and in which the rooms are usually accessible from an outdoor parking area.
- **Family Member or Friend**- A verified family member or friend of the eligible individual that agrees to temporarily house them.
- **Other Housing Related Expenses**- On a case-by-case basis and with prior-approval, Crisis Housing Vouchers may be approved for other housing related expenses. Prior approval must be requested through the Crisis Housing Voucher Exception Request Form.

When a provider utilizes a Crisis Housing Voucher, a referral to a community-based supportive housing program also must occur.

- A referral to the community-based supportive housing program Forensic HARPS must occur for individuals who meet the following criteria:
    - Have had at least two contacts with the forensic mental system in the past 24 months, or were brought to a crisis diversion facility or brought to the attention of a mobile crisis responder team via arrest diversion in accordance with RCW 10.31.110;
    - Need assistance accessing independent living options and would benefit from short-term housing assistance beyond the 14-day vouchers;
    - Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Housing Voucher;
    - Are unstably housed;
    - Are not currently in the community outpatient competency restoration program; and
    - Do not meet Involuntary Treatment Act commitment criteria (RCW 71.05).

- If an individual is not eligible for Forensic HARPS, a referral must be made to another community-based supportive housing program. This can include, but is not limited to, Foundational Community Supports Supportive Housing, traditional HARPS programs, local coordinated entry systems, or other community-based supportive housing programs.

- Referrals must be made by or within the same day as Crisis Housing Voucher utilization.

- Referrals must be made via secure email, phone call, or fax.

Adult Crisis Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Adults age 18 years or older who meet the crisis services eligibility criteria identified in the Standardized Initial Crisis Screening Protocol (SICSP) in the Behavioral Health and Recovery Division Policies and Procedures (BHRD P&P's), and are not enrolled in outpatient services, and who are referred by Crisis Connections or the Designated Crisis Responder (DCRs).
Adult Crisis Services Reporting Requirements	
Monthly Reports	• Adult Crisis Services Report • **For Adult Crisis Services providers utilizing Crisis Housing Vouchers:** Crisis Housing Voucher Log-due the 5th of the month following the reporting period

Attachments in this Section

- Attachment A: Crisis Housing Voucher Exception Request Form

4.2 Adult Inpatient Diversion Bed

The provision of one inpatient diversion bed for adults or older adults facing immediate voluntary or involuntary hospitalization. Access to the bed occurs through a Designated Crisis Responder (DCR) or Crisis Connections and is available 24 hours per day, 7 days per week. Access cannot be denied without coming to a mutual agreement with the referral source. The bed is immediately available at the time of a DCR or Crisis Connections referral unless occupied.

Professional staff are on-site 24 hours per day, 7 days per week and provide the supervision and staffing necessary to ensure the safety of the client up to and including one-to-one staffing, as needed. The Provider engages in consultation and collaboration with the involved primary treatment staff (i.e. behavioral health staff already involved in the care of the client). The Provider is responsible for and to arrange transportation to the beds for those clients who do not have an outpatient benefit and who need transportation. Clients are prompted, encouraged and counseled on appropriate medication management. Clients may stay in this bed for up to 5 days, excluding weekends, New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. If clients need to stay beyond this timeframe, and it is clinically indicated, the Provider can contact the Behavioral Health and Recovery Division (BHRD) Care Manager and discuss the extraordinary circumstances warranting a longer stay.

The Provider maintains regular and consistent quarterly meetings with BHRD, DCRs, Crisis Connections and other diversion bed Providers to evaluate the effectiveness of the program.

Adult Inpatient Diversion Bed Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Individuals eligible for this service must be 18 years of age or older and meet each of the following criteria: • Referred by the DCRs or Crisis Connections; • Are in crisis; • A mental disorder cannot be ruled out; • Are at immediate risk for voluntary or involuntary psychiatric hospitalization; • Are able to ambulate without assistive devices; and • Are willing to receive this service.
Adult Inpatient Diversion Bed Reporting Requirements	
Monthly Reports	• Adult Inpatient Diversion Bed Report in an electronic format approved by the County

4.3 Children's Crisis Outreach Response System (CCORS)

Children's Crisis Outreach Response System (CCORS) serves children, youth, and any person acting on behalf of a child or youth in King County. The program helps families achieve stability, helps prevent future crises, and helps children remain in their home. CCORS is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-11- *Children's Crisis Outreach and Response System* (CCORS). The Provider meets or exceeds all minimum licensing requirements as required by statute (RCW or WAC) for services provided under the terms of this contract. This may include, but is not limited to, Foster Family Homes for children (WAC 110-148 or its successors) and/or Child Placing Agencies (WAC 100-147 or its successors). The Provider maintains effective partnerships and collaboration with other child-serving systems, including participation in the King County CCORS Operations Meeting. CCORS is provided equitably throughout all geographic areas of King County and responds to calls originating from different parts of the child-serving system.

The CCORS program includes multiple sub-programs:

- Crisis Outreach Services
- Stabilization Services
- Non-Emergent Outreach (NEO)
- Intensive Stabilization Services (ISS)
- Crisis Stabilization Bed (CSB)
- In-home Behavioral Support Specialist(s)

The CCORS program is guided by the following minimum regulatory requirements:

- *WAC 246-341-0900 – Crisis mental health services—General*
- *WAC 246-341-0910 – Crisis mental health services—Outreach services*
- *WAC 246-341-0915 – Crisis mental health services—Stabilization service*

4.3.1 Crisis Outreach Services

Crisis Outreach Services staff maintain access to Crisis Connections 24/7. Crisis telephone response is provided 24/7 including immediate access to a mental health professional (MHP). Emergent crisis outreach services provide an outreach team consisting of, at minimum, two of the following, a Crisis Mental Health Specialist (CMS), a Family Advocate (FA) or a Certified Peer Counselor (CPC). All outreach team staff are trained in crisis management and respond within two hours of dispatch. The outreach team provides face-to-face services at the site of the escalating behavior, whether this is the child's home, a group home, another living arrangement, or a community setting, and respond and provide outreach for all referrals that meet eligibility criteria on a no decline basis.

Outreach teams provide support for immediate safety, and de-escalate, and stabilize crisis behaviors of the child or youth and their family/caregivers, in order to maintain the child or youth in the community whenever possible. Crisis Safety Plans are developed in partnership with the child or youth and their parent or caregiver and given to the child or youth and their family within 48 hours of the initial crisis outreach. This Crisis Safety Plan is updated throughout the course of the CCORS involvement to reflect new skills and strategies.

Crisis outreach is provided to unenrolled children and youth referred for inpatient hospitalization (either voluntary or involuntary) and work directly with the child or youth and their family to develop a community-based plan and/or negotiate a less restrictive alternative when it is clinically appropriate. When needed, the outreach team can provide immediate access to less-restrictive alternatives such as a Crisis Stabilization Bed (CSB). The outreach team can also provide a referral for authorization for voluntary hospitalization and coordination with the Designated Crisis Responders (DCRs) for involuntary hospitalization for youth 13 years of age or older when diversion from hospitalization is not possible and when necessary.

CCORS coordinates with new or existing community Providers, including but not limited to other treatment Providers, DCYF social workers, school staff, and law enforcement. When a child or youth has an outpatient mental health Provider or a psychiatrist, the outreach team makes contact within 48 hours of the crisis to alert the Provider and coordinate care. If the child or youth does not have an existing community Provider, the CCORS team will work to establish prompt linkages to behavioral health, child-serving, physical health, school personnel, juvenile justice personnel and/or other appropriate Providers.

Crisis Outreach Services are guided by the following minimum regulatory requirements:

- *WAC 246-341-0900(4)(5); - Crisis mental health services—General*
- *WAC 246-341-0910 – Crisis mental health services – Outreach services*
- *WAC 246-341-0915 – Crisis mental health services—Stabilization service*

4.3.2 Non-Emergent Outreach (NEO)

When the parent or caregiver and/or the child or youth does not require emergent outreach, the Provider ensures availability of NEO services Monday through Friday that occurs within 24 to 48 hours of the call. NEO services are provided according to the Next Day Appointment (NDA) and NEO minimum requirements for Crisis Response System in this manual.

4.3.3 Stabilization Services

The CCORS team provides an overall assessment of the current crisis situation and identifies the specific needs of the family/caregiver and child or youth within 72 hours of the initial crisis outreach. They actively work to engage both the child or youth and the caregiver and family in interventions or document rationale for excluding them. The CCORS team collaborates with the child or youth and their family to develop an Action Plan that identifies the priority needs of the family and details specific, concrete action steps to stabilize those needs. Clients receive psychiatric evaluation and medication management services when clinically indicated. Services are community-based and largely in-home to stabilize the situation through:

- Teaching, modeling, and coaching parents or caregivers to develop skills to manage the crisis behavior; and
- Teaching, modeling, and coaching the child or youth to develop skills to manage the crisis behavior.

Stabilization services are available for up to eight weeks as needed, and the CCORS team completes a Discharge Summary when the client is ready to discharge that includes a description of the initial crisis behavior, priority needs, action steps that were utilized to meet those needs, and recommendations for ongoing service and support. A copy of this discharge summary is provided within two weeks of discharge to the family, the referral source, and any other relevant service Provider(s).

Crisis Stabilization services are guided by the following minimum regulatory requirements:

- *WAC 246-341-0915 – Crisis mental health services—Stabilization services*
- *WAC 246-341-0900 - Crisis mental health services—General*

4.3.4 Intensive Stabilization Services (ISS)

CCORS accepts up to 17 new referrals per month as approved by a King County Behavioral Health Administrative Services Organization (BH-ASO) or a Washington State DCYF designated staff with a maximum of 50 total clients in service each month on a no decline basis. CCORS responds within two hours to emergent ISS referrals, within eight hours for referrals requiring a same day response, and within 24 hours for all other referrals. ISS staff work with a child or youth and their family as needed for up to 90 days. They complete overall assessments of the current crisis situation and identify the specific needs of the family and child or youth within 48 hours of face-to-face contact. CCORS notifies the assigned DCYF Child Welfare (CW) social workers and CW ISS designated staff or the outpatient BH therapist and the Behavioral Health and Recovery Division (BHRD) designated staff when the family refuses to participate in services or the family cannot be contacted within three business days of the referral being received.

Staff partner with the child or youth and their family to develop a Child/Youth and Family Safety Plan within the first week of services that addresses triggers and warning signs exhibited by the child or youth, identifies people, activities or skills which will reduce the frequency and intensity of the crisis episodes, helps the child or youth and their family/caregiver manage stress in a more constructive manner, and increases the safety of everyone in the home. CCORS staff create Family Action plans within two weeks of contact that identify priority needs of the family and detail specific, concrete action steps to stabilize those needs.

The program maintains a budget, within available resources of a set-aside of DCYF and/or State/Non-Medicaid funds to ensure the availability of non-categorical funding to provide emergency services to resolve or stabilize a crisis or provide services identified on the client's individualized Action Plans and consistent with CCORS Flex Fund Policy, while maintaining itemized records of the utilization of non-categorical funding that can be made available to BHRD upon request. Discharge summaries are completed that include at a minimum identification of the child or youth's name, date of birth, date referral received, date case closed, name of referring social worker or agency therapist, referral goals,

name and relationship of child or youth's caregiver, type of placement, and assessment of child or youth's functioning and placement needs (at time of referral and at time of discharge if change), and services provided during the ISS intervention. A copy of this discharge summary is provided to the referral source, CW designated staff for child or youth, the family, and other relevant service Provider(s) including MIDD Behavioral Health Sales Tax-funded wraparound facilitators.

Attachments in this Section

- ***Attachment C:*** Intensive Stabilization Services Referral Form

4.3.5 Crisis Stabilization Bed(s) (CSBs)

CCORS staff provide short-term, temporary emergency placement, care, and/or respite for enrolled and unenrolled children and youth referred by the CCORS team. The Provider must ensure all CSB homes are licensed foster homes located through the community as specified in RCW 74.15 and WAC 110-148 or their successors. CSBs have sufficient resources including personnel available to ensure the safety of the child or youth and others in the home. Daily records of behavior are maintained for each client in the CSBs. Staff coordinate with other community Providers and discharge planning is done in partnership with the family, child or youth, crisis outreach team, enrolling Provider and/or outpatient mental health therapist.

CSB capacity must be sufficient to meet the need of the CCORS and ISS programs, and ensure access or intake to the CSBs can be obtained 24/7 through the CCORS team. The child or youth receiving crisis outreach services can stay in the CSB no longer than 14 days without approval of Behavioral Health and Recovery Division (BHRD) staff. A child or youth involved in ISS may remain in a CSB up to 90 days with approval of BHRD or DCYF designated staff. CSBs are also available for children or youth enrolled in outpatient services where the CSB can serve as an option for hospital diversion. In this situation, the client will be initially approved for 3 days and extended up to 14 days with BHRD approval.

4.3.6 In-Home Behavioral Support Specialist(s) (BSSs)

In-Home BSS(s) assist families in the implementation of behavioral support programs by providing teaching, modeling, and coaching of strengths-based, positive behavioral management strategies. BSS(s) have the flexibility and availability to go into the home on a frequent basis (daily, if needed) to implement specific behavioral interventions until the family and/or child or youth are able to successfully utilize the skills on their own. BSS(s) provide ongoing supervision and/or monitoring of a child or youth at home to maintain the safety of the child or youth and other family members, including providing extra support for up to eight hours at a time during the day or overnight to assist the family in maintain safety.

CCORS Eligibility Criteria	
Medicaid Status	N/A
Age Range	3-17 years old
Authorization Needed	No
Additional Criteria	**Crisis Outreach Services and Non-Emergent Outreach (NEO)** Any child or youth ages three through 17, or person acting on their behalf, in King County, who: • Is not enrolled in outpatient services; and • Meets crisis service eligibility in the Behavioral Health and Recovery Division (BHRD) Policies and Procedures (P&P). **Intensive Stabilization Services (ISS)**

	Any child or youth ages 3 through 17, or person acting on their behalf, in King County, who has been screened and referred by the Behavioral Health and Recovery Division (BHRD) or a Washington State Department of Children Youth and Families (DCYF) or its successor designated staff where the: • Child or youth is enrolled in the BHRD funded services or using DCYF-CA services; and • Functioning of the child and/or family is severely impacted due to family conflict resulting from significant emotional or behavioral problems; and • Child is not served through other intensive community service Providers (e.g., Behavioral Rehabilitation Services [BRS]); and • Current living situation is at risk of disruption; or • Intensive Stabilization Services (ISS) are needed to safely transition a child or youth into a more appropriate living situation. **Crisis Stabilization Bed (CSB)** Any child or youth ages three through 17, in King County, who either: • Meets crisis service eligibility in the KC BH Provider Manual; • Would likely be hospitalized or experience other out-of-home placement without the use of a CSB; or • Is enrolled in the BHRD funded services and in need of a CSB for hospital diversion.
CCORS Reporting Requirements	
Monthly Reports	• Children's Crisis Outreach Response System Summary • ISS Master Client List • The County or DCYF may request additional measurable service and outcome data for services provided by the Provider. The Provider provides data collection in a manner prescribed by the County or DCYF.
Quarterly Reports	• ISS Data Summary Report • Children's Crisis Outreach Response System Quarterly Mental Health Block Grant Costs and Revenue Summary

4.4 Crisis Diversion Services

Crisis Diversion Services consists of three distinct programs serving adults in behavioral health crisis, the Mobile Crisis Team (MCT), the Crisis Diversion Facility (CDF), and the Crisis Diversion Interim Services (CDIS) as well as a pilot Behavioral Health Response Team. These programs provide a combination of outreach and facility-based crisis and stabilization services to assist individuals in behavioral health crisis due to suspected mental health, substance use, or co-occurring mental health and substance use disorders.

The program accepts referrals from the following first responders:

- Law enforcement agencies in King County;
- Fire department medical response units in King County;
- Designated Crisis Responders (DCRs) in King County;
- Hospital emergency departments (EDs) in King County; and

- As clinically appropriate, and when capacity allows, first responders from outside of King County may refer to the CDF when referring King County residents.

The MCT accepts referrals for crisis outreach services from Crisis Connections for individuals not enrolled in ICN/ASO funded services. The CDF accepts referrals from the named referral sources and from the MCT. The CDIF accepts referrals only from the CDF.

Crisis Diversion Services staff work to establish and maintain working relationships with first-responder agencies and other crisis response systems available in the County in order to facilitate collaboration and communication regarding system interaction and to identify opportunities for operational improvement. Information and assistance will be provided to first responder and stakeholder organizations as requested to ensure there is understanding regarding the services provided and the individuals who can be served by these services.

All staff members have an annual training plan that addresses issues relevant to their work and the populations that they serve and document participation in all trainings in each individual staff's personnel records. Staff persons who provide Substance Use Professional/Trainee (SUDP/T) supervision participate in Clinical Supervision Training 1 and 2, sponsored by the County.

All crisis services staff receives training or provides documentation of previous training that remains currently relevant in, at a minimum, the following topics within the first 90 days:

- Crisis Prevention Intervention training.
- Contract overview regarding program service expectations.
- Data collection, reporting, and input expectations.
- Provider clinical program requirements and policies and procedures which guide the program.

Crisis Diversion Services programs participate in all County-convened meetings relevant to the implementation and ongoing program development of the CDS programs, including the CDS Subcommittee, and comply with recommendations approved by the CDS Subcommittee regarding program development. Program staff attend other relevant community meetings as needed to address neighborhood or program concerns and support and promote the intention of the Good Neighbor Agreement. In addition, the program maintains current memoranda of agreement to ensure collaboration and communication with Valley Cities Recovery Place, King County Emergency Services Patrol (ESP), and the Sobering Center.

The provider is responsible for any County-owned Vehicles that support the transportation function of the program and will ensure adherence to Section 1.4.3 of the Provider Manual regarding County Vehicles, as well as the following additional requirements:

- At the discretion of the County, return County-owned vehicles to the County in instances where the vehicle is no longer able to perform the transportation function of the program. In such cases, the vehicle is returned in a condition reasonable to its age and mileage.
- At the request of the County, return non-County owned vehicles used to support the transportation function of the program to the County at the end of any contract period in which contract renewal is not intended by the County. In such cases, the vehicle will be returned in a condition reasonable to its age and mileage.

The Provider will do the following:

- Ensure the collection and timely submission of required data and documentation
- Ensure all CDS Programs provide and document in the clinical chart referrals and linkages to appropriate community-based services and supports, as well as efforts to assist people in accessing appropriate services and benefits, as indicated, based on the identified needs of each participant.
- The clinical record will also include documentation of an individual's stated willingness to accept a recommended referral and identify any reasons provided for refusing a referral.

Crisis Diversion Services are guided by the following WACs or any successors:

- *WAC 246-341-0900 - Crisis mental health services—General*

4.4.1 Mobile Crisis Team (MCT)

Mobile Crisis Team (MCT) staff have the necessary skills and knowledge to provide crisis outreach services with a minimum of two full-time equivalents (FTEs) per shift available for outreach. MCT staff have 24-hour access to a supervising Mental Health Professional (MHP). The MCT includes a minimum of one Certified Peer Counselor (CPC) with training in peer services in crisis environments. CPCs responding to crisis are accompanied by an MHP.

MCT are available to first responders and Crisis Connections staff 24/7 to assist with crisis de-escalation, stabilization, and transportation. In addition, the team provides crisis phone triage for calls coming from first responders that identifies MCT level of response, including dispatch or phone consult, and referral to available alternative services based on referent's request for these non-outreach services. In cases where the MCT is dispatched to the community, an estimated time of arrival by the MCT is provided to the first responder and documented in the individual's chart. MCT works to build relationships with all first-responder agencies to ensure effective collaboration and communication and to identify opportunities for operational improvement.

MCT provides face-to-face services in the community where the individual is located and responds and provides outreach for all referrals that meet eligibility criteria on a no decline basis. Calls that do not meet dispatch eligibility criteria will be provided with referrals to alternative services as indicated. Crisis outreach to individuals referred from the Crisis Connections are attempted a minimum of one time, with additional crisis outreaches attempted as clinically indicated and, on a case,-by-case basis, as determined by the MCT and documented in the clinical record or phone screening log.

MCT program staff will do the following:

- Document in the participant's clinical record or phone screening log:
  - Crisis phone triage that responds to calls from first responders and identifies MCT level of response, including dispatch, phone consult, or referral to alternative services.
  - Crisis intervention and stabilization services.
  - Resource and referral plans, and/or safety plans as appropriate to help maintain the individual until further resources are available.
  - Referral and linkage to necessary behavioral health and/or other social and healthcare services.
  - Transportation of individuals to and from available resources and diversion options, as deemed appropriate, including but not limited to: the CDF, behavioral health Provider agencies, hospital emergency rooms, the Crisis Respite Program (CRP), shelter beds, their home community, and/or other identified disposition locations.

  - Administration of the GAIN-SS tool to the participant, as feasible and with participant agreement, including a copy of the completed tool, or an explanation of why the participant did not complete the screening.
  - Include all referral documentation received from Crisis Connections in the participant clinical record.
- Document patterns of calls to determine if staffing schedules need to be adjusted to meet the demands for services.

Each MCT staff receives the following training and any other training deemed necessary or required for their positions, within the first 90 days of employment. Documentation of training completion is maintained in the staff's personnel record:

- Crisis response services and practices.
- Chemical dependency screening and intervention.
- Staff safety in the community.

In addition, each MCT staff participates in Crisis Intervention Team (CIT) trainings eight-hour in-service within the first year of employment, and documentation of training completion is maintained in the staff's personnel record:

Mobile Crisis Team services are guided by the following minimum regulatory requirements and WACs, or any successors:

- *Response Timeliness (ASO §16.3)*
  - *Emergent crisis outreach services, as identified by the referent or the clinical judgment of the MCT, will be provided within two hours of referral.*
  - *All other referrals will be identified as urgent crisis outreach services and will be provided by MCT within 24 hours of referral.*
- *General Requirements*
  - *WAC 246-341-0900 – Crisis mental health services—General*
  - *WAC 246-341-0910 – Crisis mental health services—Outreach services*

The MCT program consists of the following validated tools and evidence-based practices:

- *Global Appraisal of Individual Needs – Short Screener (GAIN-SS)*

4.4.2 Crisis Diversion Facility

CDF staff have the necessary skills and knowledge to provide crisis stabilization services, with a minimum 4:1 client to staff ratio 24 hours/7 days a week, including access to medical staff. The facility provides an environment that maintains the safety of service recipients and staff and promotes dignity and self-determination for individuals in crisis. CDF maintains capacity for 16 stabilization beds, for a maximum length of stay of 72 hours (exceptions allowed as per the developed exception protocols as approved by Behavioral Health and Recovery Division [BHRD]) to serve the individuals within the facility and is available 24/7 to respond to and accept referrals.

Every effort will be made to accommodate referrals that meet eligibility criteria for the program. CDF staff participate in a telephone screening call with all referral sources prior to accepting an individual into the facility. This screening allows the facility to determine appropriate response and intervention based on the individual's needs, clinical history, and presenting symptoms, as well as capacity to accept referrals, and may include referrals to alternative services in lieu of admission. Capacity issues

are managed by CDF staff who may decline a referral if it does not appear that the facility will have any discharges within 2 hours of the referral. Pending discharges that are expected to occur within 2 hours of the referral will allow an individual to be brought to the facility despite full capacity at time of referral. Individuals who are accepted via phone screening will be seen in a timely manner upon arrival to the CDF to minimize the waiting time of law enforcement and other first responders.

Individuals accepted by referral to the facility are provided an initial physical health screening by a medical healthcare Provider prior to admission to determine medical eligibility, and will receive an individual needs assessment within three hours of arrival.

- Individuals who do not require admission to a CDF bed for crisis stabilization, and whose needs can be managed in the community with prompt engagement in services and supports, will be provided with direct linkages to appropriate services. Individuals not admitted to the facility will have the information noted in their chart regarding the disposition and rationale for no admission.
- Referral sources will be contacted as indicated, or as requested at drop-off, to provide information on disposition of individuals referred to the CDF.
- CDF staff document in the clinical record the time of arrival at the facility and the time of admission to a CDF bed (if applicable).

Clinical records are maintained for all CDF participants admitted to the facility that detail the current presenting problem, the context of the referral, condition and functioning of the individual, an assessment of the individual's basic needs and mental health and substance use disorder service needs, and regular notations regarding services provided and progress on goals. Additionally, the clinical record includes documentation that the GAIN-SS tool was administered to the individual, including a copy of the completed tool, or an explanation of why the individual did not complete the screening.

The CDF program services include: transportation coordination; psychiatric services; stabilization services; behavioral health services and peer support; case management services that focus on specific linkage with needed services such as, but not limited to: benefits, housing, medical care, and behavioral health disorder treatment; discharge planning; nursing services within the scope of services at the facility; three meals per day with snacks and produce available on site; and shower and laundry facilities. Individuals who are admitted to the CDF and begin to show signs of withdrawal will be evaluated by the CDF staff to determine if the individual needs to be referred to other resources to manage these symptoms. Flexible funds may be utilized to access resources needed to assist in the process of engaging and stabilizing individuals, and to meet basic, immediate needs and some services as clinically appropriate beyond what is provided as part of the program's core intensive case management and stabilization services.

The CDF provides a seclusion and restraint-free environment that utilizes a recovery-oriented care system model and principles of trauma-informed care, maintains the safety of service recipients and staff, and promotes dignity and self-determination for individuals who are in crisis. Entry and exit doors are equipped with time delay locks and other security measures, such as video monitoring of all entrances and exits, to allow for continuous monitoring of the facility space and ensure that individuals do not leave the facility without the awareness of staff.

CDF staff will identify law enforcement's preference regarding contact should an individual who is brought to the CDF on a jail diversion agreement choose to leave the facility. In instances where law enforcement requests it, the CDF staff ensures law enforcement are notified when individuals are attempting to leave the facility against medical advice during the initial 48 hours after arrival or as requested. Every effort will be made to engage with and manage the process for discharge for individuals attempting to leave the facility in order to provide law enforcement with adequate time to

determine their response. CDF staff will contact the assigned King County prosecuting authority, as identified in the CSC Law Enforcement Protocol, Jail Diversion Criteria for Crisis Diversion Facility, in cases where an individual who was subject to arrest was diverted to the CDF but later declines services. In cases where an individual who was subject to arrest was diverted to the CDF and completes all offered treatment, the Provider may also contact the appropriate prosecuting authority to report the individual's success.

The CDF program includes the following validated tools and evidence-based practices:

- Global Appraisal of Individual Needs – Short Screener (GAIN-SS)
- Evidence-based substance use disorder (SUD) screening tool administered, when feasible and appropriate, to individuals who have been identified with a SUD and are in need of further screening and case management to address their SUD.
- Medication management and monitoring
- Peer Support services

Crisis Diversion Facility services are guided by the following WACs or any successors:

- *WAC 246-341-0900 – Crisis mental health services—General*
- *WAC 246-341-0920 – Crisis mental health services—Crisis Peer Support Services*

4.4.3 Crisis Diversion Interim Services

An individual may be referred by the CDF staff to the CDIS if they are homeless or at risk for homelessness, their current living situation may be dangerous or has the potential to send the individual into crisis again, their immediate needs may take longer to address after the initial behavioral crisis has resolved, or if clinically indicated and appropriate as assessed by program staff. The Provider maintains policies and procedures that identify how individuals referred from the CDF will be assessed for admission and their care will be transitioned to the CDIS.

CDIS staff have the necessary skills and knowledge to provide intensive case management services, including access to medical staff, 24 hours/7 days per week. The facility provides an environment that maintains the safety of service recipients and staff and promotes dignity and self-determination for individuals in crisis. CDIS maintains capacity for 30 interim respite beds with a maximum length of stay of 14 days (exceptions allowed as per the developed exception protocols as approved by Behavioral Health and Recovery Division). Case management services will be provided that focus on accessing benefits/entitlements as well as coordination and linkage with needed community services and supports as soon as possible to ensure linkages are made with new or current services Providers before discharge.

The CDIS program services include transportation coordination, stabilization services, behavioral health and peer support, case management services that focus on specific linkage with needed services and supports such as, but not limited to: benefits, housing, medical care, and behavioral health disorder treatment; discharge coordination; nursing services within the scope of services at the facility, three meals per day with snacks and produce available on site, and shower and laundry facilities. Additionally, at least one follow-up contact with individuals and/or service Providers will be attempted to facilitate coordination and linkage with service referrals as appropriate and feasible. Flexible funds may be utilized to access resources needed to assist in the process of engaging and stabilizing individuals, and to meet basic, immediate needs and some services as clinically appropriate beyond what is provided as part of the program's core intensive case management and stabilization services.

The CDIS provides a seclusion and restraint-free environment that utilizes a recovery-oriented care system model and principles of trauma-informed care, maintains the safety of service recipients and staff, and promotes dignity and self-determination for individuals who are in crisis. Entry and exit doors are equipped with time delay locks and other security measures, such as video monitoring of all entrances and exits, to ensure that individuals do not leave the facility without the awareness of staff.

The CDIS program includes the following validated tools and evidence-based practices:

- Evidence-based substance use disorder (SUD) screening tool administered, when feasible and appropriate, to individuals who have been identified with a SUD and are in need of further screening and case management to address their SUD.
- Vulnerability Assessment Tool (VAT) to measure the individual's vulnerability and level of functioning, and to prioritize access to shelter services, as appropriate based on the individual's needs, length of time at the facility, and willingness to participate.
- Medication management and monitoring as needed.
- Peer Support services

Crisis Diversion Interim Services are guided by the following WACs or any successors:

- *WAC 246-341-0900 – Crisis mental health services—General*
- *WAC 246-341-0915 – Crisis mental health services—Stabilization Services*

4.4.4 Behavioral Health Response Team Pilot

Each Behavioral Health Response Team (BHRT), made up of a Mental Health Professional (MHP)), one Substance Use Disorder Professional (SUDP), two Peer Navigators, with access to RN and a psychiatric provider, will work in collaboration with existing crisis response teams to respond to and help address the incidences of crisis in the community, or to address the needs of individuals with high utilization of the 911 system due to suspected behavioral health needs. Through a formal referral process, Mobile Crisis Team staff and other first responders will notify the BHRT of individuals that need behavioral health support within King County.

The BHRT works in coordination with local behavioral health agencies and other community-based programs and supports to help address the core issues that lead to crisis, or behaviors that contribute to an individual's high utilizer status. These teams must collaborate with regional outreach teams and agencies throughout King County and follow up with individuals after an acute crisis episode to establish long-term community linkages and referrals to behavioral health treatment. This team will have an awareness of how behavioral health is understood in the individual's community and will make referrals based on individual needs and desires for treatment. The team carries caseloads of up to 30 individuals at a time and will provide 30 days of intensive case management services. The team will maintain the option to provide an additional 2 months of coordination efforts using an outreach and engagement model, to ensure linkages to services and supports in the community are achieved. This approach provides for a wraparound plan with dedicated Mental Health Professionals and Mental Health Peer Navigators available to law enforcement, and other identified referral sources, during work hours. This coordinated response will provide for the ability to safely and sensitively respond to people in crisis. The goal is to provide crisis intervention services and refer to and promote treatment, and when possible, avoid incarceration and hospitalization.

The MHP is trained in de-escalation, crisis response and safety planning/risk assessments, and works with the two Peer Navigators who provide short-term intensive case management and follow up care.

The following steps assist in diverting individuals in crisis from short-term to more permanent community support services:

- Assessing the individual for short term needs, such as food and shelter.
- Connecting clients to Providers and resources that are best suited to their immediate and long-term needs.
- Providing transportation assistance to ensure connection to those long-term Providers.
- Making care plans in conjunction with support systems to minimize future 911 crisis needs.
- Identifying solutions to minimize future 911 crisis needs and assist in stabilization.

Referral & Follow-up Process:

The BHRT will take referrals from local crisis response triage systems including law enforcement agencies, 911 dispatch, local fire departments, and the Mobile Crisis Team. Expanded referral sources may be identified as resources allow in order to reduce the need for first responder involvement. These partnerships between law enforcement and other first responders, and mental health providers, is the collaborative effort necessary to respond to community members in need. This shared approach has been shown to improve engagement with people experiencing crises and reduce the rate in which individuals experiencing mental health crises are incarcerated.

Referrals to the BHRT are based on the following;

1. Follow-up with an individual who has recently been in crisis and needs a service connection,
2. Individuals that do or do not endorse behavioral health issues, however referring party suspects mental health and/or substance use disorders (MH/SUD), and are in frequent contact with the 911 system, or
3. Individuals that are experiencing homelessness and whose mental illness and substance abuse issue have risen to the levels that the behaviors are disruptive to the community.

A general email may be established so any of the participating law enforcement agencies can make a non-emergent referral for the BHRT to follow-up on as a preventative measure to a situation that may be escalating. The BHRT will outreach and engage individuals that need connection to SUD services, MH services, or medical/primary care, and will have the ability to assess housing needs.

Resource Referral & Coordination:

The BHRT team attends local networking and community meetings to maintain working relationships with local behavioral health and social service agencies for easy referral and coordination of services. The team uses a Wraparound approach when working with individuals so referrals and linkages in the community are made in coordination with the individual.

Training and Development:

The BHRT receives extensive onboarding and training to enhance their safety while in the community and working with individuals who can be unpredictable. They complete the 8-hour CIT training, along with 12 hours of Marty Smith and Crisis Intervention Training. Each BHRT also receives clinical supervision weekly and participate in on-going team meetings and trainings.

Crisis Diversion Services Eligibility Criteria	
Medicaid Status	Yes and No, serves individuals regardless of Medicaid status
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria for MCT, CDF, and CDIS	Any individual at least 18 years of age experiencing an emotional and/or behavioral disturbance, including substance use/abuse, who meets the following criteria is eligible for services: • Is in emotional or behavioral crisis that would benefit from crisis intervention services; • Agrees to participate in the services; and • Is referred by an eligible referent. • Individuals referred to the CDF meet eligibility criteria for admission to the CDF as defined in the Crisis Solutions Center (CSC) Law Enforcement Protocol, Jail Diversion Criteria for Crisis Diversion Facility, and any subsequent revisions approved by BHRD.
Additional Criteria for BHRT	• Referrals to BHRT come from eligible referral sources to help address incidences of crisis, or reduce high utilization of the 911 system, due to suspected behavioral health needs.
Crisis Diversion Services Reporting Requirements	
Monthly Reports	• CSC Actual Monthly Expenditures Report, Per Program Component; • MCT Monthly Report; • CDF Monthly Report; • BHRT Monthly Report; • BHRT Actual Monthly Expenditures Report;

Quarterly Reports	• CSC Quarterly Financial Report, Per Program Component; • MCT Quarterly Report; • CDF Quarterly Report; and • CDIS Quarterly Report. • Trueblood Enhanced Crisis Stabilization Services Quarterly Report • Trueblood Enhanced Mobile Crisis Response Quarterly Report • Mobile Crisis Block Grant Stimulus Report • Enhanced Crisis Stabilization Services Staff Details • Enhanced Mobile Crisis Response Staff Details

4.5 Emergency Telephone Services

Emergency Telephone Services (ETS) is a crisis phone line. Qualified ETS staff who are proficient or can immediately access personnel proficient in the use of Telecommunication Devices for the Deaf (TDD) for the hearing impaired or interpreters for limited English proficient populations. ETS staff answer the crisis phones within 30 seconds, and services include crisis intervention, referral information about available services, linkage to treatment resources and other information as necessary are available 24/7 to all children and adults in crisis. 70 percent of callers are immediately connected to a live telephone worker, and hold times for all other callers do not exceed an average of 60 seconds. All telephone workers are supervised by a Mental Health Professional (MHP) (WAC 388-865 or its successors). Children's Mental Health Specialists and Substance Use Disorder Professionals (SUDP) are available for consultation at all times, and telephone consultation with an MHP is immediately available to clinical staff. ETS staff are trained in crisis intervention, recognition of suicide potential, major mental disorders and related organic problems, the Involuntary Treatment Act (ITA), Substance Use Disorder (SUD) and effective ways to communicate with individuals presenting with substance use issues, diversity of communication styles, specific issues related to children, organization of the public behavioral health system and local community resources.

This crisis line provides access to the King County Next Day Appointment (NDA) system, dispatches the Mobile Crisis Team and the Children's Crisis Outreach Response System (CCORS) for individuals in crisis, and provides a single, integrated line for crisis callers where staff members can quickly assess the reason for the call and connect the caller with the appropriate resource. ETS staff connect with community partners when existing clients call the crisis line to determine if the caller can be assisted by their current outpatient Provider, or if emergent treatment is needed. ETS staff notify community partners of calls from their existing clients by communication with after-hours staff, and narrative call logs sent through secure email within 24 hours. ETS staff verify caller's Medicaid eligibility in the Extended Client Lookup System (ECLS). If a client's Medicaid has lapsed, ETS staff assist callers by giving information on how to re-enroll.

ETS staff provide 24/7 inpatient authorization services for people who are not covered by Medicaid and have an income under 220% of federal poverty for the Behavioral Health Administrative Services Organization (BH-ASO) using medical necessity to determine the need for voluntary hospitalization. ETS staff also provide care coordination and Length of Stay (LOS) management for individuals who are voluntarily admitted to the hospital and ensure that overall LOS are reduced through active facilitation of treatment and discharge planning. ETS staff also manage denials of inpatient care, including retrospective requests and denials of voluntary LOS extensions. The denial rate for voluntary inpatient hospitalization is calculated by the County using data from the Reliability of Authorization Decisions Quarterly Reports which is submitted by the Provider and requires consistency among contracted psychiatrists when denying voluntary hospitalizations. Data regarding inpatient hospitalizations is entered into the Behavioral Health and Recovery Division (BHRD) Information System (IS) Inpatient Authorization Application for each inpatient hospitalization request.

Crisis Telephone services are guided by the following minimum regulatory requirements:

- *WAC 246-341-0900 Crisis mental health (MH) services—General*
- *WAC 246-341-0905 Crisis mental health services—Telephone support services*
- *NCQA: UM 3A, 1-5; QI 4B, 1-2*

Above requirements outlined in the following Delegation Agreement, including performance expectations and monitoring requirements: Crisis Line Telephone Access Delegation Grid

4.5.1 Involuntary Inpatient Care

Medical Necessity

Medical necessity is determined according to the criteria in Chapter 71.05 RCW for adults and Chapter 71.34 RCW for youth, or their successors.

Initial Screening and Admission

- Designated Crisis Responders (DCRs) assess and, when appropriate, detain persons age 13 and older referred for involuntary hospitalization.
- Referrals by the DCRs to hospitals and/or evaluation and treatment facilities occur according to the King County 24/7 Patient Placement Guidelines. The DCR decision to involuntarily detain a person to an inpatient facility signifies that medical necessity for inpatient care has been determined and the admission is authorized.
- For other county residents detained in King County by King County DCRs the hospital must contact that other county for purposes of discharge planning.
- All initial admissions for involuntary care are for 20 days. The 20 days are counted from the date of detention, including days on non-psychiatric hospital units and days at other hospitals. Hospitals who wish an authorization for involuntary care for a person without funding documented in ProviderOne prior to discharge may request this by faxing the name of the individual to the care authorizer.

Continuing Stay Criteria and Authorization of Extensions

- Community hospitals (but not the state hospitals or the free-standing E&T facilities) must request length-of-stay extensions for the care of all persons involuntarily committed beyond 20 days at the time of the person's release from involuntary hospitalization.
  - If a client is admitted as an involuntary client and converts to voluntary within the first 20 days, length-of-stay extension requests are not needed until the 20 days from detention are used; the initial authorization for 20 days remains in place.
  - If a client is admitted as a voluntary client and is detained during the days covered by the initial authorization (generally fewer than 20 days), length-of-stay extensions requests are needed whenever the days initially authorized are used; there is no 20-day authorization for these clients.
- Hospitals are required to submit the extension request Form to Crisis Connections in order to initiate an extension request.
  - Crisis Connections may not deny any extension request for an involuntary detention.
  - Crisis Connections contact the BH-ASO clinical team whenever a hospital requests a third length-of-stay extension so that the clinical team can offer the hospital assistance with the treatment and discharge plan.
- For individuals who are admitted involuntarily, but switch to a voluntary stay following their initial admission authorization decisions and notifications will made according to Voluntary Continued Stay Requirements outlined below.

Discharge and Termination

- Discharge occurs when a client no longer meets medical-necessity criteria for admission.
- Once given, the available number of admission days will not be terminated. However, a hospital may discharge a client before maximum number of allowable admission days has been reached. When an individual is discharged, the hospital must notify the BH-ASO care authorizer.

4.5.2 Voluntary Inpatient Care

Receipt of Referral Request

- Voluntary inpatient hospitalization requests are received and processed 24 hours a day, 7 days a week. This includes all decision-making and notification.
- Crisis Connections Care Authorizer staff perform an administrative review to check for financial eligibility of individual.
    - If the individual has active Medicaid or other commercial insurance, Crisis Connections directs the referring hospital to the appropriate Managed Care Organization for authorization.
    - If the individual does not have active Medicaid other commercial insurance, Crisis Connections conducts a review for medical necessity.

Healthcare Professionals Involved in UM Decision-Making

- Crisis Connections uses licensed health care professionals to make authorization decisions that require clinical judgement.
- The following persons may approve services:
- Licensed health care professionals (WAC 246-341-0200) and/or training as substance use disorder professional (WAC 246-811-010 and RCW 18.205)
- Crisis Connections uses a senior-level behavioral health physician to oversee UM activities and make medical necessity denial decisions. The senior-level behavioral health physician is board-certified or board eligible in Psychiatry, Child and Adolescent Psychiatry, or Addiction Medicine.

Medical Necessity Review

- Crisis Connections adheres to the following definition for medical necessity:
    - WAC 182-500-0070: *a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.*
    - UM decisions, including denial decisions, are based solely on the appropriateness of the care and existence of benefit coverage. Crisis Connections will not reward practitioners or other individuals for issuing denials of coverage.
- Crisis Connections collects all information necessary to make a medical necessity determination and staff document the information used to make their UM determination. Information used can include, but is not limited to:
    - Health records
    - Conversations with appropriate Providers
    - Unique or specific needs of the individual
    - Crisis Connection’s determination of medically necessary is final until such time as a Grievance, Appeal, or Administrative Hearing of a UM medical necessity decision is made.

UM Decision-Making Criteria

Crisis Connections maintains and applies the following level of care guidelines and medical necessity criteria in any UM decision-making for voluntary inpatient hospitalization:

- Level of Care Utilization System (LOCUS)
  - Child and Adolescent Level of Care Utilization System (CALOCUS)
- In addition to the use of LOCUS and CALOCUS criterions, Crisis Connections considers specific needs of the individual when conducting UM decision-making. These factors can include but are not limited to:
  - Age;
  - Comorbidities;
  - Complications;
  - Progress of treatment;
  - Psychosocial situation;
  - Home environment;
  - Other social determinants; and
  - There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service (WAC 182-500-0070 or its successor).

Crisis Connections authorizes three, four or five initial days based upon:

- Acuity level of the individual,
- Day of the week the authorization request was received, and
- The imminent risk of harm to self or others.
- Note: weekends or holidays that occur during the anticipated stay may increase the initial days to a maximum of five days.
- Crisis Connections makes the criteria used in its UM decision-making available to Providers upon request.

Prior-Authorization Decision-Making and Notification

Crisis Connections carries out a thorough medical necessity review according to standards and guidelines described above.

- If a Crisis Connections MHP assesses an individual and determines they don't meet medical necessity, Crisis Connections will follow the appropriate denial decision requirements described below.
- If Crisis Connections determines the individual has met medical necessity criteria a written Notice of Authorization will be provided to the individual or the referent. See criteria below for more information.

Notification of Service Coverage or Authorization

- A Notice of Authorization includes the following minimum elements:
- Name of admitting hospital

The period of authorization, and that the benefit may be continued as long as:

- The services are medically necessary;
- The individual remains a resident of King County; and
- ASO coverage and funds for coverage remain.

The Notice of Service Authorization is created by Crisis Connections at the time of authorization.

All Notice of Authorizations forms are sent in accordance with timeframe standards described below.

Prior-Authorization Decision-Making and Notification Timeliness

Timeliness of UM decision-making and notification is measured from the date Crisis Connections receives the request from the individual (or from the individual's authorized representative), even if Crisis Connections does not have complete information necessary to make a UM decision. Crisis Connections documents the date a request for service is received and the date a UM decision is made, and notification sent.

- All UM decisions are made, and notices given as expeditiously as the individual's health condition requires.
- *Decision-Making Timeliness*: Crisis Connections acknowledges the request for service within two (2) hours and make a decision within twelve (12) hours of receipt of the request.
- *Notification Timeliness*: Crisis Connections gives written notification of the decision to practitioners within twenty-four (24) hours of receipt of the request.
- Crisis Connections may provide an initial verbal notification of the UM decision. Crisis Connections staff records the time and date of the notification and the staff individual who spoke with the practitioner. A voicemail is not an acceptable form of verbal notification. Written notification must be provided no later than twenty-four (24) hours after the verbal notification.

Denial Decision

Crisis Connections adheres to the following definition of an 'action' or 'denial decision':

- 42 CFR § 438.400
  - *The denial or limited authorization of a requested service, including determinations based on type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;*
  - *The reduction, suspension, or termination of a previously authorized service;*
  - *The denial, in whole or in part, of payment for a service;*
  - *The failure to provide services in a timely manner, as defined by the state;*
- National Committee for Quality Assurance (NCQA)
  - *Canceled service request due to missing or incomplete information required to render a decision (i.e. progress notes, physician notes, lab results, etc.)*

Actions decisions including any decision to authorize a service in an amount, duration, or scope that is less than requested is conducted by:

- A physician board-certified or board-eligible in Psychiatry or Child and Adolescent Psychiatry; or
- A physician board-certified or board-eligible in Addiction Medicine

The denial file includes any of the following documentation indicating appropriate physician review:

- The reviewer's handwritten signature or initials (including credentials and title); or
- The reviewer's unique electronic signature (including credentials and title) or;

- A signed or initialed note from the UM staff person, attributing the denial decision to the professional (including credentials and title) who reviewed and decided the case.

Crisis Connections provides an opportunity for a peer-to-peer review with the referring Provider, prior to the final denial decision being made.

- The peer-to-peer review is conducted between the Crisis Connections behavioral health physician and the referring Provider or facility.

Crisis Connections documents the following in the individual's denial file:

- The denial notification;
- The time and date of the notification
- Evidence the referent was notified and an opportunity to discuss the denial decision was made available.

Retrospective Authorization Requests

For Medicaid-attributed persons, the appropriate Managed Care Organization assigned to the individual carries out all functions related to Utilization Management for voluntary hospitalization.

For non-Medicaid individuals:

- A retrospective authorization may occur when an inpatient day was provided without a previous request for authorization. This applies to cases where initial authorization was not obtained or when a length-of-stay extension request was not made within the requested timeframe for a person currently admitted to the hospital.

Requests for retrospective authorization are considered only:

- When the person applies for Health Care Authority (HCA) medical program coverage during the course of the hospitalization (for the days which have occurred prior to the application) or following discharge; or
- When the failure to request a prior authorization occurred for reasons beyond the control of the hospital.

Retrospective Authorization Decision-Making and Notification Timeliness

- Timeliness of Utilization Management (UM) decision-making and notification is measured from the date Crisis Connections receives the request from the individual (or from the individual's authorized representative), even if Crisis Connections does not have complete information necessary to make a UM decision. Crisis Connections documents the date a request for service is received and the date a UM decision is made, and notification sent.
- All UM decisions are made, and notices given as expeditiously as the individual's health condition requires.
- Providers have up to 365 days from the delivery of a service to submit a "claim" or retrospective authorization request.
- *Decision Making*: Crisis Connections must make its UM decision within thirty (30) calendar days of receipt of the authorization request.
- *Notification*: Crisis Connections notifies the individual and referent within two (2) business days of the UM decision.
- When post-service authorizations are approved, they become effective the date the service was first administered.

Continued Stay Authorization Request

For Medicaid-attributed persons, the appropriate Managed Care Organization assigned to the individual carries out all functions related to Utilization Management for voluntary hospitalization.

For non-Medicaid individuals:

- Authorization for continuing stay refers to the authorization of days of hospitalization beyond the days approved in the initial authorization. This is also called a "length-of-stay extension."
- The criteria for a continued stay are the same as those for an authorization for admission.
- Extensions may be verbally requested 48 hours in advance of, but not more than 24 hours after, the expiration of the current/initial authorization.

Continued Stay Authorization Decision-Making and Notification Timeliness

- Timeliness of UM decision-making and notification is measured from the date Crisis Connections receives the request from the individual (or from the individual's authorized representative), even if Crisis Connections does not have complete information necessary to make a UM decision. Crisis Connections documents the date a request for service is received and the date a UM decision is made, and notification sent.
- All UM decisions are made, and notices given as expeditiously as the individual's health condition requires.
- *Decision Making*: Crisis Connections must make its UM decision within twenty-four (24) hours of the receipt of the authorization request.
- *Decision Making Extension*: Crisis Connections may extend the concurrent authorization review to within seventy-two (72) hours of the request for authorization, if BHRD has made at least one (1) attempt to obtain needed clinical information within twenty four (24) hours of the authorization request.
- *Notification*: Crisis Connections notifies the referent verbally or in writing of the authorization decision. Notification is given within twenty-four (24) hours of the request for services or within seventy-two (72) hours of the request for services if a decision-making extension has been made.

Special Circumstances

Change in primary diagnosis

- Hospitals have 24 hours to notify Crisis Connections whenever a hospitalized person's diagnosis changes to one that is no longer covered. The care authorizer handles this notification as a notification of discharge. Any days authorized that have not yet occurred will not be covered.
- Hospitals have 24 hours to notify Crisis Connections whenever a hospitalized person's diagnosis changes from one that is not covered to one that is. The care authorizer considers this notification as an initial authorization request.

Electroconvulsive therapy (ECT)

- Hospitals seek approval by Crisis Connections before initiating a course of ECT during a voluntary inpatient stay that has already been authorized.
- If ECT is initiated without Crisis Connections' approval, any subsequent length-of-stay authorization requests will be approved only if the ECT meets BHRD standards of care.
- BHRD does not have the authority to authorize outpatient ECT. Requests for outpatient ECT must go through the Washington Apple Health plan. (see Mental Health Services here).

Change in legal status

- When a client changes from involuntary to voluntary or from voluntary to involuntary, the hospital must notify Crisis Connections by the next business day.
- Days authorized at the time of a legal status change (from involuntary to voluntary or from voluntary to involuntary) will not be rescinded.

Children and Youth

- Children 13 years of age or older can be admitted for treatment with their written consent if the treatment facility's professionals agree and parents or guardians are not available. Parent(s)/ guardian(s) must be notified of such an admission, and they have the right to demand release unless the treatment facility petitions the court, or the youth has requested that the parent not be notified.
- A minor (any person under age 18) may be voluntarily admitted by application of the parent or guardian ("parent-initiated treatment" or PIT). The consent of the minor is not required for the minor to be evaluated and admitted as appropriate.

Emergency Telephone Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.
Emergency Telephone Services Reporting Requirements	
Daily Reports	• Daily Crisis Log • Daily Crisis Log –CC Business Line • Daily Crisis Log –CC Crisis Line
Monthly Reports	• Crisis Line Wait Time Intervals Report • Next Day Appointment Report • Mobile Crisis Team Dispatch Report • CCPAR Business Line • CCPAR Line Volume and Outcomes Report • Crisis Line Caller Data Report • FTE Call Screener Report • Voluntary Hospital Authorization Report • UM Report
Quarterly Reports	• Crisis Line Caller Data Report • Crisis Line Access Report • CCPAR Crisis Line Report • CCPAR Business Line Report
Annual/Other Reports	• Crisis Line Caller Data Report

4.6 Patient Placement Coordination

Provision of patient placement coordination for individuals who are detained and awaiting a bed in an Evaluation and Treatment Facility (E&T) or psychiatric hospital that provides treatment to involuntary patients. This program extends coverage for coordinating patient placement outside of the hours that the County Designated Crisis Responders (DCRs) provide placement coordination. Coverage is provided between the hours of 6 am and 10 pm seven days per week. A telephone number is dedicated specifically to the patient placement coordination services. Patient Placement Coordinators access the County's SBC Log to identify the patients needing placement coordination. They actively work with hospitals as well as view hospital capacity in WATrac to determine where there are open hospital/E&T beds. Patient Placement Coordinators notify hospitals with a patient on an SBC who needs to be moved when there is an E&T bed available in order for the hospital to screen that patient with the E&T. Staff update the SBC log when a patient is placed. Patient Placement Coordination staff participate in the Patient Placement Task Force meetings to help identify any barriers to placement and solutions to those barriers.

Patient Placement Coordination Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.
Patient Placement Coordination Reporting Requirements	
Monthly Reports	• Patient Placement Coordination (PPC) Outcomes Summary Report • Patient Placement Coordination (PPC) Call Volumes Summary Report
Annual/Other Reports	The Provider submits a report, in a format approved by the County, that reconciles the expenditures shown on the Provider's or subcontractor's annual financial audit to Budget, Accounting and Reporting System (BARS) expenditure categories. The report is submitted in hard copy and is due 30 days after the Provider receives its financial audit.

4.7 Substance Use Disorder Next Day Assessment Appointments

Substance Use Disorder Next Day Assessment Appointments are available for youth and adults, in SUD crisis and who are not currently enrolled in Behavioral Health and Recovery Division contracted treatment services. Services provided under the scope of this work are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-10 – Next Day Crisis Appointments (NDAs). Providers will ensure at least 10 substance use NDAs are available per week. The following services must be provided Monday through Friday, 8 a.m. to 5 p.m., excluding holidays.

Program Specific Requirements:

- Provide clinical assessment that meets WAC 246-341-0640 requirements, performed by a licensed SUDP or an SUDP Trainee under direct supervision of an SUDP as defined by WAC 246-811-010, to establish an SUD diagnosis. Based on diagnostic criteria, recommend placement in an appropriate ASAM level of care.
    - Interpreter services, including sign language interpretation and other services for clients who are sensory-impaired, must be made available as needed.
- Ensure the availability of 10 SUD NDA per week across the network, for a total of 40 possible appointments per month. Hours of appointments will be negotiated to ensure accessibility.
- Provide induction of Buprenorphine or Naltrexone within 24 hours or provide walk in referrals for medications used to treat opioid use disorder as methadone.
- Collaborate with BHRD staff and the other SUD NDA awarded agencies to help develop initial SUD NDA protocols.
- Provide follow up appointments to ensure SUD NDA clients are enrolled in outpatient services (i.e. SUD or MAT) within 5 business days of assessment, as appropriate.
- Provide access/connection to residential and long-term SUD treatment directly to the client, based on client choice, ensuring that within 3 business days of the assessment, clinical documentation is sent to BHRD's Care Coordination team for review and/or approval of residential treatment services.
- Provide Medicaid eligible clients with assistance in obtaining benefits that will enable clients to qualify for ongoing behavioral health and medical services.
- Provide referrals and assistance with connecting to long-term behavioral health or additional recovery supports as appropriate.
- Coordinate the gathering of demographic and project data for evaluation purposes.

Substance Use Disorder Next Day Assessment Appointment Eligibility Criteria	
Medicaid Status	Yes and No, serves individuals regardless of Medicaid status.
Age Range	N/A
Authorization Needed	No
Additional Criteria	Not currently enrolled in SUD treatment services **OR** not currently engaged in SUD treatment services.
Substance Use Disorder Next Day Assessment Appointment Reporting Requirements	
Monthly Reports	• SUD NDA Referral Report

4.8 Telephone Support for Crisis and Commitment Services

A dedicated crisis triage and telephone support for people who are directly calling for services through King County Crisis and Commitment Services (CCS). The telephone support line is available 24/7 to ensure that the individuals calling for assistance are directed to the crisis response that best meets their needs. Monday through Friday, eight hours per day, there is additional coverage for the CCS professional telephone line. Staff answering the professional telephone line are, at a minimum, paraprofessionals who are trained by Crisis Connections staff, and enter into the CCS Phone Message Log the caller's name and agency/system affiliation, the name and birthdate of the person about which the caller is concerned, and any pertinent additional information.

Staff answering the phone are mental health professionals or trained individuals supervised by mental health professionals. Staff identify the best resource for the caller and log every call into the Crisis Connections' Triage Log. For callers referred to CCS, staff enter the caller's name, phone number, patient's name and date of birth into the CCS Phone Message Log. All Crisis Connections Triage Logs are retained and will be transmitted to CCS if called upon to do so.

Telephone Support for Crisis and Commitment Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.
Telephone Support for Crisis and Commitment Services Reporting Requirements	
Monthly Reports	• Triage Summary Report – CCS Public Phone Line • Telephone Summary Report – CCS Professional Phone Line • Sheena's Law Report
Annual/Other Reports	The Provider submits a report, in a format approved by the County, that reconciles the expenditures shown on the Provider's or subcontractor's annual financial audit to Budget, Accounting and Reporting System (BARS) expenditure categories. The report is submitted in hard copy and is due 30 days after the Provider receives its financial audit.

4.9 Warm Line

Emergency telephone support services with Certified Peer Support Specialists for individuals experiencing a non-life threatening behavioral health crisis. Warm Line services are available a minimum of eight hours a day, seven days a week. Certified Peer Support Specialists provide emergency telephone support when more acute services are not needed. 2.0 full-time employee (FTE) positions support a minimum of 30 volunteers to staff the line. All volunteers answering the telephone are Peer Support Professionals or Certified Peer Support Specialists. Staff are provided with training in motivational enhancement and person-centered approaches.

Warm Line Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.
Warm Line Reporting Requirements	
Monthly Reports	• Warm Line Call Report • Warm Line Volunteer Report • Warm Line Profit & Loss Report • Warm Line Trial Balance Report
Quarterly Reports	• RH Call Status Report • Warm Line Caller Data Report • Warm Line Access Report • Warm Line Reconciliation Report
Annual/Other Reports	• Warm Line Yearly Access Report

5 Withdrawal Management Services

5.1 Acute Withdrawal Management

Acute substance use disorder withdrawal management services that provide a continuum of care designed from a recovery and resiliency perspective and in accordance with Washington Administrative Code (WAC) 246-341 or its successors. Clients are accepted into the program 24/7. All phone calls regarding referrals are responded to within 12 hours of receiving the referral. Individuals are not denied admission as long as they meet the established admission criteria without a review by the Nursing Supervisor or the On-Call Supervisor. Withdrawal Management Providers outside of King County must request prior authorizations from Behavioral Health and Recovery Division (BHRD). A minimum of 16 withdrawal management beds are available per day. Daily bed utilization is maintained at 80 percent or higher.

Clients receive at least one counseling session with a Substance Use Disorder Professional (SUDP) or a SUDP Trainee (SUDPT) under the supervision of a SUDP during the client's SUD withdrawal management and promote motivation to accept referral into the continuum of care for SUD treatment.

Staff are trained in the following areas:

- Systems integration in clinical practice Systems integration in clinical practice (mental health, primary care, housing, vocational, and substance use disorder- SUD systems).
- Effective referral and discharge planning.
- Best practices for medical and other services offered at the withdrawal management center.
- Cultural competency that assist staff in recognizing when cultural barriers interfere with clinical care that includes review of populations specific to agency's geographic service area and applicable available community resources.
- Procedures for how to respond to individuals in crisis that includes a review of emergency procedures, program policies and procedures (P&P), and rights for individuals receiving services and supports.

All staff providing care must complete a minimum of 40 hours of documented training before assignment of patient care duties to include:

- Basics of SUD;
- Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) and Hepatitis B;
- Blood-borne pathogens;
- Tuberculosis (TB) prevention and control;
- Withdrawal management screening and admission; and
- Signs and symptoms of trauma.

Each client is screened for SUD treatment placement and referred for treatment within 48 hours of admission. Clients who refuse a referral to ongoing treatment are provided written information regarding access to treatment. The Provider also screens every client using the Global Appraisal of Individual Needs – Short Screen (GAIN-SS) to identify potential mental health issues and make referrals to mental health services within 48 hours of admission.

Naloxone kits are provided to Medicaid-funded clients who have an opioid substance use disorder and are willing to take one. Additionally, each client in treatment receives personalized discharge planning services that include assistance in accessing and maintaining housing, assistance with accessing public transportation, coordination with medical care, coordination with mental health or other social

services, and accessing SUD treatment and self-help groups. The client receives a copy of this discharge plan, and a copy is retained in the client's file. The Provider documents linkages for SUD or mental health treatment or referrals to other services.

In accordance with Washington State House Bill 2642, individuals seeking withdrawal management services are automatically authorized for 3 days from their date of admission.
Any additional days beyond the initial 3 days must be authorized by King County on the Extension Request for Withdrawal Management form which must be submitted within the 3 days of the client's withdrawal management admission, by fax (206-205-1634) or secure email (resauth@kingcounty.gov). To support medical necessity, the provider must also submit 1) toxicology screen, 2) CIWA/COWS scores, and 3) clinical description of client's needs including intake form with dates of last use, and any current clinical notes describing severity of symptoms.

BHRD will not reimburse withdrawal management providers for any services provided following the initial 3 day period without documented authorization by BHRD.

BHRD will not reimburse withdrawal management providers for any services provided without receipt of clinical information and a documented authorization.

Data Transmission:

Within 24 hours from Admission the provider should transmit the following data through a nightly batch processing or using the web portal:

- Client demographic information;
- ASAM placement;
- Diagnosis;
- Dynamic client data;
- Income coverage;
- Medicaid coverage;
- Residential arrangement; and
- Substance use.

Following complete transmission of data, a WM benefit is created and will progress to a status of Authorization Approved (AA). Within 2-3 days of the client's admission, the WM facility is required to submit the following either through data transmission or web portal:

- Case Manager Link;
- COD screening/assessment;
- Disability;
- Program referral and
- SUD Release of Information.

The Provider observes the following if appealing a denied ETP:

- The Provider submits a written appeal within 15 business days of discharge of the client or receipt of the denial. An appeal request that is not received within the specified 15 business days will not be considered.
- Appeals contain the client medical record in its entirety as available at the time of discharge and the rationale for the appeal with supporting medical documentation as available in the client medical record, which may include factors beyond the original reason for denial.

- The final appeal decision is made by the BHRD Medical Director; and final appeal decisions are presented to the requesting Provider within 30 days. All appeal decisions are final and binding. When the ETP is not authorized either at the time of admission, during an admission, or following an admission, for reasons other than disagreements over medical necessity as mentioned above, this will not be considered a denial, and such determinations cannot be appealed.

The Provider maintains a system that coordinates provision of service through mutually agreed upon protocols or a Memorandum of Agreement (MOA). The protocols or MOA define coordination of relevant services that support the withdrawal management program and its clients and will facilitate effective and efficient referral, transfer, and information sharing. The protocols or MOAs are no older than three years. Failure to provide copies will result in the withholding of payment for services until receipt of all protocols or MOAs. The protocols or MOAs will be maintained with the following agencies:

- Harborview Medical Center
- King County Emergency Departments;
- Sobering Services;
- Evergreen Treatment Services – REACH Project;
- Evergreen Recovery Center Detox Branch;
- Downtown Emergency Service Center;
- Tacoma Detoxification Center in Pierce County; and
- CDF and/or CDIS.

Acute Withdrawal Management Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	Yes, if the Withdrawal Management Provider is outside of King County
Additional Criteria	• Individuals must be determined to be in need of withdrawal management services using an assessment instrument that incorporates the American Society of Addiction Medicine (ASAM) Criteria and the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) or their successors. • The Provider gives admission priority to individuals referred from the following King County referral sources: • Sobering Services ; • Harborview Emergency Department; • other King County emergency departments; • King County Crisis and Commitment Services; • REACH case managers; • Law enforcement; • King County Providers who are seeking withdrawal management services in preparation for entry to inpatient treatment services; and • Crisis Diversion Facility (CDF) or Crisis Diversion Interim Services (CDIS).

Acute Withdrawal Management Reporting Requirements	
Monthly Reports	95 percent of all data submissions are downloaded at the time required according to the ISAC Data Dictionary

Attachments in this Section:

- Attachment A: Withdrawal Management—Acute Inpatient Substance Use Disorder Withdrawal Management to Clients
- Attachment B: Withdrawal Management Extension Request Form

5.2 Secure Withdrawal Management (SWM)

- In response to House Bill 1713 ("Ricky's Law"), secure withdrawal management is a program for individuals who have been referred to Designated Crisis Responders (DCR's) because they, as a result of a substance use disorder, present an imminent likelihood of serious harm. Secure Withdrawal Management and stabilization services are provided to voluntary or involuntary individuals to assist the process of withdrawal from psychoactive substances in a safe and effective manner, or medically stabilize an individual after acute intoxication, in accordance with chapters 71.05 and 71.34 RCW. The length of stay for secure withdrawal management is up to 72 hours. Clients receive a medical exam and an evaluation, and get a recommendation for treatment from a psychiatric nurse practitioner. SWM facilities are medically monitored and have a regimen for evaluation and treatment. Substance Use Disorder Professionals provide onsite assessments and recommendations for the next level of care. Clients can have their 72-hour hold extended by court order to 14 days for acute treatment, and then up to 90 days in a "less-restrictive-alternative." Admissions are available to an individual twenty-four hours a day, seven days a week, per WAC 246.341-0810(4) or its successor.

For clients that elope from SWM facilities:

- When a client on a 14 or 90-day order elopes from a certified SWM facility, a representative immediately calls 911 to report the elopement.
- As soon as possible, the facility representative notifies Crisis and Commitment Services (CCS) about the elopement so that the DCR can respond appropriately if the client is apprehended.
- During normal ITA Court hours, the facility representative contacts the ITA Prosecuting Attorney to determine if the Court will issue a bench warrant for the eloped client.
- All SWM facilities have agreed to re-admit eloped clients unless the intent is to release the client from the court order.

Secure Detoxification Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Individuals eligible for this service must be 18 years of age or older and who: • Have been involuntarily detained by a Designated Crisis Responder (DCR) for a 72-hour evaluation and treatment period; or • Committed by the King County Superior Court for a 14-day period of evaluation and treatment under Revised Code of Washington (RCW) 71.05 and 71.34; or • Referred by the DCRs through the revocation process provided in RCW 71.05 and 71.34.
Secure Detoxification Reporting Requirements	
Monthly Reports	TBD
Quarterly Reports	TBD
Annual/Other Reports	TBD

6 Substance Use Disorder Residential

Behavioral Health and Recovery Division (BHRD) contracts with Substance Use Disorder (SUD) Residential programs both in King County and throughout the state of Washington. Programs are designed from a recovery and resiliency perspective that assist clients in developing skills to live in the community with minimal dependence on public safety and acute care resources. Eligible individuals receive easily accessible, culturally responsive, coordinated, comprehensive, and quality behavioral health services.

Adult SUD residential services within the identified levels of care as defined in the Washington Administrative Code (WAC) 246-341or its successors as described by the American Society of Addiction Medicine (ASAM). Services are provided in accordance with the Department of Health (DOH) regulations as stated in WAC 246-337 or its successors for a Residential Treatment Facility (RTF).

Intensive Inpatient services provide a concentrated program of SUD treatment, individual and group counseling, education, and related activities, including room and board, in a 24-hour-a-day supervised facility in accordance with WAC 246-341-1110 or its successors.

Providers ensure clients have the necessary person items (i.e. soap, toothpaste, and sanitary items), using the funds provided by BHRD and in accordance with conditions provided by BHRD, including in the daily bed rate.

Eligibility for all Substance Use Disorder Residential Programs

Eligibility for all levels of SUD Residential programs are established via the same mechanisms. Individuals eligible for SUD residential placement are King County residents and/or assigned by a managed care organization who meet SUD medical necessity standards. These individuals meet the following criteria to be eligible for this level of care:

- Clinical Requirement – must meet medical necessity
  - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for SUD;
- Specific ASAM Criteria based on the six dimensions for placement; The individual's needs cannot be more appropriately met by any other formal or informal system or support;
- Financial Requirement – must below 220% of Federal Poverty Level (for adults) or 300% of Federal Poverty Level (for youth);
- Residency Requirement – must be a King County resident; and
- Authorized by King County for SUD residential services.

Payment

- Medicaid is payer of last resort. If an individual has private insurance in addition to Medicaid, the provider must bill the insurance company prior to invoicing BHRD. BHRD will not pay above the contracted daily rate after insurance payment. If an individual has Medicare, Medicare will not pay for SUD Residential Services. However, if the provider determines the individual meets criteria for non-Medicaid funds, and has been approved by a BHRD care authorizer then they can submit an invoice for reimbursement.
- SUD residential care authorization requests should be submitted to BHRD at resauth@kingcouty.gov

Residential Admissions Process

Residential Treatment Providers ensure that priority admission is given to the Priority Populations as defined in Appendix A, Section 3.0 of the Policies and Procedures.

The Provider is an active participant in the following King County authorization process for King County residents:

- King County Care Authorizer (KCCA) forwards referral application packet with confirmation of King County authorization to the Provider;
- The Provider notifies KCCA of the Provider's decision regarding referral application within one business day;
- If the referral is accepted by the Provider, KCCA and the Provider confirm the authorized initial length of stay, determine admit date and clarify the processes or documents required to ensure a problem-free admission;
- KCCA notifies the community assessor and referred individual regarding the individual's acceptance to residential facility and scheduled admit date;
- Community assessor is responsible for arranging the individual's transportation to the facility and ensuring necessary processes/documents are completed and communicated to residential facility; and
- The Provider notifies the KCCA of the individual's admission into the facility on the actual admit day.
- See Attachment A: SUD Residential Authorization Process Flow for more details.

Continuing Stay Criteria

Continued stay reviews are person-centered based and upon the client's treatment needs and progress in residential treatment. Continued stay eligibility criteria are as follows:

- The client meets the ASAM placement criteria for the requested residential service level;
- The client has demonstrated progress toward achieving treatment goals during the initial authorization period; and
- The client's needs cannot be more appropriately met by any other formal or informal system or support.

The Provider requests a continuation of a client's stay by completing and forwarding the required Extension Request for SUD Residential form to BHRD no later than three working days before expiration of initial authorization. Failure to provide complete information may result in delayed or denied authorization. The required written documentation includes:

- Updated ASAM evaluation;
- Requested number of days for continuing stay;
- Copy of most recent Individual Service Plan (ISP);
- Description of client's progress on ISP goals; and
- Reason(s) for continued stay including projected treatment goals.

BHRD makes a decision on the continuing stay request and notify the Provider of the disposition within two working days of receiving the completed information packet.

If it is determined that the client does not meet continuing stay eligibility criteria, the Provider, client and/or client's family (if legal guardian) may appeal the disposition.

BHRD does not reimburse for SUD residential services beyond the initial authorization period without documented approval of a continuing stay request.

Treatment Goals

- The Provider services according to need, and to each client and their family or support system, in order to help the client achieve recovery and resiliency through mutually negotiated goals of treatment.
- The Provider ensures clients have a voice in developing their ISP as described in the BHRD Provider Manual.
- The Provider ensures significant others, as identified by the client, are involved in the service plan development and implementation.
- The Provider ensures treatment goals are written in the words of the client.
- The Provider ensures documentation related to progress toward treatment goals includes the client's views on their progress.

Individual Service Plan (ISP)

Each client in a SUD Residential Program has an ISP. An ISP for these programs are:

- Developed within five days of admission;
- Personalized to the individual's unique treatment needs;
- Initiated with at least one goal identified be the individual during the initial assessment or at the first services session following the assessment;
- Strengths-based;
- Inclusive of individual needs identified in the diagnostic and periodic reviews, addressing all substance use needing treatment, including tobacco, if necessary; the client's bio-psychosocial needs; treatment goals; estimated dates or conditions for completion of each treatment goal; and approaches to resolve the problem(s).
- Inclusive of goals developed with the participation of the client and other supportive persons as identified by the client;
- Inclusive of objectives, defined as short-term steps toward overall goals, that are timely, measurable, and observable;
- Updated to reflect any changes in the client's treatment needs, status, and progress towards goals, or as requested by the client; and
- Demonstrative of the client's participation in the development of the plan and that plan was mutually agreed upon with a copy provided to the client.

Access to Services

Providers ensure access to services as follows:

- The Provider accepts and makes the necessary adjustments to continue treatment for any clinically appropriate client utilizing Medication-Assisted Treatment (MAT).
- The Provider does not deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). However, the Provider reserves the right to deny admission to any individual when the Provider determines that the individual is beyond the scope of the Provider's ability to safely or adequately treat or that the inclusion of the individual in the treatment setting may interfere with, or detract from, the treatment of other clients.

- The Provider ensures that treatment services are not denied to any individual solely on the basis of that individual's drug(s) of choice.

Integrated Care Management and Coordination

Providers ensure continuity of care with the participation of clients, the community behavioral health system, the physical health system, inpatient facilities, advocates, families, housing services, employment services, education services, and other community supports as clinically indicated. Additionally, Providers work with BHRD to collaborate with the staff at the courts, probation, correctional facilities, and juvenile detention facilities, in arranging for services to individuals referred by the local justice system and State Department of Corrections.

Termination and Discharge

The following parameters guide termination and discharge in SUD residential programs.

Providers are responsible for discharge planning services which will, at a minimum:

- Coordinate a community-based discharge plan for each client served beginning at intake. Discharge planning applies to all clients regardless of length of stay or whether they complete treatment.
- Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency is made within the first week of residential treatment.
- Establish referral relationships with assessment entities, outpatient Providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities;
- Coordinate, as needed, with prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the DSHS Children’s Administration, and the DSHS Economic Services Administration including Community Service Offices (CSOs).
- Coordinate services to financially-eligible clients who are in need of medical services.

SUD residential benefit will terminate under the following circumstances:

- The authorization period expires;
- The client permanently exits the program prior to the expiration date of the authorization period;
- The client gains enough resources to lose their low-income status; or
- The Provider discharges client for disciplinary reasons and/or to ensure the safety of other clients and staff.

A terminated benefit is payable to the date prior to termination.

- When a termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by BHRD.
- The Provider submits a completed discharge report in the format provided by BHRD within one business day of the benefit termination.

SUD Residential Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	N/A
Authorization Needed	Yes
Additional Criteria	Authorized by King County for SUD residential services.
SUD Residential Reporting Requirements	
Monthly Reports	SUD Residential Census Report

Attachments in this Section:

Attachment A: SUD Residential Authorization Process Flow

6.1 Adult Co-Occurring Disorders Residential Treatment Services

This level of SUD treatment satisfies the level of intensity in ASAM Level 3.5. for adults (age 18 or older). Clients eligible for this program type must also have a co-occurring mental health issue.

6.2 Adult Intensive Inpatient

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.5. for adults (age 18 or older).

6.3 Adult Long-Term Care

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.3. for adults (age 18 or older).

6.4 Adult Recovery House

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.1. for adults (age 18 or older).

6.5 CJTA Adult Opioid Use Disorder Residential Treatment

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.3 and 3.5 for adults (age 18 or older). Clients eligible for this program type have an Opioid Use Disorder (OUD) who are being referred from the criminal justice treatment account (CJTA) system.

Program Specific Requirements

Clients eligible for this residential program Opioid Use Disorder (OUD) who are being referred from the criminal justice treatment account (CJTA) system at Pioneer Human Services.

6.6 Pregnant and Parenting Women

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.3 and 3.5 for adults (age 18 or older). Clients eligible for this program type must also be pregnant or parenting women. Enhanced curriculum and services include a focus on domestic violence, sexual abuse, mental health issues, employment skills and education, linkages to pre- and post-natal medical care, legal advocacy, and safe, affordable housing. Mental health services, including assessment/referral, follow-up, and interface with mental health professionals is also included in this treatment program.

6.7 Youth Co-Occurring Disorders Intensive Inpatient

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.5. for youth (under the age of 18). Clients eligible for this program type must also have a co-occurring mental health issue.

6.8 Youth Intensive Inpatient

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.5. for youth (under the age of 18).

6.9 Youth Recovery House

This level of Substance Use Disorder (SUD) treatment satisfies the level of intensity in ASAM Level 3.1 for youth (under the age 18).

7 Mental Health Residential

Mental Health Residential programs incorporate a recovery and resiliency perspective that enables clients to live in the community with minimal dependence on public safety and acute care resources. Programs are meant to provide residential treatment services for adults experiencing severe and persistent mental illness to promote stability, community tenure, and movement toward the least restrictive community housing option. Programs provide residential stabilization and case management services that are strengths-based and promote recovery and resiliency.

Services are meant to provide symptom relief to assist clients to find what has been lost in their lives due to their illness, including the opportunity to make friends, use natural supports, make choices about their care, find and maintain employment, and develop personal mechanisms for coping and regaining independence. Staff help clients to prepare for discharge within two years or less by providing services that promote community integration and assistance with the transition to the least restrictive community housing option.

Funding

For Medicaid-eligible individuals with no income or those who only qualify for Aged, Blind and Disabled (ABD) cash assistance, subsidy for client participation may be available. Prior approval from the Behavioral Health and Recovery Division (BHRD), and referral by King County Hospital Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) are required. Clients must meet medical necessity standards.

Priority

In addition to the priority groups identified below, Residential treatment Providers ensure that priority admission is given to the Priority Populations as defined in Appendix A, Section 3.0 of the BH-ASO Policies and Procedures. Priority groups for Mental Health Residential programs is as follows:

First priority group:

- A client from Western State Hospital (WSH);
- A client from a local psychiatric hospital;
- A client from a higher level of care; or

Second priority group:

- A client who is at risk of psychiatric hospitalization and needing a higher level of services over time to remain stable in the community; or
- A client who experiences serious and persistent mental illness and is chronically homeless.

Residential Admissions

The KCHL sends referrals including the Residential Application, Screening Form and supporting clinical documentation to the Providers.

Duties of Providers

- Offer interviews to individuals according to date and receipt of the Residential Application and Screening Form;
- Submit a Tracking Form to the KCHL if the Provider makes a determination that an individual is not appropriate for admission;

- Provide suggestions and/or recommendations to KCHL to overcome potential barriers for individuals determined not appropriate for admission;
- Participate in a weekly conference call with BHRD and other residential Providers; and
- Collaborate as needed with the KCHL to consult about individuals with high needs or unique circumstances that would prioritize the referral for placement;
- Seek approval from the KCHL Supervisor before moving a MH Residential client to a new facility; and
- Notify the KCHL when the client's MH Residential services are being terminated regardless of the circumstances.

Treatment Goals

- Provide each client and their family/support system services to assist the client toward achieving recovery and resiliency through mutually negotiated goals of treatment;
- Ensure clients have a voice in developing their Individual Service Plan (ISP), including their crisis plan and advance directives;
- Ensure significant others, as identified by the client, are involved in the service plan development and implementation;
- Ensure treatment goals are written in the words of the client; and
- Ensure documentation related to progress toward treatment goals includes the client's views on his or her progress.

Self-Medication Training

All Mental Health Residential Programs offer Self-Medication Training for clients to help clients prepare themselves for eventual discharge when they are able to step down to lower levels of care. In order to best prepare client's ability to manage their own medication on discharge, Providers:

- Develop a written protocol for teaching self-medication skills to clients;
- Assess each client at the time of their ISP and subsequent treatment reviews for self-medication training;
- Document clients' participation in self-medication training on the ISP with a separate goal and strategy for achieving proficiency; and

Standard Services across all Mental Health Residential Programs

All Mental Health Residential Programs offer the full range of individual and group services at each residential program, which includes:

- Case management;
- Medication management and monitoring;
- Independent living skills;
- Age appropriate employment, volunteer, educational, and/or normative activities;
- Interpersonal and socialization skills;
- Community integration assistance and connection to leisure and recreational activities;
- Facilitation of family support and development of relationships with other natural supports;

- Facilitation of enrollment to and engagement in substance use disorder (SUD) treatment services; and
- Discharge planning and transition services.

Required Staff Trainings

In order for clients to receive services that based in Recovery and Resiliency, staff complete training in the following subjects:

- Recovery and resiliency principles and practices;
- Motivational interviewing; and
- Trauma-informed services and supports.

Clinical Records and Documentation

Providers ensure that residential facility staff maintain clinical records and documentation. An individual chart on each client includes the following:

- An ISP that is developed within 30 days of placement and updated no less than semi-annually includes:
- Verification of client participation in the development of the ISP;
- Client strengths to be built upon in order to assist the client to achieve their goals;
- Clinically relevant treatment needs to be addressed;
- Overall goals developed with the participation of the client and other supportive persons as identified by the client;
- Objectives, defined as short-term steps that are timely, measurable, and observable toward overall goals;
- Strategies to be utilized to achieve goals and objectives;
- Modalities to be provided;
- Information for each client on the domains of community integration, and discharge/aftercare; and
- Strategies to address any barriers to transition to more independent living;
- Progress notes that document:
- Significant changes in the client's clinical and health status;
- Coordination and communication with outside Providers;
- Medical appointments; and
- Family contacts;
- Documentation of hours per week and the level of client participation in in-house and community integration activities identified on the ISP;
- Medication notes;
- A discharge plan that is developed as part of the ISP that includes:
- The minimal skills needed to live in supportive or independent housing; and
- The type of housing environment and housing supports that both the client and the treatment team have identified

- Annual eligibility reviews for continued stay clients as specified by BHRD.

Termination and Discharge

Providers are responsible for discharge planning services which will, at a minimum:

- Coordinate a community-based discharge plan for each client served under this Contract beginning at intake. Discharge planning applies to all clients regardless of length of stay or whether they complete treatment.
- Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency is made within the first week of residential treatment.
- Establish referral relationships with assessment entities, outpatient Providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities.
- Coordinate, as needed, with prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the DSHS Children's Administration, and the DSHS Economic Services Administration including Community Service Offices (CSOs).
- Coordinate services to financially-eligible clients who are in need of medical services.

7.1 Enhanced Nursing Facility Partnership Project at Benson Heights Rehabilitation Center (BHRC)

BHRC is a program designed clients participating in the Enhanced Nursing Facility Partnership Project. Intensive mental health services are provided that support rehabilitation within a skilled nursing care facility. The facility serves up to 40 clients. Clients are provided psychiatric evaluation and medication management services during their enrollment in the program. The Provider partners with BHRC staff in managing client behaviors that are disruptive to the program, including crisis response if necessary. Discharge and aftercare plans are maintained for each client including barriers that prevent a program client from moving to less intensive care and strategies and timeframes for removing those barriers.

Program staff ensure the discharge of those program clients who are determined to no longer meet criteria for the program. Discharge occurs according to the following criteria and process:

- Clients are assessed by the Behavioral Health and Recovery Division (BHRD) Clinical Specialist a minimum of once every 12 months;
- Clients are identified for discharge when they:
    - Are no longer financially or functionally eligible for the Community Options Program Entry System (COPES) or Medically Needy Waiver Program;
    - Have physical health deterioration to the extent that they no longer require the services of a mental health setting;
    - Have care needs exceeding the level of care provided by the skilled staff at BHRC;
    - Are at risk for imminent harm or at risk for causing imminent harm to other participants;
    - Refuse to participate in mental health services; or
    - Do not need daily intervention for mental health symptoms and behaviors.

- The Provider Care Coordinator consults with the BHRD Clinical Specialist and Home and Community Services (HCS) staff (by phone or in person) when the need for discharge has been identified by the HCS case manager; and
- The Provider Care Coordinator, in conjunction with the BHRD Clinical Specialist or designee, notifies HCS staff when a participant has been identified who may be appropriate for or require discharge from the facility into another appropriate or least restrictive setting.

BHRC Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	18 years and older
Authorization Needed	Yes

Additional Criteria	• Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity.
	• In addition to the priority standards stated above for all Mental Health Residential Programs, BHRC clients must meet the following requirements:
	• An individual meets functional eligibility for the Community Options Program Entry System (COPES) or Medically Needy Waiver Program, including:
	  • Requires substantial or total assistance with one or more of the following tasks:
	  • Bed mobility;
	  • Locomotion;
	  • Bathing;
	  • Transfer;
	  • Medication assistance; or
	  • Toileting; and
	  • Requires skilled nursing care or is at risk for placement in a nursing facility within 30 days;
	• An individual who has a mental illness diagnosis which is considered to be a serious and persistent mental illness.
	• An individual demonstrates serious functional impairment in several areas such as judgment, thinking, or mood, and the functional impairment must affect the client's ability to attend to activities of daily living and community living.
	• An individual is willing and able to actively participate in mental health services.
	• An individual has impairment(s) and corresponding service need(s) as a result of the covered mental illness.
	• An individual has unmet need(s) which cannot be more appropriately met by Home and Community Services (HCS), mental health services, or informal systems or supports.

	• An individual who is not eligible to receive other mental health or HCS services in a less restrictive setting. • An individual has failed in previous community-based settings and requires skilled nursing services.
BHRC Reporting Requirements	
Monthly Reports	Benson Heights Rehabilitation Center Census Log
Semi-Annual Reports	The Provider combines information with that identified in the BHRD Outpatient Benefit Scope and follow the Outpatient Benefit Scope Reporting Requirements.

7.2 Eating Disorder Services

Eating Disorder Services provides intensive outpatient, partial hospitalization, and residential services for adults and youth diagnosed with an eating disorder. This scope of work provides a continuum of care for individuals receiving treatment for eating disorders.

Intensive outpatient offers support for individuals requiring more structure and support in the community than standard outpatient services can provide. Individuals spend their days at the facility and return to their homes at night. This allows individuals to practice the skills necessary to remain healthy and protect their recovery.

Partial hospitalization offers some of the intensity and structure of residential treatment, while providing the opportunity to practice recovery outside of the controlled treatment environment during evenings at home or in peer supported apartment communities.

Residential treatment offers 24-hour support for individuals who no longer require complete medical support and stabilization.

All services must be pre-authorized. King County authorizes services for Amerigroup, Molina, and United Healthcare. Coordinated Care of Washington and Community Health Plans of Washington should be contacted directly for authorization. Care can typically be authorized for up to 30 days. Along with basic client information, Providers must submit an eating disorder assessment dated within the last three to six months that demonstrates medical necessity as well as a treatment plan that specifically addresses eating disorder needs. Renewal requests need to be submitted 5 days prior to the expiration of authorization and need to include an updated treatment plan. How to obtain authorization will depend on the individual's MCO.

Eating Disorder Services will be paid per diem. Per diem costs include psychiatric assessment, individual psychotherapy, group psychotherapy, family psychotherapy, individual nutrition appointments, and meal support defined as food eaten in a therapeutic environment with trained staff on hand to help with meal completion. Per diem costs do not include medication management visits with MD, medications, nasogastric tube and placement, wheelchair rental, pediatrics or adult medicine consultation, or lab work.

Eating Disorder Services Eligibility Criteria	
Medicaid Status	Yes
Age Range	N/A
Authorization Needed	Yes
Additional Criteria	The individual must be a King County resident with active Medicaid status.
Eating Disorder Services Reporting Requirements	
Monthly Reports	Eating Disorder Census Report

7.3 Intensive Residential Treatment (IRT)

Intensive Residential Treatment (IRT) teams work with people during discharge from state hospitals. IRT teams help individuals who have struggled to remain in community settings such as adult family homes (AFHs) or assisted living facilities (ALFs). IRT teams provide intensive behavioral health care to the individual in their facility to help them transition to a lower level of care. Teams provide wraparound discharge and diversion services with 16-hour availability, 5 days a week. The team is the primary mental health provider for the person they serve. The team works closely with the facility they live in to help staff support the individuals they serve and to provide direct clinical interventions as is medically necessary. For after-hour care the teams make arrangements with local community Providers and coordinate with local emergency departments to ensure an individual's needs are met when the team is not available. The team's clinical intervention is geared to preventing crisis and intervening at crisis onset to significantly diminish the need for after-hours crisis support.

IRT teams are a voluntary outreach-based team that provides wrap around treatment to individuals in Aging and Long-Term Support Administration (ALTSA) licensed AFHs and ALFs. They work with individuals who are discharging or diverting from state hospitals. The team coordinates with natural supports, facility staff, and other formal staff to ensure treatment is successful.

Please see the following program guidelines as identified by Health Care Authority in Attachment A: HCA IRT Program guide.

Additional IRT program information is located in on the HCA website here.

Attachments in this Section:

Attachment A: HCA IRT Program Guide

Intensive Residential Services Eligibility Criteria	
Medicaid Status	Yes
Age Range	18 years old and above
Authorization Needed	Yes, King County Hospital Mental Health Residential (HMHR) must approve and ALTSA Home and Community Services (HCS) must agree

Additional Criteria	Eligible individuals must meet the following criteria:
	• Diagnosed with a DSM 5 (or its successor) mental health diagnosis which with the appropriate clinical interventions can be reasonably assumed to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient;
	• Receiving services in a DSHS/ALTSA/HCS residential facility;
	• Presenting with symptoms of their DSM V mental health diagnosis which without this level of intervention, could put their continued success in the community at-risk;
	The individual being referred to services must also meet **one** of the following criteria at intake:
	• Diversion: A diversion means an individual who resides in their community presenting with symptoms that puts the individual at risk for a higher level of care without the intervention of an IRT team. Examples of diversion are below:
	  • At risk for involuntary treatment; or
	  • psychiatric hospitalization; or
	  • at risk of losing their living arrangement in their community; or
	  • is currently held in an emergency department or hospital awaiting placement in an inpatient facility; or
	  • Is currently held in an emergency room with no placement available due to presenting symptoms or level of need; or
	  • In a community diversion, stabilization, or triage facility that is unable to find placement due to level of acuity or need; or
	  • Will be released from a jail or prison and will need support to stay in their community.
	• Discharge: An individual admitted to a psychiatric inpatient facility, ready for discharge from the facility, with a discharge plan that includes placement in an ALTSA facility, but the symptoms of their current mental illness jeopardizes or poses an obstacle for admission to and/or continued success in an ALTSA facility.

Intensive Residential Services Reporting Requirements	
Weekly Reports	• IRT Tracker Report
Monthly Reports	• IRT Census Report

7.4 Intensive Step-Down (Geriatric Diversion)

Intensive Step-Down services are facility-based residential services and provide one of the highest levels of support. Trained staff members are present 24/7 to provide care and assistance with medication, daily living skills, meals, paying bills, transportation, and treatment management. Supports include: Peer Support, Case Management Services, Occupational Therapy, support for Chronic Medical Conditions, Living Skills, and Care Coordination with Substance Use Treatment and other medical providers.

ISD staff focus on assisting clients incorporating themselves into the community and developing natural supports, focusing on transition to long term placement in the community. This level of mental health residential treatment is generally best for clients experiencing a serious mental illness who are stepping down from inpatient in a state hospital bed or are diverting from an inpatient state hospital bed stay.

Program Specific Requirements

This program is part of the mental health residential continuum – authorizations are completed by the Hospital Placement and Diversion Liaison staff.

Intensive Step-Down Eligibility Criteria	
Medicaid Status	Medicaid is required
Age Range	18+ for the ISD level of care, 50+ for SeaMar's facility
Authorization Needed	Yes, from the Hospital Placement and Diversion Liaison staff. LOCUS Level 5 required for authorization.
Additional Criteria	The same overall requirements for the mental health residential continuum
Intensive Step-Down Reporting Requirements	
Monthly Reports	• ISD Billing Report Services Summary • ISD Residential Invoice Report
Quarterly Reports	• ISD Billing Report Services Summary • ISD Residential Invoice Report
Annual/Other Reports	Intensive Step-Down Continuing Stay Review TBA

7.5 Intensive Supportive Housing (ISH)

ISH services are provided in the community for clients who require less assistance with Activities of Daily Living (ADLs) than those who need a facility-based, higher level of care. Services are meant to help promote more independence, stability, community tenure, and movement toward normative living environments. Providers maintain a client-to-staff ratio of no more than 10:1. Staff offer clients supervised activities in which each client is encouraged to participate. Staff work closely with other agencies and systems including the Department of Social and Health Services (DSHS) workers and Social Security Administration (SSA) staff to coordinate benefits, public housing authorities for housing subsidies, Division of Vocational Rehabilitation (DVR) as indicated to initiate vocational services, and primary care providers to support access to medical/dental care.

ISH Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity
ISH Reporting Requirements	
Monthly Reports	ISH Monthly Report

7.6 Long-Term Rehabilitation Services (LTR)

LTR services are facility-based residential services. Facilities are safe, clean, healthful, and provide therapeutic environments that are appropriately licensed and meet State regulations. Staff work with clients to help them further incorporate themselves into the community to help develop natural supports.

LTR staff are aware of area resources, make them available to clients, and provide a bridge to facilitate the client's connection to and integration with local community and private entities such as fitness centers, community centers, senior centers, places of worship, recreational organizations, arts organizations, and similar organizations or groups.

LTR Eligibility Criteria	
Medicaid Status	Yes
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity
LTR Reporting Requirements	
Monthly Reports	• Long-Term Residential (LTR) Services Reimbursement Request & Billing Report Services Summary

7.7 Standard Supportive Housing Program (SSH)

Supportive housing provides more limited assistance than other Mental Health Residential Programs. Clients live in their own homes and are visited by staff members. Clients have access to someone they can call, and resources available to them if a problem does arise. Providers maintain a client to staff ratio of no more than 15:1. The Provider provides staff coverage 7 days per week, 365 days per year.

Clients receive the full array of outpatient services and assistance in meeting obligations of tenancy such as regular communication with the housing Provider and eviction prevention services. Staff work with the clients to make connections to community, social, employment, educational, leisure, recreational and spiritual activities and supports. In addition to the services listed for all Mental Health Residential programs, clients receive assistance with appropriate nutrition support, and assistance in securing a permanent subsidized housing unit upon graduation from the SSH program.

Staff work with clients to develop and strengthen activity of daily living skills to build independence and move to a less intensive service level within two years. Treatment focuses on helping the client:

- Acquire the skills and means to attend appointments and activities;
- Acquire the skills and means to meet basic nutritional needs;
- Build new and strengthen existing natural supports;
- Acquire skills to be a Good Neighbor/Tenant including budgeting, paying rent on time;
- Develop a daily structure and meaningful activities in their lives; and
- Acquire familiarity with his/her new neighborhood and surroundings.

SSH Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity
SSH Reporting Requirements	
Monthly Reports	SSH Monthly Report

7.8 Supervised Living Services (SL)

Supervised Living Services are facility-based residential services, and provides one of the higher levels of support for residents who need additional clinical support. Trained staff members are present 24/7 to provide care and assistance with medication, daily living skills, meals, paying bills, transportation and treatment management. Residents have their own bed, dresser, and closet space and generally share bathrooms and common areas. This type of housing is generally best for clients experiencing a serious mental illness which may affect their ability to perform their daily tasks.

SL residential facility staff keep a current activity schedule, offer clients a variety of appropriately supervised activities emphasizing community integration, interpersonal and socialization skills, and document on each client's ISP a goal and strategy for participation in activities.

SL Eligibility Criteria	
Medicaid Status	Yes
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity.
SL Reporting Requirements	
Monthly Reports	• Supervised Living (SL) Services Reimbursement Request Billing Report Services Summary

8 Behavioral Health Administrative Services Organization (BH-ASO) Mental Health and Substance Abuse Federal Block Grant Programs

All programs receiving funding through the Mental Health and Substance Abuse Federal Block Grant Programs are subject to additional funding requirements. Programs in this section are completely or mostly funded by these block grant programs and therefore fall under these requirements. Additional programs not in this section, which are identified on the Provider's Funding Overview as receiving partial funding from the federal block grant programs must also follow the following guidelines for that funding originating from the federal block grant programs.

- The MHBG and SABGSAPT Block Grant requires an annual peer review by individuals with expertise in the field of drug abuse treatment (for SABGSAPT) and individuals with expertise in the field of mental health treatment (for MHBG). At least five percent (5%) of treatment Providers will be reviewed. Providers are required to participate in the peer review process when requested. (42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136). The MHBG and SABGSAPT Block Grant pay for services provided prior to the execution of contracts, or to pay in advance of service delivery.

Substance Abuse Block Grant (SABG) Funding Requirements and Limitations

The Provider does not use SABG funds for the following:

- Services and programs that are covered under the capitation rate for Medicaid-covered services to Medicaid enrollees;
- The Provider's administrative costs associated with salaries and benefits at the Provider's organization level;
- Inpatient mental health services;
- Mental health services;
- Construction and/or renovation;
- Capital assets or the accumulation of operating reserve accounts;
- Equipment costs over $5,000;
- Cash payments to individuals;
- To purchase or improve land;
- To purchase, construct or permanently improve any building or other facility;
- To purchase major medical equipment;
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
- Provide financial assistance to any entity other than a public or nonprofit private entity;
- Make payments to intended recipients of health services;
- Provide individuals with hypodermic needles or syringes;
- Provide treatment services in penal or correctional institutions of the State; and

The Provider ensures that SABG funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid as follows:

Benefits	Services	Use SABG funds	Use Medicaid
Individual is not a Medicaid recipient	Any Allowable type	Yes	No
Individual is a Medicaid Recipient	Allowed under Medicaid	No	Yes
Individual is a Medicaid Recipient	Not allowed under Medicaid	Yes	No

8.1 Alcohol, Tobacco and Other Drug Prevention Coalition

This program is designed to provide effective prevention and intervention strategies for those most at risk and most in need to prevent or reduce more acute illness, high-risk behaviors, incarceration and other emergency medical or crisis responses. The Provider functions as the fiscal agent for the designated alcohol, tobacco and other drug (ATOD) prevention coalition (the Coalition) to provide services as part of the statewide Community Prevention and Wellness Initiative (CPWI). The Provider manages and supports the CPWI coalition focused on preventing ATOD use and related problems among children and youth in King County, specifically, in the community identified in the approved strategic plan/ action plan. The Provider also coordinates and implements prevention programs designed to prevent or delay the misuse and abuse of alcohol, marijuana, tobacco, and other drugs among youth up to age 18 and young adults ages 19-25.

The Provider and the Coalition participate as a part of the CPWI to enhance community prevention coalition efforts focused on preventing ATOD use and related problems among children and youth in the geographic area identified in the approved strategic plan/ action plan.

The Provider and, as requested, the Coalition attend required CPWI meetings and receive technical assistance from the funders, the State of Washington Health Care Authority (HCA) Division of Behavioral Health and Recovery (DBHR) and the King County Department of Community and Human Services (DCHS) Behavioral Health and Recovery Division (BHRD or the County). The Provider and the Coalition comply with DBHR and BHRD requests for information needed to ensure quality assurance of products and services.

The Provider and the Coalition plan, implement and evaluate CPWI services consistent with the CPWI Community Coalition Guide, and updates/ other documents provided by HCA/DBHR and/or BHRD.

The Provider is required to participate in all training events identified by BHRD and HCA, and listed in the CPWI Community Coalition Guide. The Provider must submit a written request for other non-required training events that are not already pre-approved by HCA and BHRD. For these CPWI training events, the Provider follows state travel reimbursement guidelines and rates accessible here.

The Provider is not liable for any failure of or delay in the performance of this CPWI project should the failure or delay be due to causes beyond its reasonable control. These force majeure events may include but not limited to natural and unavoidable catastrophes, war, strikes or labor disputes, embargoes, and government orders.

The Provider complies with all applicable local, state and federal laws and requirements including: (a) audit requirements described in federal Office of Management and Budget Super Circular 2 CFR 200.501 and 45 CFR 75.501; (b) prohibition of using these federal funds as a match or cost-sharing provision to secure other federal monies without prior written approval by HCA; and (c) SAMHSA

Award Terms. This includes that the Provider complies with Charitable Choice Requirements of 42 CFR Part 54 and that Faith-Based Organizations (FBO) are provided opportunities to compete with traditional alcohol/drug abuse prevention Providers for funding.

The Provider participates in a minimum of one annual review by the County and HCA as requested in order to monitor contract compliance and to observe programs that directly serve CPWI participants. The annual review includes compliance with CPWI program-specific requirements, subcontracting requirements, funding source requirements, and discussion about coalition progress/ delivery including system collaboration, cultural relevance and equity/social justice. The annual review is held at a mutually agreed upon time.

The Provider ensures a signed, written agreement with the Coalition is updated then resubmitted to the County when changes occur in roles, representatives, and/or designated parties authorized to sign.

The Provider and, as requested, the Coalition recruit and select qualified staff members who have the necessary skills and knowledge to plan and implement this ATOD prevention project, consistent with the CPWI Community Coalition Guide, to include a minimum of a 0.5 FTE Coalition Coordinator. CPWI staff participate in required trainings/ conferences and the Provider ensures proper training of primary and backup staff for Minerva data entry.

The Provider ensures a criminal background check is conducted for all staff members involved in this CPWI project including but not limited to prevention staff members, outreach staff members, etc. or volunteers who have unsupervised access to children, adolescents, vulnerable adults, and persons who have development disabilities. When providing services to youth, the Provider ensures relevant Washington Administrative Code (WAC) requirements are met such as WAC 388-06-0170.The Provider expends its funding allocation within the state fiscal year (July 1 through June 30) unless an exception is granted in advance.

The Provider agrees to submit to BHRD all advertising, sales promotion, and other publicity materials relating to CPWI in which BHRD, and HCA's names are mentioned, language is used, or Internet links are provided from which the connection of their names with Provider's services may, in BHRD and HCA's judgment, be inferred or implied. The Provider further agrees not to publish or use such advertising, marketing, sales promotion materials, publicity or the like through print, voice, the Web, and other communication media without the express written consent of BHRD and HCA prior to such use.

The Provider submits all written and printed information to BHRD for review and approval prior to publication. This includes program flyers, publications, media materials, and audiovisual prevention messages, including messaging specifically directed to youth. These documents may not be distributed until final approval is given by BHRD and, as applicable, HCA. Exceptions include: newsletters and fact sheets, news coverage, newspaper editorials or letters to the editor, posts on social media, when statewide media messages developed by HCA are localized and if the only changes are addition of local coalition information and funding source acknowledgment from coalition or public health entities, and when national prevention media campaign developed by SAMHSA are localized and if the only changes are addition of local coalition information and funding source acknowledgment from coalition or public health entities s. Coalition websites, with general information to the public, do not need to be reviewed and approved; however, content such as public awareness campaign messages placed on the websites do need preapproval.

All data and work products produced as part of this CPWI contract will be considered a work for hire under the U.S. Copyright Act, 17 U.S.C. §101 et seq, and will be owned by HCA. For data and work products not considered to be a work for hire under applicable law, but was otherwise produced pursuant to this contract, the Provider assigns and transfers to HCA, the entire right, title and interest in

and to all rights in the Work Product and any registrations and copyright applications relating thereto and any renewals and extensions thereof.

The Provider ensures that funding source acknowledgements are made on all media materials and publications (including news releases and advertising messages) developed with CPWI funds. Specifically, the materials will include text that cites the funding sources as: King County Department of Community and Human Services and Washington State Health Care Authority. The Provider may use current approved logos in lieu of the citations written in text.

If the Provider issues news releases to the media regarding this prevention project or has other media contacts discussing this project, the Provider will acknowledge its funding sources. Specifically, the Provider will cite the funding sources as: King County Department of Community and Human Services and Washington State Health Care Authority.

The Provider and the Coalition will follow branding/logo and media requirements and guidance in the CPWI Community Coalition Guide as well as on The Athena Forum including the guidelines found here. The Provider and the Coalition will also ensure adherence to King County guidance related to flyers and publications.

The Provider adheres to HCA policies related to food costs. Meals are not allowable costs with State Opioid Response (SOR) funds. Food and light refreshments are generally unallowable during CPWI program implementation except within the following parameters related to programs supported with Federal Substance Abuse Block Grant (SABG) funds:

- For approved uses of food or light refreshments, the maximum amount that the Coalition may expend for food or light refreshments is $1,000 per year;
- Light refreshment costs for training events and meetings that are longer than two hours in duration are allowable and the cost for light refreshments will not exceed $3.00 per person;
- For recurring direct service family domain programs (lasting two hours or more in duration) that are approved in the Coalition's current strategic plan/ action plan, meals supported with SABG funds may be provided for participants and will not exceed the current Washington State per diem rates as referenced in the Office of Financial Management State Administrative and Accounting Manual Section 10.90 - Travel Rates; and
- For approved substance abuse prevention training events that are at least four hours in duration, the cost for meals supported with SABG funds may be provided for participants and will not exceed the current Washington State per diem rates as referenced in Section 10.90 - Travel Rates.

The Provider adheres to HCA and BHRD issued program and fiscal policies and requirements including those specified in the "Substance Abuse and Mental Health Services Administration (SAMHSA) Award Terms," and "2021 New Contractor Fiscal & A-19 Training." According to these documents, the following are not allowable:

- Funds to supplant current funding of existing activities.
- Incentives (including cash, gift certificates and non-cash incentives) for the SABG and State funds.
- Equipment purchases over $5,000.
- Entertainment costs, which include movie tickets, theaters, amusements, diversion, social activities, sporting tickets, and incidental costs relating thereto such as meals, beverages, lodging, rentals, transportation, and gratuities (unless prior written approval granted by HCA and BHRD).
- Needle exchange programs.
- Honorariums, giveaways, and door prizes.
- Funds to pay for enforcement nor school teacher salaries.

- Promotional materials, e.g., clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags, etc. (unless approved by HCA and BHRD and includes an acceptable prevention message).
- Costs of organized fund raising.
- Lobbying expenses (i.e. cost of attempting to influence legislation pending before any federal or state legislative body) except as provided for in RCW 42.17.190.
- Excessive costs and executive pay above $199,300.

If the Provider participates in a Secure Prescription Take-Back and/or Lock Box Project that is supported with CPWI funding, the Provider will follow guidelines and requirements issued by HCA and BHRD. If the Provider receives other special and/ or enhancement funding from BHRD related to CPWI, the Provider will follow guidelines and requirements issued by HCA and BHRD. If the Provider receives SOR funds, the Provider will participate in the bi-annual (April and October) National Drug Take-Back Days and will disseminate the statewide Opioid Response campaign, Starts With One.

If there are verified cases of fraud and abuse by the Provider's employees involved in CPWI, the Provider will report this in writing to BHRD within four (4) business days and include the following: (a) Subject(s) of complaint by name and either Provider/subcontractor type or employee position; (b) Source of complaint by name and Provider/subcontractor type or employee position; (c) Nature of complaint; (d) Estimate of the amount of funds involved; and (e) Legal and administrative disposition of case.

ATOD Prevention Coalition Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	• Community members, organizations, and groups in King County per the approved coalition strategic plan/ action plan • School staff, at-risk youth (focused on middle school through 10th grade), families, and other community members in King County, in particular those identified in the approved coalition strategic plan/ action plan
ATOD Prevention Coalition Reporting Requirements	
Monthly Reports	All hours provided and services delivered during the preceding month will be submitted into the Minerva Information System (MIS) by the 15th day of each month. The Provider will submit all required data including coalition staff hours, demographic information (related to staff, coalition members and participants), service information (hours, counts, and other descriptive data), evaluations and assessments as applicable, and training information. Unless an exception is granted, Monthly Actual Expenditure Reports are also required by the fifteenth day of each month that provide additional information related to monthly original and supplemental invoices.
Quarterly Reports	Due October 15, January 15, April 15, and July 15 in the MIS

8.2 Consumer-Driven Services

This program provides a recovery-oriented Clubhouse service for King County residents who experience mental health issues. This funding is meant to ensure that Clubhouse services are available to eligible adults who are interested in participating in the Clubhouse as a way to pursue work. The Provider achieves certification from the International Center for Clubhouse Development (ICCD). The Clubhouse is operated according to the ICCD Clubhouse Standards and meets state certification requirements per Washington Administrative Code (WAC) 246-341-0730 or its successors. During hours of operation, the Clubhouse is open on a drop-in basis to provide a work-ordered day, transitional employment services, supported employment services, independent employment services, supports, and help to any member. Clubhouse staff develop and maintain on-site a monthly progress note containing a summary of consumer activities at the Clubhouse and that records their days of attendance.

Consumer-Driven Services Eligibility Criteria	
Medicaid Status	Client cannot be Medicaid-Eligible for coverage under this program
Age Range	N/A
Authorization Needed	No
Additional Criteria	• Individuals in King County who experience barriers to employment due to mental health issues. • Clients may self-refer but the Clubhouse may only request reimbursement under this program if the consumer is not Medicaid-eligible.
Consumer-Driven Services Reporting Requirements	
Monthly Reports	• Consumer-Driven Services Clubhouse Census Log • Progress note to the Outpatient Benefit holder for each enrolled consumer served that contains a summary of activities and attendance.
Annual/Other Reports	Upon request from BHRD, the Provider submits an annual report that specifies justification for the unit cost. The Provider complies with the specific requirements for financial audits or alternative as required in the Standard Contract.

8.3 KC Consumer Training

The Provider administers the King County Consumer Training Fund for clients who are involved in Behavioral Health and Recovery Division (BHRD) programs, their families, and advocates for consumers of public mental health services to attend conferences, seminars, and workshops. The Consumer Training Fund was established to provide access to training for clients enrolled in BHRD programs, their families, and advocates for consumers of public behavioral health services. Each eligible client can receive up to $500 per year. The funds are used only for conferences, seminars, and workshops that are open to the public (e.g. alternative therapy sessions or groups meetings oriented to the treatment of one individual are not acceptable). Each application from this fund includes the title and date of the conference, seminar, or workshop, amount of funds requested including a breakdown of total costs, applicant's address and phone numbers, and how the applicant meets eligibility requirements for utilizing the fund. If the applicant is a paid employee of National Alliance on Mental Illness (NAMI) Seattle, the application is also submitted to BHRD for review and approval, or denial is made by BHRD. Eligible expenses for the conference, seminar, or workshop are pre-paid by the Provider.

The Provider advertises the availability of the King County Consumer Training Fund using the United States Postal Service, the internet, and in-person contact. Information about the fund is included in the NAMI Seattle bi-monthly *Spotlight* newsletter and periodic bulletins. Information about the fund benefit is disseminated to the following organizations in King County:

- Community mental health agencies;
- NAMI-Eastside and NAMI-South King County;
- Mental health residential facilities;
- Clubhouses;
- Consumer-run organizations; and
- Other organizations that provide mental health services.

KC Consumer Training Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	• King County resident who is enrolled in BHRD programs, a family member of a person enrolled in BHRD programs, or an advocate for consumers of publicly funded mental health services. • Not Eligible: A Professional in the field of behavioral health or an employee of a community mental health agency
KC Consumer Training Reporting Requirements	
Monthly Reports	King County Consumer Training Fund Expenditures Report in a format provided by BHRD in hard copy with the invoice.
Semi-Annual Reports	King County Consumer Training Fund Status Report in a format provided by the County in hard copy with the June and December BIP.
Annual/Other Reports	King County Consumer Training Fund Conference and Seminar Approval List Annual Report in a format provided by the County in hard copy with the December BIP. The Provider complies with the specific requirements for financial audits or alternative as required in the Standard Contract.

8.4 KC Housing and Recovery Through Peer Services (HARPS)

Housing and Recovery Through Peer Services (HARPS) provides time-limited supportive housing services and housing bridge subsidy which are intended to support individuals who are exiting psychiatric or substance use disorder (SUD) inpatient facilities. HARPS is designed from a recovery perspective based on Evidence-Based Practice of Permanent Supportive Housing (EBP PSH) principles. Dimensions of EBP PSH include:

- Choice in housing and living arrangements;
- Functional separation of housing and services;
- Decent, safe, and affordable housing;
- Community integration and rights of tenancy;

- Access to housing and privacy; and
- Flexible, voluntary, and Recovery-focused services.

HARPS priority population includes individuals who are not eligible for Medicaid through Foundational Community Supports Supportive Housing Services and who are experiencing a serious mental illness, substance use disorder, or co-occurring mental illness and substance use disorder.

Per Health Care Authority (HCA) requirements, the team consists of one full time equivalent (FTE) MA Professional or Housing Case Manager/Supervisor, as long as clinical supervision by an MHP is provided, and two FTE Certified Peer Counselors (CPC).

HARPS Teams partner with Native American/Alaska Native Behavioral Health to promote culturally competent services for participants.

HARPS teams don't suggest or provide medication prescription, administration, monitoring, and documentation.

The HARPS team works with the treatment team to:

- Establish a peer relationship with each participant;
- Assess each individual's housing needs and provide verbal and written information about housing status. The physician or psychiatric advanced registered nurse practitioner (ARNP) reviews that information with the individual, HARPS team members and, as appropriate, with the individual's family members or significant others;
- HARPS team members can provide direct observation and available collateral information from the family and significant others as part of the comprehensive assessment;
- In collaboration with the individual, assess, discuss, and document the individual's housing needs and behavior in response to medication and monitor and document medication side effects. Review observations with the individual and treatment team; and
- HARPS team members must participate in the HARPS monthly administrative conference call.

HARPS Housing Services

HARPS programs are encouraged to have Housing Services policies in place to address appeals and denials and the following guidelines.

HARPS staff are mobile, engaging and providing services to identified individuals in community settings including behavioral health inpatient facilities. HARPS services supplement, not duplicate or replace, services provided by other staff involved in the client care.

The HARPS team caseload remains manageable, allowing for the flexibility to provide the intensity of services required for each individual, according to the medical necessity of each individual. It is estimated that 20% of individuals accessing HARPS housing bridge subsidy funds will receive supportive housing services from HARPS. The HARPS team supports approximately 50 individuals at any given time and assumes turnover of thirty-five percent (35%) per year.

HARPS housing specialists have the capacity to provide multiple contacts per week with individuals exiting or recently discharged from inpatient behavioral healthcare settings, making changes in a living situation or employment, or having significant ongoing problems in maintaining housing. The frequency of multiple contacts depends on individual need and a mutually agreed upon plan between individuals and program staff. Many, if not all, staff share responsibility for addressing the needs of all individuals requiring frequent contact.

HARPS teams must have the capacity to rapidly increase service intensity and frequency to an individual when his or her status requires it or if an individual requests it.

HARPS teams must have a response contact time of no later than two calendar days upon discharge from a behavioral healthcare inpatient setting, such as an evaluation & treatment center, residential treatment center, detox, or state psychiatric hospital.

Operating as a continuous supportive housing service, the HARPS team has the capability to provide support services related to obtaining and maintaining housing. This includes direct contact with landlords on behalf of the participant. Services minimally include the following:

- **Hospital Liaison Coordination:** The BH-ASO's hospital liaison must actively coordinate the transition of individuals from behavioral healthcare inpatient treatment center discharge to the HARPS Team in the community of residence in order to minimize gaps in outpatient healthcare, and housing.
- **Service Coordination:** Service coordination must incorporate and demonstrate basic recovery values. The individual has a choice of their housing options, are expected to take the primary role in their personal housing plan development, and will play an active role in finding housing and decision-making.
- **Crisis Assessment and Intervention Coordination:** Behavioral Health Crisis assessment and intervention must be available 24-hours per day, seven days per week through the BH-ASO's crisis system. Services must be coordinated with the assigned Care Coordinator. These services include telephone and face-to-face contact.

Supportive Housing Services should include the following, as determined by medical necessity:

- **Supportive Housing Services:** Assess housing needs, seek out and explain the housing options in the area, and resources to obtain housing. Educate the individual on factors used by landlords to screen out potential tenants. Mitigate negative screening factors by working with the individual and landlord/property manager to clarify or explain factors that could prevent the individual from obtaining housing. Ongoing support for both the individual and landlord/property manager to resolve any issues that might arise while the individual is occupying the rental.
    - Each HARPS Participant is assigned a peer specialist or housing specialist who assists in locating housing and resources to secure housing and maintain housing. The primary responsibilities of the Peer Specialist are to work with the individual to find, obtain, and maintain housing to promote recovery, locate and secure resources related to housing and utilities, offer information regarding options and choices in the types of housing and living arrangements, and advocate for the individual's tenancy needs, rights (including ADA Accommodations), and preferences to support housing stability. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.
    - Each individual receiving HARPS services have an individualized, strengths-based housing plan that includes action steps for when housing related issues occur. As with the treatment planning process, the individual takes the lead role in setting goals and developing the housing plan.
- **Housing Search and Placement:** Includes services or activities designed to assist households in locating, obtaining, and retaining suitable housing. Services or activities may include tenant counseling, assisting households to understand leases, securing utilities, making moving arrangements, representative payee services concerning rent and utilities, and mediation and outreach to property owners related to locating or retaining housing.
- **Housing Stability:** Includes activities for the arrangement, coordination, monitoring, and delivery of services related to meeting the housing needs of individuals exiting or at risk of entering inpatient behavioral healthcare settings and helping them obtain housing stability. Services and activities may include developing, securing, and coordinating services including:

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

- **Education Services Linkage:** Supported education related services are for individuals whose high school, college, or vocational education could not start or was interrupted and made educational goals a part of their recovery (treatment) plan. Services include providing support to applying for schooling and financial aid, enrolling and participating in educational activities, or linking to supported employment/supported education services.
- **Vocational Services Linkage:** These services may include work-related services to help individuals value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers. These activities should also be part of the individual's recovery (treatment) plan or linkage to supported employment.
- **Activities of Daily Living Services:** Services to support activities of daily living in community-based settings include individualized assessment, problem solving, skills training/practice, sufficient side-by-side assistance and support, modeling, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), environmental adaptations to assist to gain or use the skills required to access services, and provide direct assistance when necessary to ensure that individuals obtain the basic necessities of daily life.
- **Social and Community Integration Skills Training:** Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skill training and include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure individuals' time, increase their social experiences, and provide them with opportunities to practice social skills, build a social support network, and receive feedback and support.
- **Peer Support Services:** These include services to validate individuals' experiences and to inform, guide, and encourage individuals to take responsibility for and actively participate in their own recovery, as well as services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma. Peer support and wellness recovery services include:
  - Promote self-determination;
  - Model and teach advocating for one's self;
  - Encourage and reinforce choice and decision-making;

  - Introduction and referral to individual self-help programs and advocacy organizations that promote recovery; and
  - "Sharing the journey" (a phrase often used to describe individuals' sharing of their recovery experience with other peers). Utilizing one's personal experiences as information and a teaching tool about recovery.
  - The peer specialist will serve as a consultant to the treatment team to support a culture of recovery in which each individual's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, support, vocational, and community activities.

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

HARPS Housing Bridge Subsidy

HARPS programs are encouraged to have housing subsidy policies in place to address appeals, denials, and the following guidelines. HARPS apply internal controls that are aligned with generally accepted accounting principles to ensure that invoiced costs are accurate, allowable, and reasonable.

The HARPS Housing Bridge Subsidy provides short-term funding to help reduce barriers and increase access to housing. Individuals exiting detox, 30, 60, and 90-day inpatient substance use disorder treatment facilities, residential treatment facilities, state hospitals, E&T's, local psychiatric hospitals, and other inpatient behavioral healthcare settings could receive up to 3 months of housing 'bridge' subsidy.

HARPS Bridge Subsidies are temporary in nature and should be combined with other funding streams, whenever possible, to leverage resources to assist individuals with obtaining and maintaining a permanent residence.

HARPS subsidies are estimated at $2,500 per person, but can be adjusted as needed to meet Fair Market Rental Housing rates as long as the total is within the contracted amount.

Allowable expenses for HARPS Housing Bridge Subsidy include:

- Monthly rent and utilities, and any combination of first and last months' rent for up to three months. Rent may only be paid one month at a time, although rental arrears, pro-rated rent, and last month's may be included with the first month's payment. Payments beyond three months may be provided with King County pre-approval;
- Rental and/or utility arrears for up to three months if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit. The HARPS Housing Bridge Subsidy may be used to bring the program participant out of default for the debt and the HARPS Peer Specialist will assist the participant to make payment arrangements to pay off the remaining balances. Payments beyond three months may be provided with King County pre-approval;
- Security deposits and utility deposits for a household moving into a new unit;
- Rent assistance for move-in costs including but not limited to deposits and first month's rent associated with housing, including project- or tenant-based housing;
- Application fees, background and credit check fees for rental housing;
- Lot rent for RV or manufactured home;
- Costs of parking spaces when connected to a unit;
- Landlord incentives (provided there are written policies and/or procedures explaining what constitutes landlord incentives, how they are determined, and who has approval and review responsibilities);

- Reasonable storage costs;
- Reasonable moving costs such as truck rental and hiring a moving company;
- Hotel/motel expenses for up to 30 days per year per household if unsheltered households are actively engaged in housing search and no other shelter option is available. Payments beyond 30 days may be provided with county pre-approval; and
- Temporary absences. If a household must be temporarily away from unit, but is expected to return (e.g., client violates conditions of their Department of Corrections (DOC) supervision and is placed in confinement for 30 days or re-hospitalized), HARPS may pay for the household's rent for up to 60 days per year. Payments beyond 60 days may be provided with King County pre-approval.
- Rental payments to Oxford houses or other Recovery Residences on the Recovery Residence Registry located here: Workbook: Residence/Oxford House Locations (wa.gov)

HARPS services are reimbursed according to the Provider's performance on the following tasks.

Goal	Task	Performance Measure	Due Date	Payment
1	Weekly updates on number of referrals from state psychiatric hospitals (Western State Hospital and Eastern State Hospital)	Send a Word document via email to the HCA HARPS Program Manager with the number of individuals referred by the State Hospitals, date of the referral, and current housing status of hospital referrals. Do not include any identifying information in the updates.	Tuesday of each following week.	$200 per HARPS team weekly update X 4 weeks per month X 12 months for a maximum of 12 months
2	At least 2 FTE HARPS staff attend HCA facilitated training event on SAMHSA model Evidence-Based Practice of Permanent Supported Housing (EBP PSH)	Sign in sheet verifying program staff attended the HCA facilitated EBP PSH training event.	As determined by HCA	1 payment of $5,000 for training participation
3	Document HARPS Landlord Outreach and Engagement Activities in monthly HARPS Participant Log using the Landlord Outreach Tab uploaded to King County secure FTP site using designated naming convention.	At least 5 landlord/property manager contacts document in the Landlord Outreach tab of the monthly HARPS Participant Log	Due by the 10th of each following month.	12 months (assuming full staffing) @ $5,000 per report received and approved

4	Document expenditures of subsidies and submit monthly HARPS Participant Log detailing HARPS enrolled participants that receive services and/or subsidies. Information submitted will include participants that are enrolled, actively receiving supported housing services as well as those achieving 6 months of housing retention. Payment will be pro-rated for unfilled positions based upon 4 FTE.	Monthly HARPS Participant Log submitted to King County secure FTP site using designated naming convention.	Due by the 10th of each following month.	12 months (assuming full staffing) @ $5,000 per monthly HARPS Participant Log received.
5	Document and submit HARPS Quarterly Report with results of project activities including participant success story with signed release. Report shall include: 1. Describe staff development activities for reporting period (including orientation and training). 2. Indicate any other project activities or events, including meetings with local Continuums of Care, Coordinated Entry Programs, Peer Bridgers, housing, and housing services providers meetings. 3. Date(s)/duration of the training or meeting. 4. Subject of the training or meeting. 5. Discuss value/impact on the project. 6. A participant success story.	HARPS Quarterly Report submitted to King County secure FTP site using designated naming convention	Due by the 15th of the month following the quarter, according to the following schedule: • Jan – March: due Apr 15 • Apr – June: due July 15 • July – Sept: due Oct 15 • Oct – Dec: due Jan 15	4 quarterly reports @ $13,960 per report

Community Behavioral Health Rental Assistance (CBRA)

CBRA provides long-term or bridge rental subsidies for high-risk individuals with behavioral health conditions and their households. When partnered with programs offering supportive housing services, highly-vulnerable persons with complex behavioral health needs have opportunities to live independently in the communities of their choice.

When administering CBRA, HARPS Providers should follow the CBRA program guidelines and requirements found within the Program Guidelines document for the current fiscal year, which is published on the following Washington State Department of Commerce webpage: Permanent Housing Subsidy Programs - Washington State Department of Commerce

HARPS Eligibility Criteria	
Medicaid Status	Not eligible for Medicaid through Foundational Community Supports Supportive Housing Services
Age Range	18 years of age or older
Authorization Needed	Yes
Additional Criteria	• The individual is experiencing a behavioral health disorder; and • Is being released from a psychiatric inpatient setting or SUD residential treatment program; and • Is homeless or at risk of homelessness; and • Is willing to participate in the HARPS program.
HARPS Reporting Requirements	
Monthly Reports	• HARPS Participant Log-due the 10th of the month following the reporting period • CBRA Monthly Log-due the 10th of the month following the reporting period. Final reports for the biennium may be due sooner.
Quarterly Reports	• HARPS Quarterly Report – due the 15th of the month following the reporting period
Annual/Other Reports	• Upon request, Providers will submit accurate and complete information for the Annual County Expenditure Report to the Consolidated Homeless Grant Lead Contractor in the communities in which they serve. • Upon request, Providers will respond to requests for information by Department of Commerce.

8.5 New Journeys First Episode Psychosis (FEP) Project

New Journeys Coordinated Specialty Care (NJ CSC) is a delivery model designed to meet the needs of those experiencing a first episode of psychosis with treatment provided as a wrap-around intensive outpatient service. Treatment provides evidence-based health and recovery support interventions for youth and young adults when first diagnosed with Severe Mental Illness (SMI)/Severe Emotional Disturbance (SED).

King County NJ CSC Services are delivered by three contracted mental health providers who work collaboratively, have multi-disciplinary teams and provide treatment, rehabilitation, and supports to assist individuals to achieve their goals. The service array is provided on an outpatient basis with

options for home and community settings, based on each individual's needs and what they identify as helping them achieve a more meaningful life. The service components include individual and/or group psychotherapy, family psychoeducation and support, medication management, supported employment and education, case management and peer
support.

A full fidelity NJ CSC Team:

- serves up to 30 individuals ages 15-40 years old, implements a 24-month lifetime benefit limit per program participant
- engages in ongoing NJ training with University of Washington (UW) and Washington State University (WSU),
- has an HCA approved New Journeys Attestation Form, and
- actively participates in the NJ fidelity review process.

The program implements evidence based Coordinated Specialty Care (CSC) principles and practices. Providers participate in all meetings to enhance implementation and evaluation efforts, including training, meetings, and direct service.

Trainings and Meetings:

- Weekly team meetings
- Monthly role consultation and technical assistance calls
- Monthly FEP ECHO Clinic case presentations or sharing of best practices/team-based consultation
- King County New Journeys Team meetings

Direct Services:

- Community education and outreach
- Engagement and outreach services
- Screening referrals for FEP
- Intake Assessments
- Individual treatment services
- Group Sessions
- Family education and treatment
- Therapeutic psychoeducation
- Medication management
- Medication monitoring
- Community support services
- Peer support
- Supported employment and education
- Interpreter services
- Other New Journeys services.

Providers assign staff who have the necessary skills and knowledge to build capacity for the assessment, case management and treatment of individuals 15 to 40 years old experiencing a first-episode psychosis. The primary roles and responsibilities of the FEP-designated specialized clinical team are to implement the New Journeys program with accompanying interventions. The following component FTEs provide guidance to New Journeys Providers. Providers are expected to maintain ongoing consultation and coordination with Behavioral Health and Recovery Division (BHRD's) Children's Mental Health Planner to ensure the New Journeys program goals and scope are met and staffing decisions support successful New Journeys implementation.

- Program Director - 0.5 full-time equivalent (FTE) often combined with the Family Educator role;
- Prescriber - 0.25 FTE;
- Individual Resiliency Trainer (IRT) - 1.0 FTE;
- Family Education Clinician - 0.5 FTE;
- Supported Employment and Education Specialist (SEE) - 1.0 FTE;
- Case Management - 0.5 FTE; and
- Peer Support Specialist - 0.5 FTE.

New Journeys program staff maintain close communication and coordination with the BHRD Children's Mental Health Planner to support New Journeys program implementation and development across multiple King County Provider sites, and with the assistance of the BHRD Children's Mental Health Planner coordinate and collaborate with any additional King County funded activities. This includes notifying BHRD's Children's Mental Health Planner and Provider Relations Liaison of any staff changes no later than when submitting the monthly invoice.

New Journeys First Episode Psychosis (FEP) Project Eligibility Criteria	
Medicaid Status	*Medicaid and meet a in the Additional Criteria Section described below *Up to two non-Medicaid individuals per site who meet the Additional Criteria Section described below
Age Range	15 to 40 years old
Authorization Needed	Yes, up to 24 months of service

Additional Criteria	• Experiencing a first-episode psychosis
	• Diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform disorder;
	• Have received antipsychotic medications for less than one year; and
	• Reside in King County.
	• **Exclusionary Criteria includes**:
	  • Significant intellectual disability, autism or traumatic brain injury
	  • Symptoms of psychosis related to diagnoses of affective disorders (such as bipolar disorder of anxiety disorders) or personality disorders;
	• Potential New Journeys participant entry is co-managed by BHRD and the Providers offering this specialized treatment team approach.
	• Potential program participants will be <u>prioritized in the following order</u>:
	  • Enrolled with a Medicaid or non-Medicaid outpatient behavioral health benefit,
	  • Medicaid-eligible but not currently enrolled in a BHRD outpatient benefit,
	  • Non-insured individuals,
	  • Low-income individuals, or
	  • Privately insured.

New Journeys First Episode Psychosis Project Reporting Requirements	
Monthly Reports	• Monthly invoices that accurately identify if program participants are in Tier 1 or Tier 2 of the case rate model and whether their program payment coverage is Medicaid or non-Medicaid. • Each New Journeys site is expected to keep the two non-Medicaid slots full and to notify BHRD's Children's Mental Health Planner if either is vacant and the plan to fil it.

8.6 Outreach and Engagement at Matt Talbot Center (MTC)

Outreach and engagement services are provided within the City of Seattle for individuals to provide linkage to treatment and other recovery support services. That linkage is designed to best meet the individual's needs and does not give priority to programs at the Provider's agency. The Provider offers services to individuals to include:

- Engagement and Motivation to receive services,
- Engagement and motivation for recovery,
- Referral and linkages to community resources, and
- Assisting people to receive appropriate services and benefits.

The Provider tracks and maintains records which include the number of individuals outreached to, the number of individuals engaged in some type of ongoing service at MTC, the number of individuals admitted to substance use disorder (SUD) treatment, and the number and type of referrals to other recovery services. Daily logs of outreach activities performed outside of the MTC are maintained, including date, duration of service, location and name of staff conducting the service.

Per federal block grant requirements, Provider will coordinate with a Navigator to obtain Medicaid benefits for the client any time a service is provided, unless there is a tenuous engagement. If a client's funding status has changed, the agency will have a process in place on how to address any changes and assist the client to access Medicaid if they are eligible but not currently enrolled.

Outreach and Engagement at MTC Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Individuals are identified as individuals seeking assistance at MTC
Outreach and Engagement at MTC Reporting Requirements	
Monthly Reports	Outreach and Engagement FTE Staffing Report

8.7 Pregnant and Parenting Women (PPW) Services

Pregnant/Postpartum and Parenting Women (PPW) Services provides specialized PPW services for PPW clients in an SUD outpatient or MAT setting. PPW provides a continuum of outpatient and recovery support services designed from a recovery and resiliency perspective.

Goals:

- To provide intensive PPW services within an intensive substance use disorder (SUD) or intensive Medication-Assisted Treatment (MAT) outpatient setting specific to the recovery needs of the low-income PPW population.

To provide structured intensive PPW services with a family focus to promote child safety, healthy child development, and healthy family interaction and to assist the client in reaching recovery from SUD. These services include, but are not limited to arranging for other services as necessary, including prenatal and postpartum care, parenting support, health care, relapse prevention, employability assessments, and job-seeking motivation and assistance.

Program Specific Requirements:

The provider will, whenever possible, assign a primary counselor whose gender reflects the client's request.

The provider provides treatment staff with PPW-specific information and educational resources.

The provider ensures that interim services for PPW individuals are provided directly, or arrangements are made for the provision of, within 48 hours of requesting treatment, if treatment services are not available within the designated time frame. Interim services must be documented and include, at a minimum:

- Counseling on the effects of alcohol and drug use on the fetus for pregnant women;
- Referral to prenatal care, for pregnant women;
- Referral to the Public Health – Seattle & King County First Steps program, nurse outreach;
- Human Immunodeficiency Virus and Tuberculosis (TB) education; and
- TB treatment services, if necessary, for an intravenous user.

Assessment:

PPW specific assessment and treatment services are provided within 14 days of being requested by parenting and postpartum women. For pregnant women, PPW specific assessment is provided within 48 hours and treatment is provided within 7 days of being requested.

If the client is already enrolled in SUD intensive outpatient, or MAT and receiving intensive treatment, then an assessment update can be completed in lieu of another full assessment when initially requesting the PPW enhancement.

PPW specific assessments are evidence-based or a promising practice, or providers are working towards implementing. They include a family and child focus which assess the need for intensive PPW services including the following:

- A review of the gestational age of fetus;
- Mother's age;
- Living arrangements which include but are not limited to housing status, housing type, co-inhabitants, and details around whether the living arrangements are conducive to recovery;
- Family support data which includes a description of relationships with the children, significant others, and other identified family members;
- An assessment of any imminent or future risk of child abuse and neglect related to the parents'/guardians' substance use;
- An assessment of family needs; and Information obtained from at least two collateral contacts and UA results (for Children's Administration involved individuals)

A pregnant individual who is unable to access residential treatment due to lack of capacity and is in need of withdrawal management, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within 24 hours.

Individual Service Plan:

The ISP, at minimum includes:

- The family, parent and child needs that are identified during the PPW assessment
- Intensive SUD outpatient or intensive MAT services are prescribed

- Intensive PPW services and childcare that is prescribed
- Specific interventions for family, parent, and child which meets the individualized needs of the child and consultation with a therapeutic childcare expert.
- Integration of other involved parents and/or partners are included in treatment as appropriate
- Active coordination of care across systems the family, parent, and child are involved in
- In cases of CPS involvement, family reunification is addressed.

The Agency documents in the individual's service plan when their child is being returned to their care and the plans to facilitate this transition, when applicable. In addition to intensive SUD treatment or intensive MAT that the client is enrolled in, the provider delivers PPW services that may include but are not limited to:

- Evidenced-based, family centered approach that includes family counseling, parenting support and education;
- Treatment for family, parent and child that is trauma informed;
- Treatment that is focused on parent child relationship;
- Gender-specific treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, parenting, custodial issues;
- Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs and any issues of sexual abuse, physical abuse, and/or neglect;
- Linkage to co-occurring treatment and coordination of care between providers, if clinically indicated;
- Linkage to primary care for women, including prenatal care when applicable, and their children;
- Linkage to primary pediatric care including immunization for children in client's custody;
- Linkage to infant mental health services;
- Active coordination of care across systems the family, parent, and child are involved in, with a focus on parent and child treatment coordination;
- Active coordination between the childcare provider, treatment provider and parent to address and respond to the child's needs;
- Referrals to other systems and services to meet the needs of the family, parent, and child and actively coordinate care with outside systems, providers, and services;
- Job-seeking motivation and assistance; and
- Peer support services.

Childcare:

The Provider offers safe and developmentally appropriate on-site childcare services at no cost to the individual while the PPW client is participating in onsite assessment and treatment activities, and onsite support activities such as support groups, parenting education, and other supportive activities when those activities are recommended as part of the recovery process.

The Provider has a designated coordinator who has completed college credits in early childhood education or child development and/or related experience. The childcare coordinator is capable of developing, implementing, and providing developmentally appropriate childcare services including parenting education and support.

Childcare services are offered to all parents at assessment. For parents who require other childcare services, the Provider assists the parent in securing childcare arrangements.

Childcare complies with all applicable Revised Code of Washington (RCW) and Washington Administrative Code (WAC).
The Provider admits each child to services with an individual admission sheet, completed by the parent receiving intensive outpatient services, that at minimum includes:

- The child's full name, gender, age and birthdate;
- Any known medical problems, medications, and allergies with known reactions;
- Permission to call 9-1-1 for the child in a life-threatening emergency;
- A statement that the parent is the sole individual authorized to drop off and pick up the child;
- The parent's full name and dated signatures;
- Child's enrollment to childcare services date.

The Provider gives the parent an orientation to childcare services at the time of child admission that minimally includes the sign-in/sign-out log and the emergency evacuation plan for the childcare room.

The Provider maintains a daily, dated, sign-in/sign out log that each parent personally completes when dropping off and picking up their child that includes:

- The child's first and last name;
- The time in and the time out;
- The parent's signed name as the person who dropped off the child;
- The parent's signed name as the person who picked up the child; and
- A section to detail any behavioral issues that may be exhibited in childcare that could be related to abuse and/or neglect and any developmental needs allowing for documentation of therapeutic interventions that are provided as a result of exhibited behaviors.

The onsite childcare maintains a staff-to-child ratio of:

- 1 adult to 4 infants less than 12 months old;
- 1 adult to 5 children 1 to 2½ years old;
- 1 adult to 10 children 2½ to 5 years old; and
- 1 adult to 15 children 5 years and older.

The Childcare provider prohibits the use of corporal punishment or any act that willfully inflicts or causes the infliction of physical pain, including physical restraint that is injurious to the child, mechanical restraint, locked-room time-out, the use of derogatory language, or frightening or humiliating discipline.

The Childcare provider maintains procedures for handling of emergency events such as medical, earthquake, fire, and any emergency evacuations, with practice drills, which include:

- Maintaining a written Child Care Fire and Other Emergency Evacuation Plan and policy that includes parental knowledge of the evacuation plan and the evacuation meeting location;
- Conducting a monthly emergency evacuation fire drill in the child care room; and
- Maintaining a log to document all monthly emergency evacuation drills;

The Childcare provider encourages each parent to obtain health care for their child when necessary.

The Provider implements and maintains current childcare policies and procedures in the childcare room, copies of which are readily available to childcare staff.

Additional Requirements for PPW clients enrolled in Family Treatment Court (FTC)

- Providers submit a written report to the FTC Social Worker within 5 days of the assessment.
- Providers submit a copy of the client's ISP upon client consent/ROI in file.
- Providers submit a monthly report to FTC which includes information on treatment progress and not solely compliance.
- Providers notifies FTC Treatment Specialist within 2 days if a client misses an appointment.
- Providers notifies FTC Treatment Specialist within 1 day if a client has a positive/missed/diluted UA, or admits use or reports child safety concerns.
- Providers attend FTC team or wraparound meeting whenever possible or communicate progress and concerns to the FTC Treatment Specialist to represent their voice absentia.
- Providers partner with FTC around client's treatment, including outreach, engagement, finding supportive housing, and employment/vocational education and opportunities.
- Providers refer clients to residential treatment if a client meets ASAM criteria for that level of care and use FTC collateral information and consider dependency timelines before providing a final assessment.
- New staff working in the PPW program will attend training and orientation on FTC model and dependency timelines provided by the FTC Treatment Specialist.

The Provider submits SUD and MAT service encounter data by utilizing the PPW modifier "HD" into the BHRD Information System per the King Service Encounter Reporting Instructions (King SERI). The Provider ensures those PPW services that are not encounterable to BHRD are sufficiently documented in the client's record to reflect PPW Enhancement services have been provided.

Providers review client eligibility for the PPW services on a monthly basis and document findings in the clinical file.

PPW Enhancement Rate Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	• Individuals receive priority services as described in the King County BH-ASO Policies and Procedures. • Individuals must have an authorized BHRD SUD or MAT outpatient benefit • Eligible individuals must be: Women who are pregnant; or Women who are postpartum during the first year after pregnancy completion, regardless of the outcome of the pregnancy or placement of children; or Women who are parenting children age 17 and under, including those attempting to gain custody of children supervised by the Department of Social and Health Services (DSHS), Division of Children and Family Services (DCFS).
PPW Enhancement Rate Reporting Requirements	
Monthly Reports	PPW Encounters & On-site Child Care Services Report

8.8 Reaching Recovery Housing for CJ Involved

The Reaching Recovery Housing approach provides housing and appropriate housing supports for eligible adults who are involved with the criminal legal system. All Reaching Recovery Housing participants are provided with assistance in obtaining and maintaining their housing, as well as with facilitating any transition to new housing.

Reaching Recovery Housing supports are available, as resources allow, to eligible individuals for up to 24 months while other permanent supportive housing resources are identified. All attempts aremade to establish alternative resources to support long-term housing costs for participants in order to allow new participants access to the Reaching Recovery Housing resources.

Reaching Recovery Housing Eligibility Criteria	
Medicaid Status	Yes, unless covered by other identified fund sources
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	* Eligible participants include individuals who have been incarcerated in the last year or have a significant criminal history or are on probation with the Washington State Department of Corrections (DOC) or a municipal jurisdiction in King County; Regional Mental Health Court (RMHC) Project Start participants are a subset of the target populations under this section; and housing for this population must adhere to RMHC requirements and restrictions.

	* The Provider serves as the pass-through for Reaching Recovery Housing funds to support participants in maintaining stable housing, and identifies and collects any client rental responsibility, and/or other subsidies/sources of rental assistance prior to utilizing Reaching Recovery Housing funds.
	* Funding cannot be used to support vacant units, renovations, maintenance, or office space.
	* Funding may be used to assist with housing costs for the participants served in this program including:
	  * Rent, including deposits
	  * Utilities
	  * Housing related repairs for participant units as needed
	* Housing supports are tied to a participant's ongoing outpatient treatment benefit. Should an individual lose or discontinue their outpatient benefit, the provider will not continue to support housing costs. Should an individual lose their outpatient benefit, and therefore also their housing benefit, due to being incarcerated or hospitalized, the provider may submit a request for an additional housing benefit that includes the rationale for the request to the County for an additional 24-months of housing supports. The provider may also submit a request to the County for pre-approval of an additional 24-month housing benefit for participants who lose their housing and for whom there a clinically indicated rationale for supporting an additional benefit. All requests for a second authorization must be pre-approved by the County.

Reaching Recovery Housing Reporting Requirements	

Monthly Reports	• Housing Status Report, due at the same time as BIP, which includes an update of each participant engaged in a Housing Program within this scope. The report includes the full cost of rent and other housing related costs, and the amount charged to the County after other sources of funding have been utilized. In addition, the following additional data elements are included in order to rack participant housing:
	• Name of individual participant;
	  • King County Identification (KCID) Number;
	  • Cohort as identified by referral code
	  • Other housing subsidies utilized, if any;
	  • Participant rental portion, if any;
	  • Housing status;
	  • Rent costs per fund source; and
	  • Utilities and other housing-related expenses

Annual/Other Reports	Participant Transition Plans aresent to the County when a participant has been in Reaching Recovery Housing for 18 months indicating the ongoing housing plan for the participant after the 24-month Reaching Recovery Housing benefit limit is reached. The plan includes: * Details regarding how the participant's current housing will be maintained using other funding sources; or * Details regarding where the participant will be moving to if not remaining in their current housing; or * An extension request for participants for whom a longer stay is indicated, including the rationale for the extension, the length of extension request and the plan to transition the participant off the Reaching Recovery Housing benefit. Lengths of stay in Reaching Recovery Housing will in no circumstances extend beyond 36 months, and all extensions must be pre-approved by the County.
	The Provider maintains and provides to the County, upon request, financial records consistent with federal guidance per 2 CRF 200 on the program expenditures.

8.9 Recovery High School

The Recovery High School is a public sober high school operated by Interagency Schools in the Seattle Public Schools district in partnership with King County BHRD. It provides a safe and supportive environment where students actively work toward their academic, career, and recovery goals. Students earn credits toward successful graduation and build pathways to achievement in further education, prosocial activities, work, and a healthy life.

Communication and Evaluation Project (Puget Sound Educational Service District)

Nurturing the school's capacity to tell their story with data to lift up successes and support continuous improvement is one strategy for sustainability. Specifically, PSESD will focus on five areas of communication and evaluation:

- Expand analysis of existing student data and characteristics to include the 2015-16 and 2021-22school years;,
- Refresh briefs to communicate compelling information that highlights outcomes and tells the stories of student and family experiences with the school;
- Create a program evaluation plan using the Results-Based Accountability Framework;
- Develop a slide deck and outreach materials for prospective students, parents, youth treatment agencies, and academic personnel; and
- Present findings from data analysis to research and practitioner audiences in Washington.

Key audiences include King County BHRD staff, Recovery School staff, Interagency and Seattle Public Schools staff, Recovery School students and families, regional and state policy leaders, and potential and existing funding partners and donors.

Evaluation and Learning Questions

PSESD will collect answers to the questions below:
1. For students enrolled in Recovery School for at least 3 months from School Year 2015-16 to School Year 2021-22, describe the following using the Results-Based Accountability (RBA) Framework:

- How much did we do?
    - Number of students served
    - Demographics and characteristics of students served
- How well did we do it?
    - Number of credits upon Recovery School enrollment and completion or exit
    - Attendance: before Recovery School and in Recovery School
    - Graduation rate
    - Recovery, length of

2. What are the stories of students who have attended the Recovery School?

3. What are critical programmatic and structural components that contribute to the school's goal to "maintain and provide a safe sober environment where young people in recovery can pursue their high school diploma"?

4. What are priority data collection and/or analysis activities that would support ongoing learning and improvement, aligned with funded requirements?

The PSESD evaluation team works with King County BHRD and Recovery School staff to define the parameters of the student data analysis including the definition of "enrolled"; whether data is available that would allow for longitudinal analyses of enrolled student outcomes; and how best to partner with the district to access and collect student data.

Recovery School Coordinator (Seattle Public Schools)

The Recovery School Coordinator (RSC) is a 1.0 FTE that is supervised under the Prevention & Intervention section of Seattle Public Schools and based at the Interagency Queen Anne campus. Duties include fostering connections between the school and behavioral health treatment organizations; outreaching to parents, students, and school personnel to share enrollment processes; and coordinating data collection and reporting activities. This position works closely with the Student and Family Advocate and King County BHRD to identify opportunities for networking to ensure others are aware of ways to access the Recovery School.

Recovery High School Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
Recovery High School Reporting Requirements	
Monthly Reports	PSESD: • Recovery HS Evaluation Project Narrative and Expense Report • Recovery HS Transaction Recap Report SPS: Recovery HS Coordinator Narrative and Expense Report
Annual/Other	• PSESD (during the period of Oct 1, 2022 – Jun 30, 2023):Revised briefs and an additional brief describing the experiences of Recovery School students and families Results-Based Accountability plan that includes a high-level theory of change, priority indicators and measures, timelines for data collection and analysis, and a description of existing or needed data collection tools.

8.10 Recovery Support Services (Opiate Use Disorder)

In consideration of the funds awarded, the Provider provides State Opioid Response (SOR) recovery support services to eligible individuals. The SOR Grant is a two-year grant defined by the grantor Substance Abuse and Mental Health Service Administration (SAMHSA), and the Washington State SOR application submitted by Health Care Authority (HCA). SOR recovery support is a recovery program and is not meant to supplant or support existing programs experiencing fiscal challenges.

Program Specific Requirements

Implement a program to provide eligible individuals recovery services. Each person will include in their recovery plan an authorization for a Recovery Care Manager (RCM) to manage the support services and to complete required data collection.

- Provide an agency-based program consistent with the state of Washington's SOR Grant application to SAMHSA. When notified by HCA through Behavioral Health and Recovery Division (BHRD), the Provider implements subsequent modifications to grant-funded services based on guidelines from SAMHSA within 90 days.
- Ensure individuals are eligible to receive recovery supports funding by this grant.

- Train staff and peers experiencing an Opioid Use Disorder (OUD) on needs specific to the OUD population in your community within 90 days of the date the contract was executed.
- Establish support groups for individuals experiencing an OUD within 90 days of the date the contract was executed.
- Establish a referral process for individuals receiving Medication-Assisted Treatment (MAT).
- Ensure that each individual works with an RCM that may provide various social service interventions including, but not limited to managing referrals, completing required data collection, developing and managing recovery individual service plans, peer services, recovery coaching, skill development support, and discharge planning.
- Establish and maintain a Rate Table approved by the state's SOR Recovery Director through King County to be used for billing purposes. Ensure that services billed for are in agreement with the rates established in the agencies' Rate Table.
- Plan, train, and negotiate with community entities for the provision of recovery services as directed by the eligible individual.
- Provide client-directed recovery support services to eligible individuals.
- Provide sufficient staffing to implement and supervise the provision of SOR recovery services, including but not limited to, ensuring public accountability and community standards, for the provision of publicly funded social services.
- Ensure that services to eligible individuals are not denied to any individual regardless of:
- The individual's drug(s) of choice.
- The fact that an individual is taking medically prescribed medications.
- The fact that that an individual is using over the counter nicotine cessation. medications or actively participating in a Nicotine Replacement Therapy regimen.
- A Washington State resident's agency of residence. So long as funds and services are available, the Provider will, serve all eligible Washington State residents who may be transient and require services.
- Services and Activities to Ethnic Minorities and Diverse Populations:
- Ensure all services and activities provided by the Provider under this program agreement will be designed and delivered in a manner sensitive to the needs of all ethnic minorities.
- Initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention or other appropriate services, for ethnic minorities and other diverse populations in need of treatment and prevention services as identified in their needs assessment.
- Take the initiative to strengthen working relationships with other agencies serving these populations.
- Data Collection:
- Ensure that data is collected and submitted, on all SOR services, as required by BHRD and the HCA.
- Ensure that the Government Performance and Results Act (GPRA) intake interview data is collected and entered into the SAMHSA Performance Accountability and Reporting System (SPARS) as required by SAMHSA and the SOR grant for all individuals receiving grant funding.
- Ensure that 80% of individuals that receive recovery support services complete a three-month follow-up and six-month follow-up GPRA survey.
- Ensure that all discharged patients receive a GPRA discharge interview or administrative discharge.

- Respond in a timely fashion to questions about data quality and completeness.

Recovery Support Services (OUD) Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults and emancipated youth
Authorization Needed	No
Additional Criteria	• An individual whose earnings meet the agency's criteria for eligibility for social services; • Individuals with a diagnosis of an opioid use disorder or individuals with a demonstrated history of opioid overdose problems; and • American Indian or Alaska Native individuals are prioritized for services.
Recovery Support Services (OUD) Reporting Requirements	
Monthly Reports	• Recovery Support Services (OUD) Billing Summary
Annual/Other Reports	• If requested by the state Health Care Authority • Submit to the BHRD Project Manager as requested, a summary of program implementation progress including, but not limited to, successes and challenges of the program**.**

Recovery Support Services (Substance Use Disorder)

In consideration of the funds awarded, the Provider provides recovery support services to eligible individuals. SABG recovery support is a recovery program and is not meant to supplant or support existing programs experiencing fiscal challenges.

Program Specific Requirements

Implement a program to provide eligible individuals recovery services.

- Provide an agency-based program consistent with the state of Washington's guidelines. When notified by HCA, the Provider implements subsequent modifications to grant-funded services based on guidelines from SAMHSA within 90 days.
- Ensure individuals are eligible to receive recovery supports funding by this grant.
- Eligible individuals include people with a substance use disorder or individuals with a history of substance use problems.
- Establish support groups for individuals experiencing a Substance use Disorder (SUD) within 90 days of the date the contract was executed.
- Establish a referral process for individuals receiving MAT.
- Ensure that each individual has access to a peer or recovery coach. The peer or recovery coach may provide various social service interventions including, but not limited to: managing referrals, completing required data collection, developing and managing recovery individual service plans, peer services, recovery coaching, skill development support, and discharge planning.
- Establish and maintain a rate table approved by the state's SABG Recovery Manager through King County to be used for billing purposes. Ensure that services billed for are in agreement with the rates established in the rate table.

- Plan, train, and negotiate with community entities for the provision of recovery services as directed by the eligible individual.
- Provide client-directed recovery support services to no less than 270 individuals per month. If there is a specific, authorized service, needed to support the individual's recovery, the Provider may request an exemption from BHRD.
- Provide sufficient staffing to implement and supervise the provision of SOR recovery services, including but not limited to, ensuring public accountability and community standards, for the provision of publicly-funded social services.
- Services and Activities to Ethnic Minorities and Diverse Populations:
- Ensure all services and activities provided by the Provider under this program agreement will be designed and delivered in a manner sensitive to the needs of all ethnic minorities.
- Initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention or other appropriate services, for ethnic minorities and other diverse populations in need of treatment and prevention services as identified in their needs assessment.
- Take the initiative to strengthen working relationships with other agencies serving these populations.
- Data Collection:
- Ensure that data is collected and submitted, on all SABG services, as required by BHRD and the HCA.
- Ensure that adequate records are maintained that verify number of services, date of services, and cost of services that were provided to individuals eligible for recovery support.
- Respond in a timely fashion to questions about data quality and completeness.

Recovery Support Services (SUD) Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults and emancipated youth
Authorization Needed	No
Additional Criteria	• An individual whose earnings meet the agency's criteria for eligibility for social services; • Individuals with a substance use disorder diagnosis or individuals with a demonstrated history of substance use problems; and • Tribal individuals with SUD are prioritized for services.
Recovery Support Services (SUD) Reporting Requirements	
Monthly Reports	• Recovery Support Services (SUD) Billing Summary
Annual/Other Reports	• If requested by the state Health Care Authority • Submit to the BHRD project manager as requested, a summary of program implementation progress including, but not limited to, successes and challenges of the program.

8.11 Sobering Services

DCHS/BHRD funds sobering services to strengthen the availability, quality, and coordination of crisis services for people experiencing homelessness. Sobering services are a safe and secure shelter for adults to sleep off the acute effects of intoxication. They also serve as a recovery access point where people receive case management services and assistance to move towards greater self-determination

and recovery. The services are contracted out to a community non-profit that employs people trained in medical assessment and response to staff the services.

No eligible individual is refused service (unless temporarily unable to stay onsite for reasons that have been clearly documented and whose status has been communicated in advance to key partners), regardless of capacity. When the center is at capacity and an eligible individual presents for service, an individual in the current census should be discharged and assisted with an alternate placement, if one is available. The Provider coordinates these cases with the King County Emergency Service Patrol (ESP). The Provider maintains a minimum staff to client ratio of 1:15 at all times. The Provider Supervisor or Lead is present during peak admission times (8:00 pm through 2:00 am) to direct staff and assist with client triage and behavior management. Provider staff receive annual training on recovery, substance use disorders (SUD), Motivational Interviewing, skills and strategies for behavior management, and managing acute intoxication.

Sobering services include physician-approved protocols for intake screening and discharge, observations, and regular monitoring, including breathalyzer test, vital signs, head-to-toe physical assessment, and the general health screening interview. The Provider also delivers social services for clients as needed, including but not limited to housing assistance, income support, clothing, and personal hygiene resources. Each client receives discharge planning on completion of services for every admission to determine or update the need for ongoing services and to update information in the database. Each sobering service involvement is seen as a new opportunity to engage the individual in services. The Provider works to enroll individuals who repeatedly use services in withdrawal management services, SUD treatment or case management services, and collects a county High-Utilizer release-of-information (ROI) form for each client.

The King County Yesler Building will provide a temporary home for King County's Sobering Support Shelter. The shelter will operate overnight only, from 5 p.m. to 8 a.m. seven days a week, providing health-supervised shelter for up to 35 people per night. While sited at the Yesler Building, the provider will do the following:

- Accompany clients at all times while entering and exiting the premises.
- Accompany clients to and from the elevator, placing the client securely in the elevator and ensuring they are met by staff when the elevator opens.
- Accompany clients to and from the restroom facilities located on the 3rd floor.
- Ensure clients who exit onto floor 2 are immediately located and returned to the appropriate area.
- Alert the Emergency Dispatch Center (EDC) (206-296-5000) when the 5th Ave door is opened to admit or discharge a client.
- Alert the EDC whenever staff calls 911 for medical or police assistance to the premises.
- Complete sobering services include physician-approved protocols for each intake screening and discharge, observations, and regular monitoring, including breathalyzer test, vital signs, head-to-toe physical assessment, and the general health screening interview.
- Coordinate client handoff with the Emergency Service Patrol.
- Immediately report any damage which constitutes a threat to fire/life/safety to the EDC.
- Report within 3 hours, routine damage or maintenance problems associated with the space to FMD Customer Care during normal business hours – or the EDC after business hours.
- Prevent clients or staff from accessing roped off areas of the 3rd floor.
- Provide custodial care for spaces which are primarily client-focused.
- Limit access by clients and staff to non-designated use areas (as indicated on attached building/floor plans).

- Adhere to fire/life/safety training and protocols as provided by Facilities Management Division (FMD).
- Attend to Yesler Sobering Center Trash:
  - Daily: Collect, bag, and remove all garbage.
    - All bags are to be tied and secured.
    - Place garbage in bin BOS provided.
    - Take all garbage via alley to the Chinook trash compactor located at the Chinook loading dock.
  - Staff to contact the EDC at 206.296.5000 for access to the loading dock if the gate grill is closed.
  - Trash is to be placed in the compactor and compacted. (BOS to provide 1 X training and key to Pioneer Staff).
  - Bin is to be cleaned and returned to Yesler 3rd floor for next day's use.
  - Bin is to be always free of liquid and food to prevent unwanted pests.

Maintenance Requests & After-Hours Emergencies

For maintenance needs from 8AM - 4:30 PM Monday – Friday, contact the FMD Customer Care Services Team at 206-477-9400 or email customercareservices.fmd@kingcounty.gov. When reporting requests, please provide the following information:

- Nature of request (e.g., plugged toilets, lights out)
- Building name (Yesler Building)
- Location within the building (e.g., room numbers, floor, or any other identifiers)
- Pictures and/or videos
- Name of requester, phone number, and e-mail address

For Weekend and Afterhours Emergencies call the Emergency Dispatch Center (EDC) for 24/7 Support 206-296-5000.The Provider agrees to comply with all requirements for reporting Critical Incidents to the County following the standards set out in Section 12.2 Critical Incidents Program and Reporting Requirements.

Sobering Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years or older
Authorization Needed	No
Additional Criteria	• Impacted by SUD, • Experiencing homelessness, • Impacted by a co-occurring mental health disorder, • High utilizers of publicly funded crisis services, and/or • Priority Populations: homeless veterans, American Indians, and Alaska Natives
Sobering Services Reporting Requirements	
Quarterly Reports	Sobering Services Fiscal Reconciliation Report
Annual/Other Reports	If requested by DCHS/BHRD

8.12 Therapeutic Child Care

Childcare services which are designed for families in recovery. This program is designed to provide therapeutic childcare for children of parents who are currently participating in publicly funded outpatient substance use disorder (SUD) treatment. Children attending this program are in therapeutic childcare services for a minimum of four consecutive hours, excluding transportation time. New families enrolling in Therapeutic Child Care meet with staff and go through the program objectives and the process of therapeutic childcare services, parent-defined goals for the child and family's participation in the services, and complete and sign a written agreement to participate in the services. Therapeutic childcare includes, but is not limited to:

- Developmental, family psychosocial, and health assessments,
- Written individualized treatment plans,
- Therapeutic and behavioral interventions, and
- Parenting education and skills training.

Each child receives the following assessments within two weeks of the first day of admission:

- Developmental Assessment including gross motor, fine motor, and communication/language skills,
- Comprehensive family psychosocial assessment addressing strengths and weaknesses of the child-parent interactions and behavior with information gathered during the intake process and home visit, direct observation, family characteristics, family status information, and information provided by other service systems involved with the family, including the parents' SUD treatment staff.
- Initial health assessment completed by a licensed practitioner of the healing arts to include an assessment of physical growth and nutrition status, inspection for obvious disabilities, inspection eyes, ears, nose, throat, visual screening, auditory screening, screening for cardiac abnormalities, screening for anemia, assessment of immunization status and updating, and referral to dentist for children three years and older.

The ISP is completed within 40 days of admission and updated at least every three months and includes:

- Identified areas of concern;
- Specific services to be provided;
- Individual responsible to provide each specific service;
- Frequency of the services;
- Method of the services; and
- Timelines for reaching intended outcomes.

Therapeutic Child Care services include:

- Therapeutic and behavioral interventions provided with both child and family using individual and group play therapy;
- Parenting education; and
- Parent Skills training.

A discharge and transition plan should be established and implemented 90 days in advance of the completion date. This plan should be provided to the parents' SUD treatment staff and should include the reason for the child and parent exiting from the services, the child's developmental, emotional, behavioral, and medical status, a description of the child and parent progress on the goals and objectives, and recommended continuation planning and all referrals for the family. If the parent is unexpectedly discharged from SUD treatment for any reason, the child may continue to participate in the services for up to one month to facilitate transition.

Therapeutic Child Care Eligibility Criteria	
Medicaid Status	N/A
Age Range	Birth to 6 years of age
Authorization Needed	No
Additional Criteria	• Children from birth to six years of age not currently involved with Child Protective Services (CPS) who have parents that are actively participating in publicly funded SUD treatment services. • Priority is given to infants and children of pregnant and postpartum women, up to one year postpartum.
Therapeutic Child Care Reporting Requirements	
Monthly Reports	• The Provider completes the report form as provided by the County showing the amount billed to King County BH-ASO and the amount received from King County BH-ASO for each service month. • The Provider reports monthly to the County, in a format provided by the County, the following information: • A daily enrollment with actual dates and hours of attendance by each child for the calendar month including the number of home visits, noting the branch and site location; • The monthly unduplicated number of admissions, enrollments, and discharges; and • The monthly source of referrals of children referred.
Annual/Other Reports	• The Provider submits their current State of Washington Child Care License for each branch site by the month following renewal.

8.13 Tribal Mental Health Services

Program or services designed to provide outpatient mental health services to children, adults, older adults, and families of tribes in the King County Region. The Provider develops culturally responsive mental health services designed to improve and promote mental health services for Tribal members and include opportunities for mentoring, teaching skills, establishing teamwork, enhancing decision-making, improving self-confidence and self-esteem, and providing services to the community. The Provider ensures the following psychiatric services are available to eligible individuals:

- Assessment,
- Medication evaluation, management, and review; and
- Consultation.

Tribal Mental Health Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Eligible individuals are those individuals who are members of, or are related to, members of the contracted Indian Tribe and are in need of mental health services and supports.
Tribal Mental Health Services Reporting Requirements	
Quarterly Reports	The Provider submits the Mental Health Services Quarterly Report with the BIP in hard copy to the Behavioral Health and Recovery Division (BHRD) Provider Relations/Contract Specialist as follows: • The report for January 1 through March 31 is due by April 15; • The report for April 1 through June 30 is due by July 15; • The report for July 1 through September 30 is due by October 15; • The report for October 1 through December 31 is due by January 15.

8.14 Tribal Substance Use Disorder Services

Program or services designed to provide outpatient substance use disorder (SUD) services to youth, adults, older adults, and families of tribes in the King County Region. The Provider develops SUD services designed to improve and promote SUD services of Tribal members that are determined to be clinically necessary, culturally appropriate, and improve an individual's ability to maintain recovery and resiliency. Substance Use Disorder Professional's (SUDPs) or Substance Use Disorder Professional Trainee's (SUDPTs) under the supervision of a SUDP assess and assign an ASAM level of care for each of the six dimensions and an overall level-of-care placement recommendation at the following treatment points for all clients receiving SUD services:

- Assessment,
- ISP reviews, and
- Discharge.

Client's ISPs possess the following characteristics:

- Reflects client strengths and needs as identified in the client assessment;
- Establishes individualized, time-limited, measurable, and achievable goals and objectives;

- Documents client involvement in ISP development; and
- Reflects clinical progress or lack thereof.

Tribal SUD Treatment Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Eligible individuals are those individuals who are members of, or are related to, members of the contracted Indian Tribe and are in need of mental health services and supports.
Tribal SUD Treatment Services Reporting Requirements	
Quarterly Reports	The Provider submits the SUD Services Quarterly Report with the BIP in hard copy to the Behavioral Health and Recovery Division (BHRD) Provider Relations/Contract Specialist as follows: • The report for January 1 through March 31 is due by April 15 • The report for April 1 through June 30 is due by July 15 • The report for July 1 through September 30 is due by October 15 • The report for October 1 through December 31 is due by January 15

9 Behavioral Health Administrative Services Organization (BH-ASO) Miscellaneous Programs

The following programs are managed by the BH-ASO and receive funding from a diverse body of state and federal funds.

9.1 Adult Inpatient Diversion Bed

A minimum of one inpatient diversion bed is provided for adults or older adults facing immediate voluntary or involuntary hospitalization. Access to the bed is determined by the Designated Crisis Responders (DCRs) or Crisis Connections on a no-decline basis. Access to the bed is available 24/7 and is immediately available at the time of a DCR or Crisis Connections referral unless occupied. Professional staff are on-site 24/7 if the bed is occupied. Staff coordinate care with other primary treatment staff. Clients are prompted, encouraged, and counseled on appropriate medication management as needed. Clients have a maximum five-day length-of-stay policy for the bed excluding weekends, New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. Any stays beyond this time frame go through an approval process with Behavioral Health and Recovery Division (BHRD). The Provider meets quarterly with BHRD staff, DCRs, Crisis Connections and other diversion bed Providers to evaluate the effectiveness of the program. The Provider is responsible for and arranges transportation to the beds for those clients who do not have an outpatient benefit and need transportation.

Adult Inpatient Diversion Bed Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years of age or older
Authorization Needed	No
Additional Criteria	• Are in crisis; • A mental health diagnosis cannot be ruled out; • Are at immediate risk for voluntary or involuntary psychiatric hospitalization; • Are able to ambulate without assistive devices; and • Are willing to receive this service.
Adult Inpatient Diversion Bed Reporting Requirements	
Monthly Reports	The Provider submits the Adult Inpatient Diversion Bed Report in an electronic format approved by the County to the BHRD Secure File Server according to the Secure File Transfer instructions provided by the County. The Adult Inpatient Diversion Bed Monthly Report includes data information drawn from the BHRD Information System (IS), including King County Identification Number, authorization number, authorization status code, start date, end date, and a signature verifying accuracy of the data being submitted in the report.

9.2 Criminal Justice Treatment Account (CJTA) for Adults Involved with the Criminal Legal System

CJTA is a state-based fund source that may be used, in a limited capacity, to provide substance use disorder (SUD) assessments, engagement, referral, transition planning, and outpatient treatment services in jail. This is determined on a case-by-case basis and requirements are defined in Revised Code of Washington (RCW) 71.24.580.

This fund source is also directly connected to the King County Adult Drug Diversion Court (ADDC) to provide enhancement payments to agencies that are directly contracting with ADDC in order to provide residential/inpatient SUD treatment, intensive outpatient SUD treatment services, opiate substitutions services and support services throughout King County.

Additional Criteria	• Enhancement rates are paid to Provider Agency based on average number of clients served per the BHRD IS and data provided by King County Drug Diversion Court. Biannual checks are completed to verify client participation based on evidence of encounterable services in BHRD IS per client per month and active ADDC benefit. Modifications to the monthly enhancement rates may be made based on number of individuals served. Urinalysis-Only clients are not eligible. • Any ADDC drug court client who is enrolled in MAT; or Non-Medicaid ADDC clients who are not enrolled in the King County behavioral health system and who currently reside outside of King County. These clients must have prior approval from King County drug court."

CJTA may also be used for the following:

- To purchase Naloxone and other needed pharmacy requirements though Kelley-Ross Pharmacy.
- Reimbursement for up to six non-Adult Drug Diversion Court (ADDC) urinalysis (UAs) per client.

9.2.1 Jail-based Medication for Opioid Use Disorder (MOUD) for Persons Transitioning to Inpatient/Residential Services

A coordinated buprenorphine prescription program operated between Public Health, Adult Drug Court, and Kelley Ross for persons in custody who are transitioning to a SUD inpatient or residential facility. This program allows for stable access to necessary MOUD prescriptions for persons in custody with a diagnosed MOUD to support successful treatment. All persons in custody with a substance use disorder are eligible, however, if Medicaid cannot be used approval must be provided by Adult Drug Court.

9.3 Crisis Respite Program (CRP)

This program provides temporary shelter and/or residential care for individuals in crisis in need of case management support and connects clients to mental health or substance use disorder treatment and other services as needed. The Provider maintains a Crisis Respite Program with a minimum capacity of 20 crisis respite beds **in which length of stay is based on clinical necessity** and provides transitional case management services for adults from eligible referral sources. Capacity is managed to ensure appropriate acceptance of referrals between the hours of 7:30 am and 11:30 pm. The Provider maintains sufficient and qualified staff to ensure care for clients accepted into the crisis respite beds including case managers, residential counselors, a part-time Advanced Registered Nurse Practitioner, and a supervisor who is a Mental Health Professional (MHP). Staffing changes are approved by Behavioral Health and Recovery Division (BHRD). CRP services include shelter or residential services, access to and services of a psychiatrist for consultation, medication evaluation services by an ARNP,

case management services, assistance with linkages to more permanent housing and treatment services, and referrals for substance use disorder (SUD) assessment as needed.

CRP Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by an approved referral source (with priority for homeless individuals when the CRP is operating at capacity) including: • King County Crisis and Commitment Services; • Involuntary commitment single bed certification patients King County; • Harborview Medical Center (HMC) Psychiatric Emergency Service (PES) or any hospital emergency room within King County (eligibility applies only to referrals of individuals leaving the HMC PES or hospital emergency rooms who are not eligible for the Crisis Solutions Center [CSC]); • Any psychiatric inpatient unit or evaluation and treatment facility in King County; • Adult Inpatient and Residential Liaisons and/or Western State Hospital Staff Social Workers; • The Seattle Municipal Mental Health Court and the King County Regional Mental Health Court; • Any King County Withdrawal Management Service; • The Mobile Crisis Team if not referred to the CSC; • HMC Psychiatric Consultation Services: and • Internal referrals including CDIS, CDF, PACT, mental health outpatient high level of care, HOST, or other extremely vulnerable individuals when there is low census.
CRP Reporting Requirements	
Monthly Reports	• CRP Census Log • CRP Referrals Denied
Annual Reports	CRP Annual Staffing Plan with the January BIP in an electronic format approved by the County.

9.4 DRS Care Coordination

Diversion and Reentry Care Coordination provides Substance Use Disorder assessments for individuals who are currently involved in a Mental Health Court, Drug Court or working with release planners in the jail. The focus is to ensure that adult individuals with behavioral health conditions who have contact with the criminal legal system have access to resources and treatment services that reduce court involvement and future contact with the criminal legal system.

Diversion and Reentry Care Coordination Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	For the SUD assessment services, individual opting into or opted into any of the adult specialty courts in King County.
Diversion and Reentry Care Coordination Reporting Requirements	
Monthly Reports	Diversion & Reentry Outreach Log, for SUD services (as provided by the County).

9.5 Hepatitis AIDS Substance Abuse Program (HASAP)

Substance Use Disorder (SUD) treatment and intervention services for Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis C Virus (HCV)-positive clients at host agencies and integrated SUD services within the host agency's overall program model and Provider organization. A Substance Use Disorder Professional (SUDP) is out stationed to provide adult care enhancement services at the host agency. A full time employee (FTE) staff person provides not less than 115 hours per month of direct services to clients or consultation for the host agency staff. The staff provide the following adult care enhancement services in conjunction with other Provider staff:

Screening and/or assessment:

- Initial SUD screening using the GAIN-SS is maintained on current clients and all new placements, to assist in determining the need for additional SUD or mental health treatment services; and
- Based on the results of the SUD screens, individual assessments may be completed and maintained on current clients and all placements identified as needing a full SUD treatment assessment;
- Individual treatment, to be provided no less than once for every 20 hours of treatment services;
- Group treatment services, to be provided by a HASAP adult care enhancement SUDP, at least two times per week at the host agency, when possible;
- Continuing care planning;
- Case management:
- Case management services are provided by a SUDP who assist clients in gaining access to needed medical, social, educational, and other services, but does not include direct treatment services in the sub-element; and
- May include the coordination of referrals to inpatient services as determined and assessed by a SUDP; and

- Outreach services, which may include activities funded to provide Community Education, Community Outreach, Intervention and Referral, and Crisis services in the community.

HASAP Eligibility Criteria	
Medicaid Status	Non-Medicaid Only
Age Range	N/A
Authorization Needed	No
Additional Criteria	• Individuals meet the standards for low-income client eligibility as described in the King County BH-ASO low-income eligibility tables, located in the ISAC Notebook under "Income Transaction." For access to the ISAC Notebook, please contact your agency's ISAC representative. • Individuals are determined to be in need of outpatient services, as assessed by a Substance Use Disorder Professional (SUDP), using the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) instrument.
HASAP Reporting Requirements	
Monthly Reports	A HASAP Adult Care Enhancement report that lists total payroll hours and days worked each month.
Quarterly Reports	The Provider submits a Quarterly Evaluation Report in a format provided by the County. The deadline for submitting quarterly reports BHRD is the 10th day the month after the end of a quarter (for example, when the quarter ends on March 31st, the report is due April 10th).

9.6 Homeless Outreach, Stabilization, and Transition (HOST)

An outreach-based program which provides outreach identification, engagement, re-engagement, stabilization, and transition services to homeless individuals with serious mental illness or co-occurring serious mental illness and substance use disorders (SUD). The intent of the program is to ensure that individuals with serious mental illness or co-occurring serious mental illness and SUD who are homeless or at risk of becoming homeless receive mental health services, SUD services, and referrals to other appropriate services. Staff coordinate services with PATH-funded outreach, engagement, and transitional services. Dedicated staff work on identifying individuals in the emergency shelter program and in the broader community who are currently authorized to receive Behavioral Health and Recovery Division (BHRD) mental health outpatient services, but who have not received services for 90 days or more. The staff attempt to re-engage the client back into care.

In coordination with PATH, the Provider meets requirements as stated in the Intended Use Plans (IUP) Government Performance and Results Act (GPRA) goals.

For enrollment to HOST, staff first complete the following steps:

- Briefly investigate whether each potential enrollee has received behavioral health services including looking the individual up in the state ProviderOne database;
- If the individual is listed in ProviderOne as associated with another behavioral health entity or if other information suggests residency in another county, contact King County Behavioral Health and Recovery Division (BHRD) so BHRD can contact the other entity to clarify residency;
- Wait to enroll the individual in PATH or HOST until this investigation is complete; and

- If the individual is determined to be a King County resident, request an authorization with a start date that reflects services already provided by PATH or HOST.

HOST staff ensure the following outreach and engagement services are provided:

- Identification and assessment of clients who are homeless to determine eligibility;
- Assessment and development of comprehensive short-term service plans for identified individuals;
- Referral and linkage to necessary mental health, SUD, and/or other social and healthcare services, including medical treatment and dental services;
- Access to psychiatric evaluations, psychiatric medications, and general health screenings;
- Assistance with securing entitlements, including Medicaid;
- Eligibility determination for authorization into ongoing mental health services and facilitation of the authorization process;
- SUD screening and assessment; and
- Crisis intervention during hours of program operation.

As needed, the following intensive case management and stabilization services are provided. Clients appropriate for these services are identified and referred through outreach and engagement. The services include:

- Outreach and relationship building;
- Individualized service plans;
- Psychiatric services, evaluation, and medication management;
- 24-hour crisis assistance;
- Employment services;
- SUD screening and assessment;
- Participation in the treatment and support of clients who are incarcerated, hospitalized, or in SUD treatment;
- Assertive advocacy;
- Family support and education;
- Discharge, treatment planning, and linkage supports to treatment Providers or other ongoing services for clients leaving the intensive case management and stabilization service; and

Transition, including:

- A 45-day period of overlap services for all clients referred to an outpatient benefit, or to Long-Term Rehabilitation (LTR) services, or to a Standard Supportive Housing (SSH) benefit to ensure that a treatment alliance is formed with the case manager, LTR Provider or SSH Provider; and
- Linkage and confirmation of the linkage process for clients referred to other ongoing services that include information exchange, confirmation of acceptance by the receiving organization, accompanying the client as needed to a screening and intake meeting and initial appointments, and confirmation of ongoing service by the receiving organization.

The HOST program maintains limited Flexible Funds to be used on resources need to assist in the process of engaging and stabilizing clients, buy basic and immediate necessities and some services, and not be used for services already provided as part of the core intensive case management and stabilization services.

HOST Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	An individual meeting all of the following criteria is eligible to participate in the HOST Project: • The individual must be at least 18 years of age; • The individual must be homeless or at imminent risk of homelessness; • The individual appears to have a serious and persistent mental illness; and • The individual is unable or unwilling to access services through the traditional MH treatment Providers due to clinical reasons. • An individual who is at least 18 years of age and homeless and is currently authorized to a mental health outpatient benefit but has not received services for 90 or more days.
HOST Reporting Requirements	
Monthly Reports	KCMHP Transition Report in an electronic format provided by the County
Quarterly Reports	HOST Report

9.7 ITA Transportation

ITA transportation services are provided for individuals who are transported to Involuntary Commitment Court on gurneys and are awaiting an Involuntary Treatment Act (ITA) hearing at the Involuntary Commitment Court at the Ninth and Jefferson Building (NJB) located on the University of Washington Harborview Campus and the King County Courthouse.

Individuals are closely monitored to ensure that they are safe while on a gurney, that they do not get off their gurney or out of restraints (unless the treating hospital has so indicated through specific directions to the transporting team) and that their needs are met (e.g., assisting when individuals are too hot/cold, need to use the bathroom).

In addition, the Provider will ensure:

- Individuals are closely supervised at all times. The exception to this is when individuals are meeting with their attorneys.
- Crew members understand their responsibility to sit or otherwise position themselves to be able to observe and hear the individuals being transported.
- Crew members follow the use of restraint protocols as provided by the hospital. If there appears to be a need to do things different than recommended, crew members will bring the matter to the attention of the hospital representative and the individual's defense attorney if available, who may need to bring the matter into court.

- Crew members understand their responsibility to escort individuals into the courtroom, whether on or off the gurney, such that at least one crew member is in the court room with the individual at all times. The exception to this is the point during each hearing where the crew member may be asked to step out so the individual and attorney can talk privately.
- Transportation services are coordinated in such a manner that provides a single transport to multiple scheduled hearings and a single crew to safely monitor individuals.

ITA Transportation Eligibility Criteria	
Medicaid Status	N/A
Age Range	Ages 13 and Up
Authorization Needed	Yes
Additional Criteria	Individuals coming from community hospitals that utilize the King County Involuntary Commitment Court and Evaluation and Treatment (E&T) facilities
ITA Transportation Reporting Requirements	
Monthly Reports	ITA Court Times Report

9.8 Legal Intervention and Network of Care (LINC)

The Legal Intervention and Network of Care (LINC) program is a comprehensive diversion care management team that delivers intensive supports and linkages to resources in order to divert adults and older adults with behavioral health conditions from prosecution for certain misdemeanors and low-level felonies. These time-limited diversion services include community-based care coordination, legal coordination, robust individual support, peer support services, and on-demand mental health and co-occurring disorder treatment as well as transitional respite beds and day treatment services as needed. Services are delivered by a team of clinicians, peer specialists, a psychiatric prescriber, and a jail/court-based competency boundary spanner. Services are evidence based or promising practices and include trauma informed care, motivational interviewing, and companion-based intensive care management, as well as respite care in a staff supported environment.

Legal Intervention and Network of Care Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Existing misdemeanor or low-level felony charge or pre-filing investigation within King County; • Identified as eligible for a diversion program by a prosecutor in a jurisdiction within King County; • Have a current major mental health disorder/diagnosis under the Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSM-V), or its successors; • Amendable to receiving services and to sign releases of information with regard to status and progress in the program in order to update the relevant prosecuting attorney and other identified treatment Providers or stakeholders; • Have received a court order for competency evaluation or competency restoration services within the last 12 months or are likely to receive an order for competency services on the current legal charge(s).
Legal Intervention and Network of Care Reporting Requirements	
Monthly Reports	LINC Report
Annual/Other Reports	• The Provider submits a one-time-only report providing cumulative statistics for the contract period and a description and analysis of program activities, successes and challenges identified for the contract period, with the November invoice due December 15th. • Any other requested reports by the County.

9.9 PATH

Projects for Assistance in Transition from Homelessness (PATH) provides outreach, engagement, and transitional support services to individuals with serious mental illness or individuals with co-occurring serious mental illness and substance use disorder (SUD) who are homeless or at risk of becoming homeless. The program utilizes outreach case managers to provide outreach, engagement, and/or case management services for individuals experiencing homelessness in King County.

For additional PATH Program requirements, please see Attachment A, "PATH Statement of Work," below.

PATH Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Individuals eligible for Project for Assistance in Transition from Homelessness (PATH) services are those who: • Are homeless or at imminent risk of homelessness; • Have a diagnosable and persistent mental or emotional impairment that seriously limits the individual's major life activities and may also have a co-occurring SUD; • Are not receiving other BHRD funded ongoing services. Individuals are not PATH-eligible when: • They are enrolled in other BHRD programs and are receiving all necessary services that will transition them from homelessness into psychiatric and medical services, community mental health or co-occurring SUD services, case management services, secure housing, employment services, and/or other services that will assist them in avoiding homelessness;
PATH Reporting Requirements	
Monthly Reports	• PATH HMIS Report
Quarterly Reports	• PATH FTE Report • PATH Performance Report
Annual/Other Reports	• PATH Application • The Provider submits a one-time-only report providing cumulative statistics for the contract period and a description and analysis of program activities, successes and challenges identified for the contract period. • Any other requested reports by the County.

Attachments in this Section:

- Attachment A: PATH Statement of Work

9.10 Pathfinder Peer Project

The Pathfinder Peer Project is a grant-funded program under the State Opioid Response (SOR) that builds on the established Washington State Health Care Authority (HCA) Projects for Assistance in Transition from Homelessness (PATH) program to provide substance use disorder (SUD) peer recovery support in emergency rooms and homeless encampments. The project links individuals to needed treatment, including Medication-Assisted Treatment (MAT) services, and assist in navigating systems and addressing barriers to independence and recovery.

For additional Pathfinder Peer Project program requirements, please see Attachment B, "Pathfinder Peer Project Statement of Work" below.

Pathfinder Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals with an unmet treatment need who are experiencing an OUD and are: • Reentering into the community from correctional facilities; • Experiencing homeless; • At risk of overdose; or • A member of a Tribal community. Note: Individuals may be identified for Pathfinder by PATH staff, but may not be simultaneously enrolled with both programs.
Pathfinder Reporting Requirements	
Monthly Reports	• HMIS report indicating the number of individuals experiencing or at risk of homelessness and suspected of an OUD contacted though outreach and engagement efforts. • HMIS performance report (GNRL-220) indicating the number of individuals experiencing or at risk of homelessness and suspected of an OUD contacted though outreach and engagement efforts. Due by the 20th of the following month. • Rental Assistance Bridge Subsidy Tracker indicating demographic information and expenditure details. Due 15 days from the end of the previous month.
Quarterly Reports	• Pathfinder Performance Report Report on the activities of the Peer pathfinder project using the HCA template to document the steps, successes and lessons learned. Due by the 20th of the following month.

Attachments in this Section:

- Attachment B: Pathfinder Peer Project Statement of Work

9.11 Transition Support Program (TSP)

The Transition Support Program (TSP) supports the discharge and community transition of adults involuntarily detained at psychiatric hospitals and evaluation and treatment (E&T) facilities. TSP services are intended for individuals that are not connected or are marginally engaged with the publicly-funded behavioral health system. TSP provides crisis consultation and support, care management and coordination, medication support, and peer services as well as mental health assessment, treatment, and consultation. Services are intended to be temporary with the goal of enrolling clients in clinic-based, behavioral health services and/or other relevant community supports within 90 days. TSP assistance may extend beyond this timeline based upon client needs and objectives. Caseload capacity for the fully staffed TSP team is approximately 95 clients with a goal for the project to assist 460 unduplicated clients annually. TSP is a multi-disciplinary team that consists of the following specialties and capacities.

- Peer Specialists;
- Psychiatric Prescriber;
- Physical health assessment, treatment, consultation, and health education;
- Mental health assessment, treatment, consultation, and support; and
- Substance use disorder (SUD) assessment, treatment, consultation, and support.

The TSP team performs the following duties in a timely manner:

- Attempts initial engagement with referred individuals within 24 hours or the next business workday;
- Provides the full array of TSP services countywide in a timely manner, Monday through Friday, 9 a.m.-5 p.m.;
- Provides a wide range of assertive engagement and patient activation strategies which correspond to the individual needs, strengths, culture, age, literacy, language, and social supports of each client;
- Engages clients in person-centered discharge planning in coordination with hospital discharge planners. Such planning encourages the active participation of the clients and their natural supports and is focused on the client's identified needs and objectives;
- In coordination with hospital discharge planners, helps clients identify, contact, and engage the community Providers required to achieve the care transition goals. These community supports may include, but are not limited to, medical and behavioral health treatment, housing, benefits, social supports, home support services, and employment assistance;
- Provides clients ongoing support following hospital discharge to ensure they are actively engaged with the identified community Providers and are receiving the services necessary to sustain them in the community and avoid future hospitalizations. Follow-up support will primarily consist of face-to-face, community contacts unless the client requests and/or would be better served by other types of support;
- Assists hospital staff efforts to apply for and secure financial and medical benefits for program clients; and

- Assists program clients with transportation, which may include accompanying clients to appointments and/or helping to increase their skills in using public transportation.

Transition Support Program Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years of age or older
Authorization Needed	No

Additional Criteria	• Individuals involuntarily detained at King County psychiatric hospitals and E&T facilities who meet the following conditions:
	  • Not enrolled or marginally engaged in the publicly funded behavioral health system; and
	  • Willing to participate in TSP.
	• Priority is given to individuals that are placed on Single Bed Certifications (SBCs) and/or exhibit a history of frequent psychiatric hospital admissions or other high-intensity services.
	• The majority of individuals are King County residents, but the program serves individuals without regard to their county of residence.

Transition Support Program Reporting Requirements	
Monthly Reports	Transition Support Program Staffing Report Transition Support Program Exit Disposition Report

9.12 Telephone Support for Crisis and Commitment Services (formerly known as Triage for Crisis and Commitment Services)

The Provider provides crisis triage and telephone support for people who are directly calling for services through King County Crisis and Commitment Services (CCS). The Provider provides 24/7 coverage of the CCS public telephone line to ensure that the individuals calling for assistance are directed to the crisis response that best meets their needs. Provider provides Monday through Friday coverage for the CCS professional telephone line.

For the Crisis and Commitment (CCS) public telephone line (263-9200), the Provider:

- Provides coverage 24 hours a day, 7 days per week, 365 days per year;
- Ensures that the staff answering the telephone are mental health professionals or trained individuals supervised by mental health professionals;
- Identifies and dedicates a telephone number specifically for the CCS public call line to be forwarded to on an ongoing basis;
- Determines the best resource for the caller (Mobile Crisis Team, Children's Crisis Outreach Response Services, CCS, etc.);
- Enters every call into Crisis Connections Triage Log;
- For callers referred to CCS, Crisis Connections enter the caller's name, phone number, patient's name and date of birth (DOB) into the CCS Phone Message Log; and
- Retains the Crisis Connections Triage Log for their records and to transmit to CCS if called upon to so.

For the CCS professional telephone line (263-9202), the Provider:

- Provides coverage Monday through Friday, eight hours per day, including holidays;
- Ensures that the staff answering the telephone are, at a minimum, paraprofessionals who are trained by Crisis Connections staff; and
- Enters into the CCS Phone Message Log the caller's name and agency/system affiliation, the name and birthdate of the individual about which the caller is concerned, and any pertinent additional information.

Telephone Support for CCS Reporting Requirements	
Monthly Reports	• Triage Summary Report – CCS Public Phone Line • Telephone Summary Report – CCS Professional Phone Line
Annual/Other Reports	The Provider submits a report, in a format approved by the County, that reconciles the expenditures shown on the Provider's or subcontractor's annual financial audit to Budget, Accounting and Reporting System (BARS) expenditure categories. The report is submitted in hard copy and is due 30 days after the Provider receives its financial audit.

9.13 Intensive Care Management Team (Vital)

The Vital program delivers comprehensive and integrated services to adults who are experiencing behavioral health challenges and require an intensive level of support and community outreach. Individuals may also be experiencing homelessness. The multi-disciplinary team consists of a supervisor/team lead, four care manager staff, a behavioral health specialist, an occupational therapist, a registered nurse, a Psychiatric Advanced Registered Nurse Practitioner (ARNP) or Psychiatrist, and a Primary Care ARNP or Medical Doctor who provides physical health care to participants. Services utilize evidence-based or promising practices, such as, Motivational Interviewing, Trauma Informed Care, and operate from a harm reduction approach. The team works closely with dedicated prosecuting attorney staff from the King County Prosecuting Attorney's Office and the Seattle City Attorney's Office in order to divert the filing of charges or collaborate on creative dispositions of criminal court cases that are focused on reducing jail time and ongoing and future criminal legal system involvement.

Intensive Care Management Team (Vital) Eligibility Criteria	
Medicaid Status	N/A, but Medicaid can be used for outpatient services, if eligible
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals meet both of the following criteria: • Four or more bookings in the King County Jail within a rolling 12-month period; and • That occurs twice in a three-year time frame.
Intensive Care Management Team (Vital) Reporting Requirements	
Monthly Reports	• Vital Housing Log •
Annual/Other Reports	• Ad-hoc reports as required for evaluation. • Provide a minimum of one program case study or participant vignette describing the participant's background, treatment, and outcomes. • Any other requested reports by the County.

9.14 Diversion and Reentry Housing and Support

Diversion and Reentry Housing and Support programs provides supportive housing, related housing case management, on-site support services, and assistance securing permanent housing for individuals who have a behavioral health condition and criminal legal system involvement and may be released from jail directly to housing and services or experiencing homelessness. Interim housing programs provide up to 12 months of housing support while the tenant is enrolled in affiliated DRS programs, and permanent housing programs provide time unlimited housing support.

DRS Housing and Support Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 years and Older
Authorization Needed	No
Additional Criteria	• Adults who are, or are at risk of experiencing homelessness • Have a behavioral health condition • Have come into contact with the local criminal legal system and/or are referred by a program that is part of the (DRS) continuum of care. • Actively involved in an adult specialty court in King County or participating in a legal diversion program.
DRS Housing and Support Reporting Requirements	
Monthly Reports	DRS Interim Housing Report
Annual/Other Reports	• Minimum of one anonymous, individual vignette describing the individual's background, services received, and outcomes. • Any other requested reports by the County

9.14.1 Housing Services for King County Regional Mental Health Court

Housing services provides 30 units of reentry interim housing for King County District Court Regional Mental Health Court (RMHC)/Regional Veterans Court (RVC) participants. The program is required to provide interim housing and support and align with the mission of RMHC/RVC to engage, support, and facilitate the sustained stability of individuals with mental health disorders within the criminal legal system, while reducing recidivism and increasing community safety.

Housing Services for King County Regional Mental Health Court Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 years and Older
Authorization Needed	No
Additional Criteria	• For housing services, adult individuals who are opting into or currently participating in Regional Mental Health Court/Regional Veterans Court. • For the SUD assessment services, individual opting into or opted into any of the adult specialty courts in King County.
Housing Services for King County Regional Mental Health Court Reporting Requirements	
Monthly Reports	• Housing Data and Status Report • Housing Data Log, as provided by the County

9.15 Veterans Reentry Services Program

The Veterans Reentry Services Program (VRSP) provides screening and benefits assistance for eligible veterans who are incarcerated or at risk of incarceration in the King County Correctional Facility (KCCF) in Seattle and/or the Maleng Regional Justice Center (MRJC) in Kent. VRSP staff facilitate a weekly Reentry Resource Group for individuals housed at the MRJC, when feasible and as available. VRSP staff may work with the Reentry Case Management Program to provide support services around accessing: Veterans Administration (VA), Veterans Benefits Administration, Veterans Health Administration or other veterans' benefits.

Veterans Reentry Services Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals who meet the above eligibility and will not be transferred to a Washington State Department of Corrections (DOC) facility or out-of-county facility.
Veterans Reentry Services Program Reporting Requirements	
Monthly Reports	• Veterans Flex Fund Expenditure Report • Veterans Staffing Report
Annual/Other Reports	• Minimum of two VRSP case studies or individual vignettes describing the participant's background, treatment and outcomes. • Any other requested reports by the County

9.16 Youth Support Services Outstation/Recovery School

Youth Support Services (YSS) clinicians provide outreach and/or engagement services for youth and young adults and linkage to treatment and other recovery support services. The following array of services are provided: brief intervention, motivational interviewing, building community connections and supportive relationships, life skill education, substance use disorder (SUD) and mental health (MH) screening, creating connections to education, healthcare, housing and/or job-seeking opportunities, case management services, engagement services, and assistance with entry into the SUD and/or MH treatment system.

Deliverables:

- Establish relationships with eligible youth and young adults
- Maintain regular contact with these individuals
- Refer participants to services, including behavioral health supports, as well as housing, employment, and/ or educational supports
- Assist eligible youth in lowering use of drugs/ alcohol or maintaining sobriety

Youth Support Services Outstation/Recovery School Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth ages 12 through 25 years old
Authorization Needed	No

Additional Criteria	• King County Resident
	• The focus of this program are youth and young adults who are:
	  • Involved with drugs or alcohol;
	  • Involved with risky behaviors; and/or
	  • Involved, or at risk for involvement, in the juvenile justice system.

Youth Support Services Outstation/Recovery School Reporting Requirements	
Monthly Reports	Youth Support Services Narrative Report including information on how the program deliverables were met
Quarterly Reports	YSS Excel Report –due the 15th of the month following the last month in the quarter that includes: • The number of youth reached per month, • The number of youth referred to SUD treatment, • The number of youth referred to non-treatment services, and • Information on relationships established with youth.

10 MIDD Behavioral Health Sales Tax Locally Funded Programs

The following programs receive funding through MIDD Behavioral Health Sales Tax. All programs that have MIDD funding as a funding source provide services in accordance with the associated MIDD Initiative. Additionally, the following programs are not the only MIDD funded programs. Some may be in other sections of this Provider Manual, as they better fit under another section. If a program receives MIDD funding on an agency's "Funding Overview," then the Provider must follow MIDD requirements for that program.

MIDD Service Improvement Plan and MIDD 2 Implementation Plan

Providers implement services and programs as described in MIDD planning documents which includes the *MIDD Service Improvement Plan* and *MIDD 2 Implementation Plan*. Proposed programmatic changes to MIDD initiatives are reviewed and approved by BHRD in advance of any change being made.

MIDD Performance Measurement and Evaluation

Providers participate in MIDD performance measurement and evaluation activities as detailed in Performance Measurement and Evaluation (PME) Plans. PME Plans are co-developed for each program with Providers and DCHS staff. Providers work with the PME Evaluation Team and BHRD program managers to identify the program-specific data elements, performance targets and metrics, and data transmission methods which are detailed in PME Plans.

Providers submit data electronically to DCHS/BHRD via the secure file server using a spreadsheet format provided by the County, the Client Outcomes Reporting Engine (CORE) online data submission system or the BHRD Information System. Data are due 15 calendar days after the end of the month for which quarterly/monthly data are being reported unless otherwise specified in PME Plans. Data will be complete and accurate. PME reviews each data submission and work to support Providers if any data corrections are required. If submitted data require correction, data will be corrected and resubmitted within 14 calendar days of notification.

Providers will also comply with the *MIDD 2 Evaluation Plan* for MIDD-funded programs as applicable.

10.1 1811 Intensive Case Management Services

The 1811 Eastlake residential facility is a project sponsored by the Downtown Emergency Service Center. The project provides supportive housing to 75 formerly homeless adults with chronic alcohol addiction. Residents are permitted to possess and consume alcohol in their rooms and are not required to enroll in treatment as a condition of their housing.

Assisting clients in achieving and maintaining stability and progress toward recovery by advocating for services and resources. That includes but is not limited to the following:

- Collaborate with the Department of Corrections (DOC) to maximize treatment outcomes and reduce the likelihood of re-offense in cases where a program participant is under supervision by the DOC.
- Work with therapeutic courts including drug courts and mental health Providers to maximize positive outcomes for clients.
- Coordinate with local Washington State Department of Social and Health Services (DSHS) offices to assist clients in accessing and remaining enrolled in supportive housing programs.
- Program Managers must also develop a Client Master Record on all clients in a format approved by King County.
- Complies with the MIDD Evaluation Plan and the MIDD Data Submission.

- Plans outings and on-site activities to improve participants' daily living skills and increase the level of meaningful activity in participants' lives.
- Facilitates engagement of participants through creative, resourceful strategies that build trust and confidence.

1811 Eastlake Eligibility Criteria	
Medicaid Status	N/A
Age Range	Over 18
Authorization Needed	No
Additional Criteria	• Individuals must be diagnosed as moderate or severe substance use disorder (SUD) and have a history of high utilization of crisis services at the following locations: Sobering Services, Harborview Medical Center (HMC), and/or King County Correctional Facility. • Individuals must meet the standards for low-income client eligibility as described in the King County BH-ASO Policies and Procedures.
1811 Eastlake Reporting Requirements	
Monthly Reports	1811 Intensive Case Management Report
Quarterly Reports	1811 Intensive Case Management Quarterly Report

10.2 Behavioral Health Services in Rural King County

The Rural Behavioral Health Projects are focused on supporting rural, community-driven behavioral health services in unincorporated King County and contribute to the MIDD Behavioral Health Sales Tax Policy Goal of "improve health and wellness of individuals living with behavioral health conditions" in rural, unincorporated areas of King County. The program is provided in accordance with the MIDD Plan Initiative SI-02 Behavioral Health Services in Rural King County through the MIDD 2 Service Improvement Plan (SIP).

Types of projects/activities may include but are not limited to:

- Activation of coalitions in assessing gaps, planning and implementation of behavioral health strategies and/or services
- Stigma reduction efforts and promotion of inclusive community models
- Trainings to enhance knowledge, impact attitudes and contribute to a collective efficacy
- Pilot programs that expand behavioral health-related services to underserved, non-Medicaid eligible residents

Behavioral Health Services in Rural King County Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	N/A
Behavioral Health Services in Rural King County Reporting Requirements	
Monthly Reports	Rural Behavioral Health Project Report
Annual/Other Reports	MIDD Evaluation Plan

10.3 Children's Domestic Violence Response Team (CDVRT)

The CDVRT provides behavioral health and advocacy services to children who have experienced DV, and support, advocacy, and parent education to their non-violent parent. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-08 – *Children's Domestic Violence Response Team* as outlined in the MIDD initiative description: CD-08 Description

The CDVRT provides services to children ages 0 to 17 years old and their families who are experiencing domestic violence. Services include:

- Screening through a parent and child interview, as well as established standardized screening tools.
- Assessment, therapeutic interventions (using evidenced based practices such as CBT), service coordination, linkage to needed services and supports, advocacy, and supportive services.
- Development of a staff team which includes both children's mental health specialists and children's DV advocates and may include other team members identified by the child and family, including supportive family members, case workers, and teachers.

- Engagement through structured activities (e.g. “Meet and Greets”, monthly Family Dinners) designed to support children and families to learn about the program, develop skills and provide a safe space to share experiences with others in similar circumstances.
- Coordination of care with referring sources and across disciplines.

The CDVRT program will:

- Provide monthly data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan MIDD Evaluation Plan for CD-08.
- Provide CDVRT services for a minimum of 85 unduplicated families with 150 children annually.

CDVRT Eligibility Criteria	
Medicaid Status	N/A
Age Range	0-17
Authorization Needed	No
Additional Criteria	Reside in King County and experience domestic violence
CDVRT Reporting Requirements	
Monthly Reports	CDVRT Summary; client data submission through CORE
Annual/Other Reports	CDVRT Outcomes Report

10.4 Community-Based Therapeutic Intervention and Capacity Building

Community-Based Therapeutic Intervention and Capacity Building funds community-based models that provide behavioral health programming with a therapeutic intent to individuals and/or communities that are not typically well served by the mainstream system, with an emphasis on culturally and linguistically responsive programming.

Services may include but are not limited to:

- Support groups and community building activities
- Individual therapy or counseling.
- Culturally relevant activities that promote engagement and improve the mental health and well-being of the participants; and/or
- Programming or services that support people to return to live their best lives by addressing underlying behavioral health issues.

Specific Program Requirements

- Provide culturally and linguistically responsive therapeutic activities and services
- Provide therapeutic activities and services to populations that have behavioral health needs that aren't being effectively met by the mainstream behavioral health system
- Not currently receiving MIDD funding for related program
- Providers will engage in quarterly meetings with King County staff
- Providers will attend quarterly collaborative meetings for either the Community Owned Behavioral Health Collaborative or the Rural Behavioral Health Collaborative, as appropriate.

Community-Based Therapeutic Intervention and Capacity Building Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	All
Authorization Needed	No
Additional Criteria	N/A
Community-Based Therapeutic Intervention and Capacity Building Services Reporting Requirements	
Monthly Reports	Community-Based Therapeutic Intervention and Capacity Building Narrative Report
Quarterly Reports	
Annual/Other Reports	• Community-Based Therapeutic Intervention and Capacity Building Services Year-end Summary Report • Any other reports or information requested by BHRD, including presentations regarding program or project

10.5 Corrections-based SUD Treatment Services

In-custody substance use disorder (SUD) treatment services are provided to adult men with varying lengths of stay at the Norm Maleng Regional Justice Center (MRJC) in Kent. The program has a maximum capacity of 36 participants on any given day. Evidence-based tools and a curriculum adapted to serve people of color are applied utilizing a trauma-informed, modified Therapeutic Community (TC) approach; cognitive behavioral interventions are applied to address criminogenic risk factors. The program is funded by the MIDD Behavioral Health Sales Tax Initiative RR-12 – *Jail-based Substance Abuse Treatment.*

Corrections-based SUD Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults aged 18 Years or Older
Authorization Needed	Yes
Additional Criteria	Adult men demonstrating medium to high risk for substance abuse via a validated Risk-Need-Responsivity (RNR) tool who are incarcerated at, or transferred to, the MRJC for a projected period of 14 days or longer, and who: • Meet the established classifications criteria approved by the King County Department of Adult and Juvenile Detention; and • Meet medical necessity for outpatient or intensive outpatient SUD treatment.
Corrections-based SUD Services Reporting Requirements	
Annual/Other Reports	• Corrections-based Annual Outcome Report which describes the activities, successes and challenges of the program and a summary of the accomplishment of outcomes/goals of the program. • Participates with the MIDD Evaluation Plan

10.6 Crisis Outreach Response—Young Adults (CORS-YA)

The program provides crisis outreach response services for young adults (ages 18-24) living in King County-identified residential programs. If an individual is identified to be in need of crisis support, timely crisis response services, provided by the Children's Crisis Outreach Response System (CCORS), will be available and responsive to the individual and staff at the residential program to aid in de-escalation and crisis stabilization.

CRISIS OUTREACH RESPONSE SYSTEM-YOUNG ADULT Eligibility Criteria	
Medicaid Status	N/A
Age Range	18-24 years old
Authorization Needed	No
Additional Criteria	Any young adult age 18-24 in King County: • Experiencing behavioral and/or emotional distress in need of crisis intervention; and • Currently living in a County-identified Homeless Youth Residential program bed.
CRISIS OUTREACH RESPONSE SYSTEM-YOUNG ADULT Reporting Requirements	
Monthly Reports	Young Adult Outreach Response System Summary

10.7 Domestic Violence Behavioral Health Services

Co-locates a licensed Mental Health Professional (MHP) with expertise in domestic violence and substance abuse within a community-based domestic violence survivor advocacy organization to provide brief behavioral health treatment, referral and supports for domestic violence survivors served by the agency. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-10 – *Domestic Violence and Behavioral Health Services and System Coordination* as outlined in the MIDD initiative description: PRI-10 Description

DV-BH Services programs include:

- Minimum staffing of a 1.0 full-time equivalent (FTE) licensed Mental Health Professional (MHP) with expertise in domestic violence and substance abuse.
- Clinical supervision for MHP staff to ensure services are in compliance with the Washington Administrative Code (WAC) for behavioral health services and relevant mental health practice standards.
- Initial screening for domestic violence (DV) survivors using a standardized measure to identify potential behavioral health concerns.
- Behavioral health services including:
  - Assessment to identify individual's specific behavioral health needs and the types of interventions to address those needs.
  - Culturally relevant, brief behavioral health therapy and support through group and/or individual sessions in an individual's preferred language.
- Referrals to behavioral health treatment Providers for individuals who need more intensive services.
- Consultation for DV advocacy staff and community behavioral health treatment agencies regarding the unique needs of DV survivors in providing behavioral health treatment and supports.
- Completion of client outcome measures at baseline and at least one repeated measure during the treatment process.

- Collaboration with the System Coordinator to promote cross-systems training among the domestic violence, sexual assault and behavioral health treatment systems.
- Developing collaborative relationships with behavioral health treatment Providers to facilitate referrals for individuals who need more intensive treatment services.
- Providing monthly data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan: MIDD Evaluation Plan for initiative PRI-10.

Domestic Violence Behavioral Health (DV-BH) Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth or adults (no age restrictions) who identify as DV survivors
Authorization Needed	No
Additional Criteria	Must have no other source of payment for services (i.e. does not have Medicaid, other insurance, etc.)
Domestic Violence Behavioral Health (DV-BH) Services Reporting Requirements	
Monthly Reports	DV-BH Staffing, DV-BH Service Summary, client data submission through CORE
Annual/Other Reports	DV-BH Annual Outcomes Report

10.8 Domestic Violence Behavioral Health Services with Culturally Specific Supports

Culturally specific and linguistically appropriate services for domestic violence survivors who are refugees or immigrants and receiving domestic violence (DV) advocacy services at the Refugee Women's Alliance (ReWA). DV Advocates under the supervision of a Mental Health Professional (MHP), provide brief behavioral health treatment, referral and supports for domestic violence survivors in their native language. In addition, this program manages funds for interpreter services for the other domestic violence and sexual assault Provider network agencies to ensure that immigrant and refugee survivors receive services in their language of choice. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-10 – *Domestic Violence and Behavioral Health Services and System Coordination* as outlined in the MIDD initiative description: PRI-10 Description

DV-BH Services and Culturally Specific Supports program includes:

- Minimum staffing of a 1.0 full-time equivalent (FTE) licensed Mental Health Professional (MHP) consultant with expertise in domestic violence and substance abuse who supervise the work of the DV Advocate staff providing behavioral health services.
- Regular MHP supervision and support individually and in group for DV Advocates to ensure services are in compliance with the Washington Administrative Code (WAC) for behavioral health services and relevant mental health practice standards.
- Services provided by DV advocates who reflect the culture and are bilingual or multilingual in order to more readily and directly address the cultural and linguistic needs of the individuals served and provide an enhanced treatment experience.
- Behavioral health services provided by DV advocates who under the supervision of the MHP including:

- Initial screening for domestic violence (DV) survivors using a standardized measure to identify potential behavioral health concerns.
- Assessment to identify individual's specific behavioral health needs and the types of interventions to address those needs.
- Culturally relevant, brief behavioral health therapy and support through group and/or individual sessions provided in the individual's preferred language.
- Referrals to behavioral health treatment Providers for individuals who need more intensive services.
- Completion of client outcome measures at baseline and at least one repeated measure during the treatment process.
- Consultation for community behavioral health staff and DV advocates from outside programs regarding the specific needs of refugee and immigrant survivors of domestic violence.
- Collaboration with the System Coordinator to promote cross-systems training and cultural awareness among the domestic violence, sexual assault and behavioral health treatment systems.
- Developing collaborative relationships with behavioral health treatment Providers to facilitate referrals for individuals who need more intensive treatment services.
- Management of funds designated for interpreter services for the domestic violence and community sexual assault program (CSAPs) initiative Providers.
- Providing monthly data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan: MIDD Evaluation Plan for initiative PRI-10.

Domestic Violence Behavioral Health (DV-BH) Services and Culturally Specific Supports Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth or adults (no age restrictions) who identify as domestic violence survivors. Primary population served are refugees or immigrants.
Authorization Needed	No
Additional Criteria	Must have no other source of payment for services (i.e. does not have Medicaid, other insurance, etc.)
Domestic Violence Behavioral Health (DV-BH) Services and Culturally Specific Supports Reporting Requirements	
Monthly Reports	DV-BH Staffing, DV-BH Service Summary, Interpreter Services Summary, Monthly client data submission through CORE
Annual/Other Reports	DV-BH Annual Outcomes Report

10.9 Domestic Violence/Sexual Assault Behavioral Health Systems Coordination

Provides system coordination and training activities to promote cross training and increased collaboration, policy development, and specialized consultation between behavioral health treatment Providers and agencies providing domestic violence and sexual assault services throughout King County to improve the responsiveness of services to survivors with behavioral health concerns. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-10 – *Domestic Violence and Behavioral Health Services and System Coordination* as outlined in the MIDD initiative description: PRI-10 Description

DV-SA BH Systems Coordination includes:

- Minimum staffing of a 1.0 full-time equivalent (FTE) System Coordinator/Trainer with expertise in domestic violence and sexual assault and knowledge of behavioral health issues experienced by survivors.
- Developing an Annual Training Plan each year in collaboration with KC BHRD which may include training provided to specific initiative partners, the gender-based violence community network, as well as community behavioral health system Providers.
- Providing specialized cross-system training for a minimum of 160 clinical or advocacy staff from community behavioral health, domestic violence and/or sexual assault agencies each year.
- Regular collaboration with BHRD to address system issues, share information and prepare for quarterly initiative meetings. Meeting follow-up.
- Collaboration and relationship building between the behavioral health, domestic violence, and sexual assault service systems to promote cross-systems training and increased knowledge and awareness across disciplines. This includes regular collaboration, coordination and relationship building with other initiative contracted Providers.
- Coordination or provision of specialized consultation for or between sexual assault, domestic violence and behavioral health agencies on issues impacting behavioral health treatment for survivors.
- Providing research and practice recommendations to inform the development of policies and procedures to assist domestic violence, sexual assault, and behavioral health providers better serve survivors who are experiencing behavioral health issues.
- Providing monthly reports and data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan: MIDD Evaluation Plan for initiative PRI-10.

Domestic Violence-Sexual Assault Behavioral Health Systems Coordination Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	N/A
Additional Criteria	Community-based Providers who offer domestic violence, sexual assault or behavioral health services to survivors are eligible for this service.
Domestic Violence-Sexual Assault Behavioral Health Systems Coordination Reporting Requirements	
Monthly Reports	DV-SA System Coordination Staffing, Training Report, Activity Report
Annual/Other Reports	MIDD Annual Report

10.10 Emergency Dept/Psych Emergency Services Care Manager

Harborview Medical Center (HMC) Psychiatric Emergency Services (PES) employs staff responsible for addressing the needs of individuals who are repeatedly admitted to the PES or Emergency Department (ED) as a whole, due to either substance use disorder (SUD) or mental illness or both. The program is funded through the MIDD Behavioral Health Sales Tax Plan Initiative CD-05 – *High Utilizer Care Teams*.

The goal of the program is to reduce the number of these individuals using costly interventions such as jail, ED, and hospital admissions by providing increased coordination between the PES, the ED, and outpatient behavioral health providers. Services are focused on high utilizer clients defined as a person who visits the PES or ED 4 or more times within 90 days, uses Sobering Services 10 or more times in a month, or is identified by staff as a particularly challenging client to serve successfully.

Program Specific Requirements

The program provides coverage between the hours of 8 am to 5 pm Monday through Friday. Staffing, at minimum includes, 2.0 full-time equivalent (FTE) Care Managers,1.0 FTE Program Assistant, and .3 Administrative Support.

Services may include, but are not limited to:

- Facilitate diversion from voluntary and involuntary psychiatric hospitalization when clinically appropriate.
- Provide Care Reviews defined as case-specific staffing that includes all community and program staff involved with the client with a goal of problem solving, service development, and intra- and inter-system care coordination.
- Case management and housing assistance services.
- Linkage to outpatient behavioral health services, including mental health, SUD, developmental disability.
- Maintain data and quality review for continuous performance improvement.
- Maintain a voucher fund to provide client specific expenditures (e.g. food, housing, transportation).

Care Managers conduct clinical screenings as needed, refer clients to the most culturally and geographically appropriate outpatient Provider, provide consultation when SUD is suspected or known, streamline the referral process to outpatient Providers for intake appointments to best meet the needs/preferences of clients, and maintain a current working knowledge of community and social services and their referral procedures.

Program Assistant will collect and enter data as needed for reporting requirements and provide general assistance to the program.

The program will comply with the MIDD Evaluation Plan.

Emergency Department/Psych Emergency Services Care Manager Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 and up
Authorization Needed	No
Additional Criteria	None
Emergency Department/Psych Emergency Services Care Manager Reporting Requirements	
Monthly Reports	• ED PES Care Manager FTE Report • ED PES Care Manager Voucher Detail Report
Quarterly Reports	ED PES Care Manager Log

10.11 Emergency Department (ED) Behavioral Health Rapid Response Team

As part of providing Quality Coordinated Outpatient Care within the Mental Illness Drug Dependency (MIDD) strategy SI-03, an Emergency Department Utilization Management (EDUM) initiative has been developed. The goals of the initiative are to: (a) rapidly engage individuals experiencing frequent behavioral health-related ED visits into outpatient behavioral health care, and (b) reduce behavioral health-related avoidable ED visits. Rapid response team interventions are specifically aimed to improve rapid engagement in behavioral healthcare post ED-discharge and community stabilization. A small workgroup with Providers and key hospital and King County Integrated Care Network (KCICN) stakeholders will be convened to determine final operational details.

The program will:

- **"Champion" a small workgroup in planning** final operational details of the clinical model with support for coordinating the workgroup from KCICN and HMA in late 2018
- **Operate regionally positioned teams** on First Hill (coordinating with Harborview, Swedish, Virginia Mason) and South King County (coordinating with St Francis, Multicare, Valley Medical, Highline).
- **Form a care team** with funding calculated on the basis of 5.0 FTE staff and 0.50 FTE supervisor. At least one staff member must have medical training – i.e., nurse or higher level. The team should include a peer support component.
- **Conduct population-based systematic identification** of super utilizers of ED in King County and monitor utilization over time using CMT's PreManage system
- **Provide rapid response and care coordination** upon notification of a client's ED visit, with Eds, Managed Care Organization care coordinators, and BHAs to engage clients in care
- **Provide evidence-based interventions to reduce high ED use** including transitional care, assertive community engagement, motivational interviewing, support (including peer support) for client engagement in treatment

- **Use measurement-based treatment-to-target** with systematic tracking, using a registry, of key outcomes and adjusting care when outcome goals are not achieved

EDUM – Rapid Response Teams Client Eligibility Criteria	
Medicaid Status	Medicaid eligible individuals are prioritized
Age Range	Adults at 18+
Authorization Needed	No
Additional Criteria	• Are ED super-utilizers – having had 20 or more ED visits within the previous 12 months • Behavioral health disorder cannot be ruled out; and • Are willing to receive this service.
EDUM – Rapid Response Teams Reporting Requirements	
Monthly Reports	Depending on decisions regarding program design and metrics for bonus payments, the Provider may need to submit monthly reports including, but not limited to the number of individuals who meet eligibility criteria who are: identified, approached, consented and served. The report would be in an electronic format approved by the County to the Behavioral Health and Recovery Division (BHRD) Secure File Server according to the Secure File Transfer instructions. BHRD develops (in consultation with the Provider) a monthly report that tracks the key metrics for the EDUM initiative: • ED rate per 1000 Medicaid lives reduced • ED utilization for clients served by the rapid response teams • Follow-up after ED for mental Illness (increase within 7 and 30 days) • Follow-up after ED for substance use disorders (increase within 7 and 30 days)
One-time Report	The Provider submits a one-time-only report – after six months in operation – providing cumulative statistics for the contract period and a description of program activities, successes and challenges.

10.12 Emerging Issues in Behavioral Health

Emerging Issues in Behavioral Health, as outlined in the MIDD 2 Improvement Plan, is funded through MIDD Behavioral Health sales tax revenue to address new or evolving behavioral health needs in King County that are not being addressed by other funding sources. Contracted community-based organizations (CBO) develop and implement program models to meet various identified emerging needs.

2023-2024 Providers and programming includes:

- **Tubman Center for Health and Freedom:** Funds a project that includes research, analysis, and creating models for behavioral health training programs to ensure they develop practitioners who can provide services community needs and wants – particularly for the Black community.

- **YMCA in Greater Seattle:** Funds the Education Enhancement Program to address the regional, local, and national shortage of behavioral health providers by creating a pathway for existing nonprofit staff to become a master's level behavioral health practitioner.

- **Lutheran Community Services Northwest:** Funds the Islamic Trauma Healing program to provide culturally responsive and trauma-informed behavioral health services to Afghan refugee community in King County.

- **Seattle School District of King County:** Supports Seattle Public School students with information and skills they need to stay safe and large organizations with system of response through opioid education and overdose prevention.

Specific Program Requirements:

- Organizations are expected to be available to present on program progress at King County Integrated Care Network meetings, at MIDD Advisory Committee Meetings and other meetings as requested by King County
- End of project deliverables will include a final report that outlines project accomplishments, challenges, lessons and any findings relevant to behavioral health programming in King County
- Final project presentations will be required at KCICN and MIDD Advisory Committee meeting
- Attend quarterly meetings with King County staff

Emerging Issues in Behavioral Health Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	All
Authorization Needed	No
Additional Criteria	N/A
Emerging Issues in Behavioral Health Program Reporting Requirements	
Monthly Reports	Emerging Issues in BH Program Narrative Report
Quarterly Reports	
Annual/Other Reports	• Emerging Issues in BH Program Annual Report Template • Emerging Issues in BH Program Project Final Report at the end of funding period, and any agreed upon deliverables • Any other reports or information requested by BHRD

10.13 Family Support Organization

This program provides resources and support to families in King County, including youth peer and parent/caregiver partner supports. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-12- *Parent Partners Family Assistance* as outlined in the MIDD initiative description: CD-12 Description.

The Provider, Guided Pathways Support for Youth and Families (GPS), ensures equitable access to services throughout the King County region. This Family Support Organization hires, trains, develops and retains staff that reflect the cultural and ethnic diversity of the children, youth and families engaged in the services.

- Parent/caregiver partners are Washington State Certified Peer counselors or have experience providing or receiving paraprofessional parent/caregiver peer supports. They also have lived experience as a parent/caregiver of youth receiving services from child-serving systems (e.g., mental health treatment system, substance use disorder treatment system, child welfare and juvenile justice system).

Youth peers are between the age of 18 – 28 with lived experience in utilizing mental health, substance use disorder, juvenile justice or Wraparound services.

Program staff, including parent/caregiver partners and youth peers, provide:

Flexible and accessible parent/caregiver and youth peer support;

- Referrals to the King County Behavioral Health System, the Children's Administration, and other child-serving systems as needed;
- Parents/caregivers with effective advocacy tools for receiving support for these systems;
- Assistance to parents/caregivers in navigating child serving systems;
- Support to parents/caregivers and youth through mentoring and sharing of their own experiences as service recipients in child-serving systems from a recovery-oriented perspective in order to promote hope and self-determination; Culturally relevant supports that are in accordance with the ethnic and cultural values and beliefs of the individual(s) and families served and are customized and flexible to meet the needs and goals of the individual(s) and families served;
- Collaboration and active participation with relevant organizations to include the King County Community Collaborative, the King County Peer Support Network, and King County Community Resource Teams; and
- Leadership, training and support related to peer workforce development.
- The Provider provides an annual work plan with budget to King County for review and approval. This plan includes minimum service delivery numbers and the following activities provided by the Family Support Organization:
    - Family-oriented social events to be held regularly throughout the year. Events are located in King County and are open to the public. Volunteers and families receiving services are engaged in the planning and implementation of the family social events, with the support of staff and based on the interests and needs of the participating volunteers and families. These events focus on community building and building family-to-family connections to increase access to and awareness of other families who have a shared experience of receiving services from the child-serving systems. The events may also be educational.
- Parenting education: Occurs in collaboration with other child-serving organizations. The Provider participates in or sponsors parenting education opportunities. The Provider leverages existing parent and family trainings in the community and bases any additional Provider-generated trainings or pilot curriculums on the community needs assessment and related Provider research in order to prevent duplication of services. The Provider sponsorship of trainings includes publicizing the training through the Provider Network and collaborating partnerships, and providing additional supports as needed for the training or to the trainer(s). All trainings are located in King County, are open to the public, and have varying locations in an effort to reach residents in several geographic areas within the County. Training topics may include: Individual Education Plans (IEPs); Finding and selecting specialized childcare; Child-serving systems navigation; Advocacy; Parent-to-parent support; and other topics as identified by the Provider.

- Youth peer support: The Provider selects or develops a support group facilitation model appropriate for youth. The Provider recruits, trains, and supervises volunteer youth peers to provide peer support and youth support groups. Youth peers that are recruited draw upon their own experiences in child-serving systems to support the needs and goals of peers. The Provider provides support in person at their offices, in homes, in the community, over the phone or via the computer. The Provider pilots peer counseling and drop-in programs located in King County schools as identified in the annual work plan.

- Information and referral: The information and referral database and telephone service focuses on the specific areas of expertise related to family and parent supports for families that could benefit from services and/or assistance with linkage to child-serving systems (the service is non-duplicative in nature, providing referrals to 2-1-1 or other referral services for broader supports such as housing and employment). The Provider recruits, trains, and supervises staff or volunteers to provide information and referral services to children, youth, and families by phone. The Provider may also distribute information via a website, newsletter, traditional media and/or social media.

Family Support Organization Eligibility Criteria	
Medicaid Status	N/A
Age Range	Individuals up to age 21 and their families/caregivers and extended support system.
Authorization Needed	No
Additional Criteria	Live in King County, would benefit from services, agree to participate in services and are receiving or may benefit from receiving services from any of the following child serving systems: mental health, substance use disorder, child welfare, juvenile justice, developmental disabilities and or special education programs.
Family Support Organization Reporting Requirements	
Monthly Reports	GPS Progress Report MIDD Evaluation Data Report/ Reporting into CORE
Quarterly Reports	None
Annual/Other Reports	GPS Work Plan and brief year-end summary MIDD Annual Report.

10.14 Family Treatment Court Wraparound

The Provider ensures Wraparound Services to clients of King County Family Treatment Court (FTC).

This program seeks to:

- Reduce the number of people with mental illness and substance use disorders using costly interventions like jail, emergency rooms, and hospitals;
- Divert youth and adults with mental illness and substance use disorders from initial or further justice system involvement;
- To ensure the full involvement and partnership of families in the care of their children; and
- To improve outcomes for Division of Children and Family Services (DCFS)-involved families through multi-system planning and coordination.

This program adheres to the principles and values of Wraparound as outlined by the National Wraparound Initiative. Caseloads in this program are approximately 15 to 23 families per year. FTC Wraparound staff attend all County-convened MIDD Wraparound trainings. FTC Facilitator works with FTC staff to maintain a steady stream of referrals and waitlist for Wraparound Services. When capacity becomes available, ETC Facilitator reaches out to the first client on waitlist at the next available court date. They schedule, organize, and facilitate FTC Family Team Meetings, ensure that each family referred is informed and trained in the Wraparound process, include natural supports for inclusion on the family team within the first 30 days of contact, in conjunction with the family, and using the

guidelines specified by the NWI, ensure that they assist in a strengths, needs, and cultural discovery assessment with each family within the first two weeks of contact with the family, assist in the development of the individualized Wraparound individual service plan (ISP) within 45 days of the first team meeting, and ensure the need for a safety plan is assessed within 45 days of first team meeting.

As needed, a safety document is individualized to the circumstances of the individual and may be created by the client with FTC Wraparound Facilitator, Court Appointed Special Advocates (CASA), DCFS Social Worker, Substance Use Disorder Professional (SUDP), and/or any other member(s) of the team as appropriate. They share the individualized Wraparound ISP, safety plan, and all plan updates with all family team members as needed; convene family team meetings on a schedule agreed upon by the family and team to assess and monitor progress; monitor and review the ISPs for progress; make assertive efforts to ensure that each family referred is engaged in the Wraparound process; assist the family and/or identified natural support to develop a transition plan at the conclusion of Wraparound, and as needed, to assume the role of Facilitator for the family team prior to discharge from Wraparound.

FAMILY TREATMENT COURT WRAPAROUND Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Individuals are referred by FTC and are diagnosed with a substance use disorder (SUD) and in need of outpatient SUD services, as assessed by a Substance Use Disorder Professional (SUDP) using an assessment instrument that incorporates American Society of Addiction Medicine (ASAM) Criteria and the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM_V), or their successors.
FAMILY TREATMENT COURT WRAPAROUND Reporting Requirements	
Monthly Reports	Family Treatment Court Report
Annual/Other Reports	The Provider provides an Annual Outcome Report which describes the activities, successes and challenges of the program and a summary of the accomplishment of outcomes/goals of the program.

10.15 Forensic Treatment Program at CCAP

Substance use disorder (SUD) treatment and mental health services (including pre-treatment services) are provided to appropriate adult men and women court-ordered to the Community Center for Alternative Programs (CCAP) in Seattle. The services are evidence-based and adapted to serve people of color, utilizing a trauma-informed, modified Therapeutic Community (TC) approach and cognitive behavioral interventions to address criminogenic risk factors. The program is partially funded by MIDD Behavioral Health Sales Tax Initiative RR-02 – *Behavior Modification Classes for Community Center for Alternative Program Clients.*

Forensic Treatment Program at CCAP Eligibility Criteria	
Medicaid Status	Yes and No
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Pre-Treatment, Screening and Assessment: Adjudicated and pre-trial adults who are ordered by King County District Court or King County Superior Court to report to CCAP; • SUD Outpatient Services: CCAP participants who meet medical necessity for outpatient or intensive outpatient (IOP) treatment services; and • Mental Health Outpatient Services: CCAP participants who are assessed as appropriate and eligible for a Mental Health Outpatient Benefit as descried in the Medicaid State Plan.
Forensic Treatment at CCAP Reporting Requirements	
Monthly Reports	• As requested by DCHS evaluator CCAP Staffing Report; • Forensic Treatment Flex Fund Expenditures Report; • Forensic Treatment Subsidized Client Report; • Forensic Treatment Services Denial Report
Quarterly Reports	As requested by DCHS evaluator
Semi-annual Reports	As requested by DCHS evaluator
Annual/Other Reports	• Annual Outcome Report which describes the activities, successes and challenges of the program and a summary of the accomplishment of outcomes/goals of the program. • Participates with the MIDD Evaluation Plan.

10.16 Housing Outreach Partners (HOP)

Housing Outreach Partners provides four regionally positioned behavioral health/medical teams to provide outreach/engagement, stabilization, and limited acute response for residents in Seattle Housing Authority (SHA) and King County Housing Authority (KCHA) buildings (HA residents) who may be at risk of housing instability. The target SHA/KCHA buildings are designed for seniors and people with disabilities. Residents typically have the ability to stay stably housed with minimal on-site supports. The focus population (a subset of the residents of these buildings), have behavioral health issues, often accompanied by medical care issues, that can create challenges for HA staff, themselves, and other

residents that may compromise housing stability. This program is funded by the MIDD Behavioral Health Sales Tax Initiative S103.

Program Specific Requirements

Teams receive referrals from HA staff and/or King County Behavioral Health and Recovery Division (BHRD), a division of King County Department of Community and Human Services. Teams work collaboratively with HA staff who facilitate introduction to target buildings and provide assistance in identifying HA residents with suspected unmet needs. In SHA buildings HOP teams also need to work collaboratively with other service Providers to maximize effectiveness and avoid duplication of service. HOP teams engage HA residents to provide:

- Assertive outreach, engagement, stabilization and linkage to care (typically ~3 months) for the focus population within 3-5 targeted HA buildings, transitioning to subsequent buildings when appropriate, and retaining residual contact with previous building(s) as needed. HOP goals are to:
  - Engage or re-engage the focus population in behavioral health and/or health care or other human services for those with need for such services,
  - Improve housing stability, functioning, and quality of life for the focus population, and
  - Decrease associated building problems and lost occupancy
- Limited acute, non-crisis response to HA residents in targeted and additional buildings including:
  - Interacting with Crisis Connections to triage acute events,
  - Responding to requests from building staff regarding acute events, and
  - Consulting and providing informal training to HA building staff regarding crisis management
- Outreach expectations: 3 in-person contacts before discontinuing engagement efforts
- Exit expectations: 3 outreach attempts before discontinuing enrollment
- Typical challenges of HA residents for HOP team to address include:
  - Poorly controlled or troubling substance use issues
  - Creating disturbances (e.g., excessive noise, repeated requests or complaints, numerous or unauthorized guests, inadequate control of pets/service animals, verbal/physical conflicts or exploitation, damaging property), or poor life skills and self-care (e.g., hoarding, poor apartment hygiene, isolation, smoking violations, self-harm, financial instability)
  - Medical care support for individuals with behavioral health conditions – the most common being: hypertension, diabetes and hyperlipidemia. Support for appointment attendance and medication adherence could be included in the intervention targets
- Multidisciplinary staffing must be able to address the focus population's mental health and substance abuse needs and coordinate their medical care needs. Staffing must include individuals skilled in behavioral health interventions in addition to a Substance Use Disorder Professional (SUDP) and nurse who provide consultation and services as needed.
- Geographic expectations: Teams are responsible to serve HA buildings across the entire King County region.
- After hours care: Teams must provide <u>each</u> targeted building at least 3 hours/week of service after 5pm.

Referral Processes and Data Flow

Referrals to the program may come from two sources: (1) directly from HA building staff and (2) from BHRD based on client lists from Has matched to BHRD service data. Sound provides regular communication with HA building management regarding the status of service engagement with individuals referred.

Performance Measurement and Evaluation

The HOP program works collaboratively with the King County Performance Measurement and Evaluation (PME) team to develop a PME 'plan.' The PME plan details data collection methods for the performance measures described below as well as other evaluation and Continuous Quality Improvement (CQI) elements.

Performance Measurement and Payment Milestones

Metric name	**Definition/How measured**	**Upfront %/ Incentive %**	**Upfront month**	**Incentive pay determination month (by 15th of last month listed)**	**Incentive payment month**
Early implementation - 3 months (Dec – Feb) total $437, 218					
Collaborative design	Developed written referral and operating protocols with Crisis Connections, SHA, KCHA and BHRD	70% 30%	January	February	March
Hiring rapidly	9 of 11 staff hired				
Data flow	Initiated electronic data and report transmission (per PME plan)				
Process - 4 months total $582,958 (March – June performance)					
How much?					
New enrollees	Monthly avg of 35 new enrollees	60% 40%	March	March-June	July
# Served	Monthly avg of 125 enrolled with at least one service in month				
How well?					
Linkage to care	65% of enrollees exited in month have at least 1 confirmed linkage				
Outcome – 6 months total $874, 437 (July - December performance)					
Anyone better off? NOTE: **Must also maintain "How much" and "How well" rates for incentive**					
Housing stability	Statistically significant reduction in challenging behaviors log (by 6 months post) as leading indicator of housing instability (per PME plan)	50% 50%	July	July-December	January

PME/BHRD Activities

PME/BHRD provides evaluation and program reports that describe:

characteristics (e.g., demographic, diagnostic of individuals (a) outreached (b) enrolled

- # of outreaches total and per individual enrolled (from monthly report)
- # of service contacts and service hours per enrolled individual (from data transaction or report
- # of acute events and nature of acute events (from monthly report)
- Nature of service response to indicators of housing instability.

PME/BHRD collaborates with the HOP team and HA staff to develop and implement:

- Reporting of indicators of housing instability and acute events (e.g., 911 calls, etc.)
- HA staff interviews or survey
- Client interviews or survey
- Agency staff interviews or survey

Continuous Quality Improvement (CQI)

PME/BHRD facilitates meetings with the agency and HA – at least quarterly – in which performance measurement and data from reporting and evaluation are discussed as a means to identify program strengths and areas for further improvement. These meetings are also the forum for determining steps that the program, SHA/KCHA and/or BHRD may take to support program improvement efforts.

Housing Outreach Partners Eligibility Criteria	
Medicaid Status	N/A
Age Range	18+
Authorization Needed	Yes
Additional Criteria	SHA/KCHA residents that are part of focus population in targeted buildings - referred by BHRD or SHA/KCHA
Housing Outreach Partners Reporting Requirements	
Monthly Reports	HOP Acute Event and Housing Instability Indicator Report(s) TBD
Other Data	Submission of data into the BHRD Information System

10.17 Juvenile Justice Assessment Team (JJAT)

An integrated team that provides multi-disciplinary, culturally specific screening, assessment and short-term intervention services to juvenile justice (JJ) involved youth in order to improve service coordination and divert youth with behavioral health needs from initial or further justice system involvement while reducing the incidence and severity of substance use disorders and mental and emotional disorders.

The Juvenile Justice Assessment Team (JJAT) consists of seven members: two Substance Use Disorder Professional's, two Mental Health Professionals who provides JJ-related liaison services, a Program Supervisor, Program Coordinator, and a .8 Psychologist from King County Superior Court. Services are provided as described in the JJAT Referral Process document and in the youth's community whenever possible within seven days using prioritization protocols. Occasionally, in some urgent situations, assessments are completed on demand, same day as referral. A comprehensive assessment summary is presented in a standardized report within seven days from the date of the assessment interview or as needed to comply with court requests and to facilitate treatment placement.

The JJAT team is also responsible for developing and maintaining collaborative working relationships with JJ programs/initiatives and youth-serving systems to ensure coordinated and comprehensive services and discharge plans.

The JJAT team is responsible for following: the JJAT Program Guidelines and Protocols document.

Juvenile Justice Assessment Team Eligibility Criteria	
Medicaid Status	N/A
Age Range	12 – 20 years of age
Authorization Needed	Youth involved in juvenile court and have an active case and are determined to have a behavioral health concern
Additional Criteria	None
Juvenile Justice Assessment Team Reporting Requirements	
Monthly Reports	Juvenile Justice Assessment Team (JJAT) FTE Report

10.18 Law Enforcement Assisted Diversion (LEAD)

The Law Enforcement Assisted Diversion (LEAD) program is a program to divert adult individuals engaged in low-level drug crime, prostitution, or other collateral crime due to drug involvement or quality of life from the criminal legal system. LEAD intercepts the individual to address the behavioral problem at the point of (or before) law enforcement response to divert drug-involved individuals, among others qualified for diversion, into a community-based intervention. LEAD features case management and outreach services, whenever possible and appropriate, with such services delivered by one or more licensed community behavioral health agencies. Such services utilize evidence-based or promising practices, such as Motivational Interviewing, Trauma Informed Care, and harm reduction approaches.

LEAD supports engagement in the community and addressing neighborhoods' concerns with criminal activity and public safety, while providing ongoing education and ongoing dialogue with community leaders. The prosecution coordination component of LEAD supports prosecutors to make informed discretionary decisions about whether to file charges, recommend pretrial detention or release conditions, reduce charges, recommend incarceration after conviction, and/or dismiss charges, in a way that supports the intervention plan designed for the particular participant. The final component, system advocacy, is an effort to address and remove system and institutional barriers encountered by participants that impede their access to resources which are essential to improved functioning and quality of life.

The Provider:

- Collaborates with law enforcement agencies throughout King County, who may be operating an existing LEAD intervention to provide effective training of and engagement with front-line law enforcement (officers and sergeants). The training and engagement enlists officers' active participation in this approach, familiarizes them with harm reduction principles, and utilizes their experience and knowledge of the street-involved population.

- Supports prosecutorial coordination of LEAD participants referred or filed criminal cases with the LLP established by LEAD case managers.

- Provides overall project management of the initiative, maintaining fidelity to the LEAD core concepts needed for alignment with this evidence-based model.
- Reports to the inter-jurisdictional Policy Coordinating Group (PCG) pursuant to MOU.
- Subcontracts with case management and outreach providers under the direction of the PCG, including conducting solicitations for additional providers when directed by the PCG and running competitive RFP's when directed by the PCG.
- Provides legal services for LEAD program participants who face legal obstacles to stabilization and recovery.
- Facilitate geographically focused multi-partner meetings/case conferencing sessions about individuals with particular impact.
- Facilitate legal system coordination conferencing between prosecutors and case managers.
- Supports the collaboration with local neighborhood, grassroots, and advocacy organizations in order to sustain ongoing participation by and transparency to the community.
- Supports and collaborates in removing legal obstacles to improve life circumstances, which may included barriers to housing, employment, and other resources.
- Supports and coordinate with public defenders to receive defense-initiated social contact referrals and to ensure defenders integrate LEAD into defense planning for resolution of filed cases, as appropriate.
- Any expansion of LEAD program requires budget approval, if utilizing MIDD/BHRD funds.

Law Enforcement Assisted Diversion Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Residents of, or are experiencing homelessness in, King County or were immediately prior to incarceration or another institutional stay. • Willing or will be willing to signs Releases of Information (ROIs) with regard to status and progress in the program in order to update the prosecuting attorney and other identified stakeholders. • Eligible for the LEAD program as identified by law enforcement partners under expanded eligibility criteria.
Law Enforcement Assisted Diversion Reporting Requirements	
Monthly Reports	LEAD Staffing Report for all contracted and subcontracted agencies providing LEAD services.

Quarterly Reports	• LEAD Summary Reports • CORE data submitted for contracted and subcontracted agencies
Annual/Other Reports	• Two vignettes from individuals served in the program • Any other requested reports by the County

10.19 Low-Barrier Buprenorphine Service Expansion

As recommended by the Heroin and Prescription Opiate Task force, Behavioral Health and Recovery Division (BHRD) is partnering with community services Providers to address the region's heroin and opioid epidemic. As a result, Low Barrier Buprenorphine Services Expansion and Coordination was created to provide access to buprenorphine [an opioid partial agonist] for all people in need of services, in low-barrier modalities close to where individuals live. Moreover, individuals experiencing opioid use disorder, who desire opioid agonist pharmacotherapy with buprenorphine, have access to low-barrier treatment on demand. Treatment on demand is defined as the individual meeting with a prescriber immediately, or on day one or day two, to initiate treatment. A low-barrier or "buprenorphine first" model of care aims to use buprenorphine treatment induction and stabilization as the priority health intervention. Individuals who 1) are experiencing homelessness, 2) have limited or no support systems, and/or 3) have complex medical and behavioral health needs may experience difficulty successfully engaging and receiving care at traditional opioid treatment programs. A low barrier model of care is an alternative approach to opioid treatment that is client-centered, focused on harm reduction, and designed to engage a greater number of individuals experiencing opioid use disorder in effective opioid treatment.

The Provider delivers and/or facilitates system-wide rapid access to low-barrier treatment on demand that serves individuals with substance use disorders who have not been able to successfully access services. The Provider dedicates nurse care managers, care navigators, substance use disorder professionals, physicians, advanced registered nurse practitioners or other medical Providers to work at the site. When possible, the Provider bills Medicaid through the managed care organizations (MCOs) for reimbursement for prescriber time related to buprenorphine/MAT, those clients with Medicaid prescriptions are filled through pharmacies which have working relationships with the Provider. For those participants without Medicaid, flexible funds built into the program budget are utilized with some flexible funds also utilized to cover Medicare part D copays, in instances when clients lack resources.

When possible, the Provider identifies individuals with opiate use disorder who are willing to engage in buprenorphine treatment through existing programs providing outreach and engagement, crisis intervention and stabilization, and where appropriate, emergency shelter services, and permanent supportive housing. The Provider may provide treatment in the community to those who demonstrate a willingness to participate in buprenorphine treatment but for various reasons are not able to get to the clinic space. Mobile medical options may be provided when appropriate. As deemed appropriate by the Provider, it may provide clients experiencing polysubstance use with buprenorphine treatment and enroll them in the Provider's outpatient treatment program where they receive individualized treatment focused on all substances.

The Provider is encouraged to train nurses and Providers to utilize the Clinical Opioid Withdrawal Scale (COWS) to determine stages of intoxication and withdrawal, so that buprenorphine induction can proceed safely and expeditiously. The Provider may, as it deems appropriate, offer and provide services from a team of clinicians. This team may include medication management and case managers from the mental health, substance use disorder, housing, employment, crisis, shelter and nursing programs.

If waitlists develop, the Provider's ensures patient access to stabilization and support transition into traditional programs and recovery support services.

When possible, the Provider is encouraged to communicate with King County's Behavioral Health Administrative Services Organization's (BH-ASO's) behavioral health network agencies, Community Center for Alternative Programs (CCAP) and area jails to identify and refer individuals in need of MAT low-barrier access programs to ensure those in greatest need have access.

When the Provider is responsible for coordinating buprenorphine treatment rather than directly providing it, the Provider acts as the main centralized access point for those seeking buprenorphine treatments from the BH-ASO and do the following:

- Facilitate efficient and timely access to buprenorphine services;
- Discuss MAT treatment options with callers; and
- Work collaboratively with MAT treatment providers to identify attainable recovery supports.
- Dedicate one full-time equivalent (FTE) position identified as the Medication-Assisted Treatment Coordinator (MATC) to work with the Alcohol and Drug Abuse Institute (ADAI) at the University of Washington to populate the buprenorphine database. The MATC is responsible for the following:
- Identifying which buprenorphine Providers work with specific populations of people, including specific ethnicities or age groups;
- Identifying which buprenorphine Providers are willing to work with people who are polysubstance users;
- Identifying which buprenorphine Providers have a low-barrier, harm-reduction focus of services;
- Documenting and identifying successes as well as barriers in accessing MAT services;
- Leading a quarterly buprenorphine coordination meeting with support from King County, which would include but is not limited to representatives from MAT prescribers, substance use disorder (SUD) Providers, public health, hospital social workers, and other outreach workers;
- Conducting follow-up calls to Crisis Connection callers who consent to be contacted about their ability to connect with the MAT referrals they were given;
- Providing resources for individuals being released from incarceration and for those working with the incarcerated population who are looking for same-day access to buprenorphine services throughout King County;
- Ensuring the resource information included in the database is accurate and up-to-date multiple times per week.

Low Barrier Buprenorphine Service* Coordination *Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	• Individuals receive priority services as described in the Behavioral Health and Recovery Division (BHRD) Provider Manual • Individuals reside in King County • Individuals meet the medical criteria as identified by the attending physician • Individuals meet the Provider's program eligibility criteria
Low Barrier Buprenorphine Service Reporting Requirements	
Quarterly Reports	• Low-Barrier Buprenorphine Report in a format approved by BHRD.

Annual/Other Reports	• The Provider participates with the MIDD Evaluation Plan. • Data are due 15 calendar days after the end of the month for which data are being reported, unless stated otherwise. Data is complete and accurate. King County Behavioral Health and Recovery (BHRD) reviews each data submission and notifies the Provider of any needed corrective action. Data is corrected and resubmitted within 14 calendar days of notification.

10.20 Medication-Assisted Treatment – Shelters/Encampments

Opioid use disorder is an ongoing problem for many living in our County and providing them with access to evidence-based treatment is critical to promote recovery. Access to treatment is particularly challenging for those people utilizing shelters and encampments throughout the County who cannot or will not travel to clinics or medical offices. Providers provide Medication-Assisted Treatment (MAT) to people utilizing King County shelters and encampments. This program is funded by the MIDD Behavioral Health Sales Tax Initiative CD-07.

Program Specific Requirements

- Find, engage, assess and provide MAT (buprenorphine) in non-traditional settings directly to people utilizing shelters and encampments to allow them to begin the recovery process.
- Serve people residing in shelters and encampments in both Seattle and King County based on data provided by Public Health – Seattle/King County fatal and non-fatal overdose dashboards, other reliable data sources and the provider's knowledge of high need areas of the County. The Provider consults the County and the Public Health Mobile Street Medicine Team about the location of geographical service areas outside of Seattle where there is a high need for MAT services to this population.
- Develop collaborative working relationships with organizations that have credibility with people utilizing shelters and encampments including the new Public Health Mobile Street Medicine Team and other behavioral health and primary care Providers serving this population.
- Meet directly with the Public Health Mobile Street Medicine Team and the other Provider-supported with these funds to coordinate delivery of these MAT services throughout King County.
- Provider keeps informed of changes to federal and state laws and regulations to allow MAT to be provided in the most creative and flexible manner possible to effectively serve this population.
- Whenever possible, provide MAT services to people utilizing shelters and encampments outside of normal business hours.
- Work collaboratively with the County's Performance, Measurement and Evaluation team to develop performance measures related to the required MIDD Sales Tax evaluation process. The Provider collects client enrollment and demographic data in a format that aligns with King County. The format that data is reported to King County depends on the program model and specific service delivered. King County is moving toward client-level data collection for services that work with clients over time. Service and outcome information is collected in a format appropriate to the program model. Information about clients served should be collected continuously by the funded program and is regularly reported via DCHS' online reporting system currently under development. Data is used to assess the quality of the services that clients receive, and the outcomes related to the program participants. Client-level data elements include client demographics, basic information about services provided, and outcomes of those services. The County works with Providers to determine which client-level data elements are appropriate for the service provision model and for the data collecting process that MAT programs develop.

- Participate with the Department of Community and Human Service Behavioral Health and Recovery program manager to develop periodic narrative reports to share information about milestones, program success or lessons learned, operations, participant stories, system change efforts and other requested information. The frequency and specific content of narrative reports is determined in collaboration with King County during the first few months of the contracting period.
- Participate in quarterly Medication for Opioid Use Disorder (MOUD) meetings hosted and sponsored by the County and the Crisis Connections Recovery Helpline.

Medication-Assisted Treatment – Shelters/Encampments	
Medicaid Status	N/A
Age Range	Adults and Youth
Authorization Needed	No
Additional Criteria	None
SOR Recovery Support Services Reporting Requirements	
Monthly Reports	MAT – Shelters/Encampments FTE Report
Quarterly Reports	MAT- Shelters/Encampments Quarterly Report
Annual/Other Reports	• Upon request, contribute to the MIDD Behavioral Health Sales Tax annual report • MIDD Behavioral Health Sales Tax Evaluation Plan

10.21 Older Adult Substance Use

The Older Adult Substance Use program provides substance use disorder (SUD) services to elderly and disabled adults with SUD needs. Generally, services occur in the individual's natural environment. The program serves people age 60 or older and/or Medicaid Title XIX Case Management Core clients who are in need of SUD services. The Older Adult Substance Use program provides outreach, engagement, and treatment services which include evaluations, ongoing counseling, and referrals to appropriate resources, treatment, and medical care, and individualized treatment plans. The Older Adult Substance Use program also researches and develops resources, provides case staffing, and provides consultation to mental health staff and professionals from community agencies, including the Aging and Disability Services (ADS) and ADS subcontracted agency case managers, related to substance use issues, assessment, and care planning. Examples of appropriate referrals can include, but are not limited to, the following:

- Reclusive individuals who need, but refuse to access medical, mental health, or substance use disorder services
- Individuals who, due to substance use problems, suddenly deteriorate or change behaviors which put them at risk of hospitalization
- Individuals at risk of personal safety, inadequate nutrition, survival, and/or self/neglect
- Individuals of questionable competency unable to manage their own affairs
- Services are provided during normal office hours Monday through Friday.
- Clients are seen in order of referral unless referent identifies needs as more urgent.
- The Older Adult Substance Use program is required to meet the following performance commitments (PC):
    - PC #1: 42 seniors and disabled clients with substance use challenges receive in-home client evaluation, counseling, and develop treatment plans.

  - PC #2 The Substance Use Disorder Professional (SUDP) provides 35 consultation sessions (each of 6 case management agency locations quarterly and an additional consultation session per case management agency as requested) to professionals and case managers on substance abuse issues, assessment, and care planning.
  - PC #3: 2.0 FTE Substance Use Disorder Professional (SUDP) provides substance use disorder services to people 60 years of age and older and Title XIX ADS & sub-contracted agency case management clients 18 years of age and older for 12 months.
- The Provider notifies Behavioral Health and Recovery Division (BHRD) of all staff changes affecting the program within seven (7) days of the resignation, firing or any other change. A plan for replacing the staff person including a timeline is submitted within fourteen (14) days of the resignation, firing or any other change. This includes the names of the staff involved in and/or impacted by staff changes.
- The Provider maintains timely and accurate records which reflect service levels, participant characteristics, specific actions taken to assist participants, service outcomes, and expenditures.
- The Provider does not require individuals who are eligible for services to participate in other services, activities, or programs as a prerequisite to receiving services, including, but not limited to religious activities.
- The Provider provides information and referral to other appropriate agencies if clients cannot be served by the Provider.
- The Provider identifies the services as funded by the City of Seattle Human Services Department and Aging and Disability Services, the local Area Agency on Aging for Seattle-King County, in all communication with members of the public and recipients of services. The Provider also posts a notice to this effect in a prominent place at each Provider location where such services are provided.
- The Provider develops, implements, and maintains a tool to determine client satisfaction with contract funded services.
- Program Personnel Qualifications/Staffing Expectations a. Staffing levels are maintained at a 1.0 FTE b. Qualifications for the 1.0 FTE substance use disorder counselor: i. Certified as a Substance Use Disorder Professional (SUDP); and ii. Geriatric experience preferred.
- The Provider conducts comprehensive in-home client evaluations, provides ongoing counseling, refers clients to appropriate community resources and medical care, increases socialization and, in most cases, develops an individually tailored plan for each client. The SUDP uses a variety of approaches to build rapport with clients to place necessary resources in the home. When appropriate, arranges for a psychiatrist to evaluate the client. B. Facilitates case staffing, makes care and treatment recommendations to ADS and sub-contracted agency case managers. C. Provides research and develops substance use resources, provides informal training and consults with professionals from community agencies (including the ADS & subcontracted agency Case Managers) on substance use issues, assessment, and care planning. D. Reviews medications and treatment plans with a psychiatrist and makes recommendations to prescribing physician when appropriate.
- Communication with ADS Case Manager: The substance use disorder counselor communicates or corresponds with the ADS or subcontracted agency Case Manager as follows: a. To confirm receipt of referral within 3 business days. B. When the initial home visit is scheduled or if unable to contact the client after three (3) attempts. C. If the client declines services. D. To provide a six-month individual services plan. E. If any significant events arise with the client. F. When services with the client have been terminated.

- The Provider maintains compliance with all Washington statutory and case law pertaining to adult protective services.
- The Provider operates under the principle of the least restrictive alternative to promote the older person's control and independence to the greatest extent possible.
- To ensure quality provision and coordination of services, the Provider informs BHRD and ADS of any changes in program service capacity.
- The Provider coordinates regularly with ADS Program Specialist and ADS case management team to ensure effectiveness of services.
- Consultant and evaluation services provided by the Contract include:
    - Outreach, engagement, and treatment services to clients.
    - In-Home Evaluations/Counseling: A comprehensive level of functioning and substance use disorder assessment is completed in the residences of the referred adults. Documentation becomes part of the client's permanent, confidential client record. The evaluation should include a narrative summary, diagnostic impression, and therapy goals.
    - Referrals to appropriate community resources, treatment, and medical care as needed.
    - Care Planning and Consulting: Develop an individual service plan for each client using a variety of approaches to build rapport with clients, provide a variety of resources, and increase socialization. When appropriate, the SUDP arranges for a psychiatrist to evaluate the clients.
    - Case Staffing: The SUDP participates in case staffing, make care planning and treatment recommendations to ADS and ADS subcontracted agency case managers, and review medications and treatment plans with the psychiatrist, making recommendations when appropriate. Staffings may occur in person or remotely using Skype or other teleconference technology.
    - Development of Substance Use Resources: The SUDP researches substance use resources and provide feedback to professional team members and ADS and subcontracted agency case managers regarding available community services.
    - Communicate with the client's physician regarding medical issues and medication review or recommendations.

- Expert consultation regarding SUD and geriatric mental health issues with ADS & ADS subcontracted agency case managers so that case managers within the Area Agency on Aging (AAA) have received a consult opportunity every quarter. Consultations may occur in person or remotely using Skype or other teleconference technology.

Older Adult Substance Use Eligibility Criteria	
Medicaid Status	Yes
Age Range	60 years of age or older or Medicaid Title XIX Case Management Core clients, defined as 18 years of age or older, financially and functionally eligible for Medicaid Personal Care, Community First Choice, COPES, New Freedom, or Roads to Community Living services.
Authorization Needed	Yes
Additional Criteria	Individuals must be in need of substance use disorder services and agree to services. Individuals must reside in King County.
Older Adult Substance Use Reporting Requirements	
Monthly Reports	• Older Adult SUD FTE Report • Older Adult SUD Performance Report
Semi-annual Reports	• Older Adult SUD Narrative Report regarding program challenges and successes

10.22 Mental Health First Aid

A program designed to increase the number of people in the community trained in Mental Health First Aid (MHFA) in order to reduce the stigma associated with behavioral health disorders and connect individuals with services before they reach a crisis. Trainings are provided for a variety of groups and populations including, but not limited to the public, peers, behavioral health workforce, and other private and public organizations. The MHFA program is operated by the MHFA Coordinator.

The MHFA Coordinator is responsible for scheduling and managing a combination of direct MHFA trainings and train-the-trainer courses determined by community capacity and interest and working with the Behavioral Health and Recovery Division (BHRD) Project Manager to determine target groups for trainings; identify a pool of individuals interested in becoming trainers; determine where and when MHFA courses should occur, what administrative support is required, and how to reach populations that may benefit most; and track budget expenses.

The MHFA Coordinator also facilitates instructor learning collaborations, coordinates with existing community efforts, works to create a sustainable model in King County, conducts outreach, identifies areas of strengthening the delivery of the curriculum(s), including cultural adaptability and inclusiveness, works with state and local partners to implement programs and advocacy work to shape public policy, and coordinates and plans an annual statewide MHFA instructor summit.

Mental Health First Aid Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
Mental Health First Aid Reporting Requirements	
Monthly Reports	• Mental Health First Aid FTE Report that lists total payroll hours and days worked. • Mental Health First Aid Performance Report.

10.23 Peer Bridger Program

The Peer Bridger programs provide transitional support for adult individuals who have been hospitalized psychiatrically at Navos and Harborview. Teams of certified peer specialists (paid staff who have lived experience with behavioral health issues themselves) work in coordination with the inpatient treatment teams to identify individuals in need of this support, and to develop individualized plans to promote each person's successful transition to the community. Peer Bridgers work with individuals for up to 90 days after discharge. Services after discharge are numerous and focus on establishing outpatient care and problem solving many life challenges in the community.

RR-11a *Peer Bridger Program*	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	King County resident hospitalized psychiatrically at Navos and Harborview
RR-11a *Peer Bridger Program Reporting Requirements*	
Monthly Reports	• Peer Bridger Program FTE Report • Peer Bridger Program Voucher Report

10.24 Rapid Re-housing

The provision of housing services to eligible King County residents. Services are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative RR-04 Rapid Re-housing Oxford House Model. Eligible individuals for this exhibit are homeless King County residents who are applying to live in a King County Oxford House and have not lived in an Oxford House for the previous 12 months. Priority for this work is given to people who are enrolled and participating in an outpatient benefit with a King County contracted Provider and completing substance use disorder residential treatment.

Oxford House has two full time employees (FTEs) fully dedicated to King County residents and King County Oxford House, ensuring collaboration with Behavioral Health and Recovery Division (BHRD) and ICN partners. One FTE provides engagement to eligible individuals and support while they transition into and live in King County Oxford Houses. This includes determining and communicating a method for Providers to refer people for funding assistance, assuring each individual meets program eligibility criteria, tracking each individual by month to certify they are living in a King County Oxford House and working with individuals to address barriers to housing retention. The second FTE helps increase the housing stock available to individuals served in the Rapid Re-housing program by adding new properties.

Each eligible individual accepted into the program receives up to four months of housing and personal support at $800 per month while actively working on a plan to ensure continued housing and personal expenses are available once the four months ends.

RR-04 *Rapid Re-housing Oxford House Model Eligibility Criteria*	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	King County resident living in a King County Oxford House
RR-04 *Rapid Re-housing Oxford House Model Reporting Requirements*	
Monthly Reports	• Rapid Re-Housing FTE Report • Rapid Re-Housing Report
Annual/Other Reports	MIDD Evaluation Plan

10.25 Recovery Café

Recovery Café provides for the development of a new Recovery Café location, including the recruitment of staff and securing the lease for, and initiating the renovation of, the new location. Services provided under this scope are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative RR 09 – New Recovery café.

Recovery Café proceeds with activities toward implementing the new Recovery Café, including, securing the lease for the new location, determining, and beginning the implementation of the building renovation plan and recruiting/hiring program leadership staff and program staff.

Recovery Café ensures that it is reviewing its architectural and construction plans with, and complying with, the regulating agencies and jurisdictions related to the building site and renovations for the new location.

Recovery Cafe expends funds from the construction fund to support the expenditures of securing and maintaining the building lease and of preparing for demolition and construction. Recovery Cafe spends

funds according to the start-up plan for the operations fund to support the expenditures of salary and benefits for staff, direct administrative costs, and indirect costs.

Except as otherwise provided herein, Recovery Cafe will not assign any portion of its rights or responsibilities under this Contract or transfer or assign any claim arising pursuant to this Contract, without the prior written consent of the County. No less than 60 days in advance of a proposed assignment, Recovery Cafe will deliver to the County its request for consent to any such assignment, which will include information regarding the proposed assignee's mission, legal status, and qualifications to manage and operate the premises and to ensure provision of the same level of services. Within 15 days after such request for consent assignment, the County may request additional information reasonably available to Recovery Cafe about the proposed assignee. The County reserves the right to approve Recovery Cafe's proposed assignee or to conduct a selection process before approving an assignee. Any assignment without prior written consent by the County will be void.

RR 09 – *Recovery Café*	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
RR 09 – *Recovery Café*	
Monthly Reports	Recovery Café Development Monthly Costs
Annual/Other Reports	MIDD Evaluation Plan

10.26 Reentry Case Management Services

The Reentry Care Management Team provides comprehensive transitional reentry case management services to adults transitioning out of the suburban jails in South and East King County and supporting reentry from the Maleng Regional Justice Center. The team focuses on providing integrated services to adults who are experiencing behavioral health challenges (mental health and/or co-occurring substance use), need an intensive level of community-based support, and may be experiencing homelessness.

Reentry services works with adults who are transitioning out of a suburban jail in South and East King County and/or:

- Are not actively engaged in another behavioral health program;
- Require transitional support to maintain community connections;
- Are experiencing homelessness;
- Are cycling through the jails.

RCMS is an intensive, flexible, community-based team that works to connect individuals to behavioral health treatment, primary health care, and any other services that can assist with skill development. Services provided will approach center around the participants' self-determination and individual recovery goals. Additionally, RCMS provides ongoing coordination with criminal justice system partners in order to support reentry and reduce incarceration and crisis system utilization.

All Reentry services will work to assist an individual through identified goals for up to 180 days that could include:

- Linkage to all social services including behavioral health and primary care
- Outreach and harm reduction-based care coordination
- Housing and housing stability focus
- Veterans Services (if qualifies)

Reentry Case Management Services Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals who meet the above eligibility and will not be transferred to a Washington State Department of Corrections (DOC) facility or out-of-county facility.
Reentry Case Management Services Program Reporting Requirements	
Monthly Reports	Reentry Case Management Staffing Report
Annual/Other Reports	• Minimum of two case studies or individual vignettes describing the participant's background, treatment and outcomes. • Any other requested reports by the County.

10.27 South King County Pretrial Services

This scope of work provides the behavioral health services component of a new court-ordered pretrial services program in South King County that connect eligible adult felony pretrial defendants with secure linkages to substance use disorder (SUD) and mental health services, public benefits, and educational and vocational resources incorporating a validated needs assessment tool. Behavioral health services offered through this program are culturally responsive, emphasize harm reduction, and utilize a trauma-informed, modified Therapeutic Community (TC) approach in order to address criminogenic risk factors. This scope of work is funded by Mental Illness and Drug Dependency *(MIDD) Behavioral Health Sales Tax Fund Initiative RR – 15.*

South King County Pretrial Services differs from King County's existing Community Center for Alternatives Program (CCAP) in that this program aims to utilize a trauma-informed and person-centered human services versus a corrections approach as reflected by the following programmatic elements:

- Services are sited at an outpatient behavioral health facility with trauma-informed modifications to on-site security features
- Pilot participants are not required to remain at the facility all day; rather, they only attend sessions and groups identified in their individualized service plan and weekly schedule
- Positive urinalysis (UA) tests do not result in remand to jail if the participant continues to show up and engage in services (multiple positive UAs may result in a court sanction); [NOTE: A revision to the Superior Court Conditions of Conduct Order may be required.]
- Behavioral health team works collaboratively with DAJD employed caseworkers to develop and monitor an integrated case plan that:
    - Based on on-site assessment, connects individuals with the appropriate substance use disorder, mental health, or co-occurring services.
    - Reinforces any preexisting connections to community-based case management, care coordination, or intensive behavioral health services the participant may have (e.g. LEAD, PACT).

- Provides a comprehensive discharge plan that supports the participant in their transition from court-ordered to voluntary, community-based services.

South King County Pretrial Services Eligibility Criteria	
Medicaid Status	Yes and No
Age Range	Adults Age 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Pre-Treatment, Screening and Assessment: Adjudicated and pre-trial adults who are ordered by King County Superior Court to report to South King County Pretrial Services; • SUD Outpatient Services: South King County pretrial services participants who meet medical necessity for outpatient or intensive outpatient (IOP) treatment services; and • Mental Health Outpatient Services: South King County pretrial services participants who are assessed as appropriate and eligible for a Mental Health Outpatient Benefit as described in the Medicaid State Plan.
South King County Pretrial Services Reporting Requirements	
Monthly Reports	• South KC Pretrial Staffing Report • South KC Pretrial Flex Fund Expenditures Report • South KC Pretrial Subsidized Client Report • South KC Pretrial Treatment Services Denial Report
Quarterly Reports	As requested by DCHS Evaluator or PSB Investment Monitor
Semi-annual Reports	As requested by DCHS Evaluator or PSB Investment Monitor
Annual/Other Reports	• South KC Pretrial Annual Outcome Report which describes the activities, successes, and challenges of the program and a summary of the accomplishment of outcomes/goals of the program • Any additional reporting needed for compliance with MIDD Evaluation Plan, and PME Plan.

10.28 Clubhouse Services

Individuals enrolled in Behavioral Health and Recovery Division (BHRD) programs are eligible for Clubhouse services. Clubhouse services are available to eligible adults who are interested in participating in the Clubhouse as a way to pursue work. The Clubhouse is a community intentionally organized to support individuals living with the effects of mental illness and certified by the International Center for Clubhouse Development (ICCD). Through participation in a Clubhouse, members are given the opportunities to rejoin the worlds of friendships, family, important work, employment, education, and to access the services and supports they may individually need. A Clubhouse is a restorative environment for people who have had their lives drastically disrupted and need the support of others who believe that recovery from mental illness is possible for all.

The Provider operates the Clubhouse according to the ICCD Clubhouse Standards and meets state certification requirements per Washington Administrative Code (WAC) 246-341-0730 through 246-341-0736 or its successors. During hours of operation, the Clubhouse is available on a drop-in basis to provide a work-ordered day, TE services, supported employment services, independent employment services, supports, and help to any member. The Provider coordinates services with the Outpatient

Benefit holder as needed to ensure effective and efficient service provision. The Provider sends a monthly progress note to the Outpatient Benefit holder, containing a summary of consumer activities at the Clubhouse and that records their days of attendance.
Individuals receiving Medicaid are also eligible to receive Day Support Services within the Clubhouse model. These services must adhere to all relevant and appropriate Medicaid requirements. Day Support Services are described in the Medicaid State Plan Attachment 3

Clubhouse Services (Hero House NW) Eligibility Criteria	
Medicaid Status	No for Clubhouse Services, Yes for Day Support Services within the Clubhouse model
Age Range	18 and older
Authorization Needed	No
Additional Criteria	For Clubhouse Services, clients must be receiving outpatient and/or residential services. Clients may self-refer, but the Clubhouse may only request reimbursement if services are within the context of ongoing collaboration with the outpatient and/or residential treatment Provider. Clubhouse services must be deemed medically necessary as evidenced by assessment and diagnosis conducted by the outpatient and/or residential treatment Provider. For Day Support Services, it is not required that a client is receiving outpatient and/or residential services. Day Support Services must be deemed medically necessary as evidenced by assessment and diagnosis conducted by the Clubhouse.
Clubhouse Services (Hero House NW) Reporting Requirements	
Monthly Reports	Clubhouse Census Log

10.29 Sexual Assault Behavioral Health Services

Co-locates Mental Health Professional (MHP) staff with expertise in sexual assault and substance abuse within a Community Sexual Assault Program (CSAP) to provide brief behavioral health treatment, referral and supports for sexual assault survivors served by the organization. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-09 – *Sexual Assault and Behavioral Health Services* as outlined in the MIDD initiative description: PRI-09 Description.

SA-BH Services programs include:

- Services provided by Mental Health Professional (MHP) staff with expertise in sexual assault and substance abuse.
- Clinical supervision for MHP staff to ensure services are in compliance with the Washington Administrative Code (WAC) for behavioral health services and relevant mental health practice standards.
- Initial screening for sexual assault (SA) survivors using a standardized measure to identify potential behavioral health concerns.
- Behavioral health services including:
    - Assessment to identify individual's specific behavioral health needs and the types of interventions to address those needs.

  - Evidence-based trauma-focused therapy for those children, teen, and adult survivors of sexual assault who would benefit from the therapy.
  - Culturally relevant services to sexual assault survivors from immigrant and refugee communities in their own language.
  - Sexual assault-specific advocacy services on behalf of survivors until they are able to act on their own behalf.
  - Referrals to behavioral health treatment providers for individuals who need more intensive services.
- Completion of client outcome measures at baseline and at least one repeated measure during the treatment process.
- Developing collaborative relationships with behavioral health treatment providers to facilitate referrals for individuals who need more intensive treatment services.
- Consultation for community behavioral health or domestic violence agencies to ensure behavioral health treatment that addresses the specific trauma of sexual assault and/or specific consultation on complex cases.
- Collaboration with the System Coordinator to promote cross-systems training among the domestic violence, sexual assault and behavioral health treatment systems including training on evidence-based practices for use with sexual assault survivors who are diagnosed with posttraumatic stress disorder and/or depressive/anxiety disorders.
- Providing monthly data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan: MIDD Evaluation Plan for initiative PRI-09.

Sexual Assault Behavioral Health (SA-BH) Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth or adults (no age restrictions) who identify as sexual assault survivors
Authorization Needed	No
Additional Criteria	Must have no other source of payment for services (i.e. does not have Medicaid, other insurance, etc.)
Sexual Assault Behavioral Health (SA-BH) Services Reporting Requirements	
Monthly Reports	SA-BH Service Summary, Monthly client data submission through CORE
Annual/Other Reports	SA-BH Annual Outcomes Report

10.30 Substance Use Disorder Peer Recovery Services

Substance use disorder (SUD) peer recovery services are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative *PR-11b– Peer Support.* This funding integrates SUD peer recovery services within recovery community organizations that are not certified/licensed to provide SUD treatment services.

Contracted agencies provide 1.0 full-time equivalent (FTE) peer recovery coaches. Duties include training and supervising peer recovery coaches to provide recovery services which include, but are not limited to peer mentoring or coaching, recovery groups or circles, recovery resource connecting and building community. The FTE refers people to support services in the community as needed. Each

individual served has a record established that records items such as screenings, documentation of services and any program agreements such as recovery plans.

Substance Use Disorder Peer Recovery Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years or older
Authorization Needed	No
Additional Criteria	• Meet the standards for low-income individual's eligibility. • Individuals are amenable to and requesting peer recovery services.
Substance Use Disorder Peer Recovery Services Reporting Requirements	
Monthly Reports	SUD Peer Recovery Services FTE Report
Annual/Other Reports	MIDD Evaluation Plan

10.31 Youth Connection Services

This program provides behavioral health supports and prevention services to youth experiencing homelessness or who, as a result of being disconnected from their families, have come into contact with law enforcement, the juvenile justice system and/or have been identified through at-risk youth or truancy petitions. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-02 – *Youth and Young Adult Homelessness* and CD-16 – *Youth Respite Alternatives.*

Youth Connection Services is a collaborative approach to serving youth and families and diverting them from law enforcement and juvenile justice involvement. A youth respite drop-in facility works in conjunction with youth peer and parent peer services provided by the Children's Crisis Outreach Response System (CCORS). Once a referral is made, Crisis Connections determines the level of need and dispatches CCORS staff as either an emergent or non-emergent outreach. For an emergent outreach, the outreach team responds within 2 hours to provide face-to-face crisis stabilization services at the site of concern on a no-decline basis. The program also ensures that children or youth receiving a crisis response receives continuity of service through connecting with relevant ongoing community-based services. For a non-emergent outreach, a youth peer or parent peer is dispatched to work with the youth and/or the youth's family to facilitate continued community-based service.

- Goals of this program:
  - Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals.
  - Increase the safety of youth who are facing crisis situations.
  - Increase use of community alternatives to hospitalization and incarceration.
- Objectives of this program:
  - To support youth who have had initial contact with the criminal justice system or other high-risk activity.
  - To divert youth from more significant criminal justice involvement.
  - To ensure culturally responsive and trauma-informed services that address the needs of youth and their family members.

- Support law enforcement in their ability to provide appropriate referral for services to youth who may benefit from behavioral health treatment, coping skills and support resources.

Youth Connection Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	12-18 years old
Authorization Needed	No
Additional Criteria	Non-Emergent Outreach (NEO) Any child or youth ages three through 17, or person acting on their behalf, in King County, who are presenting with high risk factors including but not limited to: • Criminal activity; • Truancy; • Family conflict; • Homelessness or at-risk of homelessness; • Gang involvement/association; or • Substance use or abuse behaviors Referrals may come from anywhere, but priority is given to youth referred by law enforcement personnel in Auburn, Federal Way and Kent. Service Area: encompasses King County geographic areas including the following cities and zip codes **Auburn** (98001, 98002, 98071, 98092), **Federal Way** (98003, 98023, 98063, 98093) and **Kent** (98030, 98031, 98032, 98035, 98042, 98064, 98089).
Youth Connection Services Reporting Requirements	
Monthly Reports	Youth Connection Services Service/System Coordination Summary
Annual/Other Reports	Youth Connection Annual Report including: • A description of the activities, successes and challenges of the program; and • A summary of the accomplishment of outcomes/goals of the program.

10.32 SBIRT – Emergency Department Services

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders (SAMHSA, 2017). Administered to patients who have presented themselves to the emergency department, SBIRT Clinicians utilize validated screening measures to quickly assess severity of substance use, and as indicated, initiate a brief intervention which may or may not be followed by referral to treatment.

Components of SBIRT Clinical Practice

SBIRT consists of three components that are delivered according to the spirit, skills, and strategies of Motivational Interviewing. *Screening* is defined as using a validated tool that quickly assesses the severity of an individual's substance use to guide the level of intervention. Providers are to use the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) Plus 2. In the event that administering the screening tool is not clinically indicated, the SBIRT Clinician may proceed to the Brief Intervention. An example of this occurs when the individual presents with a clear need for substance

use disorder treatment. Deciding not to screen should be a rare occurrence and based on clinical justification for altering the practice.

The next component in SBIRT is conducting the *Brief Intervention* according the individual's needs. The general goal of the brief intervention is to guide individuals through considering the impacts of substance use on their physical and behavioral health and motivating behavior change. The essential elements are (a) exploring feedback about substance use, (b) eliciting the individual's thoughts on what they might be willing to change, (c) enhancing self-efficacy and commitment to change, (d) supporting the individual by understanding their perspective and drawing upon natural strengths and supports, and (e) negotiating a change plan with follow up. The brief intervention may be focused on harm reduction or treatment options, depending on the individual's goals, values, and culture.

The final component in SBIRT is *Referral to Treatment*. Based on the individual's needs, the SBIRT Clinician may provide referrals to the continuum of substance use disorder treatment such as withdrawal management, brief therapy, outpatient treatment, or inpatient treatment. As mental health conditions often co-occur with alcohol and drug use, an individual may benefit from co-occurring disorder treatment. Referrals to culturally appropriate and trauma-informed community resources are encouraged as there are many pathways to recovery.

Brief Therapy (BT) is available at one site for individuals who may benefit from short-term treatment. Generally limited to 5-12 sessions, it is a systematic focused process that relies on assessment, patient engagement, and rapid implementation of change strategies. SBIRT Clinicians may provide a "warm handoff" from one provider to another to build on the motivation created during an SBIRT service.

Qualified Personnel

The Provider has one or more SBIRT Clinicians to implement SBIRT in accordance with funding stipulations. SBIRT Clinicians have at least one of the following clinical licensures/certifications as described in the Washington Administrative Code: (a) Substance Use Disorder Professional, (b) Mental Health Counselor, (c) Marriage and Family Therapist, (d) Social Worker. Additionally, they (a) have experience working with individuals who may have mental health and/or substance use disorders (SUD), (b) have completed agency-approved SBIRT training, (c) are able to use validated screening tools such as the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) Plus 2, and (d) have skills in Motivational Interviewing to facilitate effective brief interventions and referrals to treatment.

The Provider has a SBIRT Implementation Lead in accordance with funding stipulations. The SBIRT Implementation Lead has (a) expertise in hospital operations, systems, and workflow; (b) skills in facilitating change management; and (c) the ability to engage leadership support. Lastly, the Implementation Lead ensures participation by themselves, SBIRT Clinicians, and other identified personnel in quality improvement efforts as scheduled by the County, such as learning collaborative sessions and requests for information.

Payment Models

Providers are paid according to one of two structures as arranged with the County: the FTE-based model or the deliverables-based model. In the FTE-based model, providers are paid monthly per FTE according to funding stipulations on the invoice. In the deliverables-based model, the provider is paid monthly at a rate arranged with the County for implementing the activities listed in the SBIRT-EDS Deliverables table.

SBIRT-EDS DELIVERABLES	METHOD OF MONITORING AND DUE DATES
1. Provision of screening and referral to treatment services by qualified personnel as described in the BHRD Provider Manual as part of the SBIRT model utilizing AUDIT-C Plus 2 with client level data collected and according to the MIDD Performance, Measurement, and Evaluation (PME) Plan	**Quarterly CORE submissions <u>due no later than</u>:** **Q1 (Jan-Mar) by 04 14 2023** **Q2 (Apr-Jun) by 07 14 2023** **Q3 (Jul-Sept) by 10 16 2023** **Q4 (Oct-Dec) by 01 16 2024**
2. Coordination with ED Social Workers and other professionals as needed to further efforts toward universal screening in the ED, such as offering training on effective SBIRT service delivery and clinical consultation.	**Annual Overall ED Admissions Demographic Report due no later than Jan 31, 2024 via email**
3. Continue to expand delivery of culturally appropriate and trauma informed SBIRT services (e.g., staff training, in-services, connections with community organizations, adapting practices, language accessibility)	Monthly Narrative Report described in #5
4. Participate in the SBIRT-ED Learning Collaborative in an effort to (a) support continuous quality improvement in SBIRT-ED delivery; (b) integrate new advances in the field of SBIRT into local practice, and (c) enhance the clinical skills of SBIRT providers in King County emergency departments.	Quarterly as scheduled
5. Monthly Narrative Report	**For January through November, the Monthly Narrative Report is due no later than the 15th following the end of the service month.** **The December service month report is due on January 10, 2024.**

SBIRT-EDS Eligibility Criteria	
Medicaid Status	N/A
Age Range	As clinically appropriate
Authorization Needed	No
Additional Criteria	Individuals who present at the emergency department for medical attention
SBIRT-EDS Reporting Requirements	
Monthly Reports	For FTE-based payment model: • SBIRT-EDS FTE Report For the deliverables-based payment model: • SBIRT-EDS Monthly Narrative Report
Annual/Other Reports	For both payment models: • Provide specific information about the initiative for the MIDD Annual Report as requested by the County. • Annual Overall ED Admissions Demographic Report due no later than Jan 31, 2024 via email

10.33 School-Based SBIRT

School-Based Screening and Brief Intervention and Referral To Services (SB-SBIRT) seeks to promote mental health and prevent substance use among middle and high school students (age 10-24). Schools and their community partners collaborate to offer SB-SBIRT during the school day, which also assures that additional supportive adults are available to students within their schools and community. This screening provides a snapshot of students' immediate needs, allowing the program to focus on prevention through a semi-structured brief intervention model to facilitate access to relevant services and supports which may include treatment.

The Provider supports and collaborates with their identified middle and high schools to conduct screening for identified students using the Check Yourself screening tool, conducting brief interventions with students through reinforcing existing strengths, and provide students with referrals and follow-up as needed. They also engage parents/caregivers to participate in individual/family brief interventions or parent group sessions. Program staff attend and participate in a monthly learning collaborative with-in but not limited to their group, as well as quarterly in-person meetings to discuss the progress of the program.

The Provider:

- Supports and collaborates with their identified middle and/or high schools to create an SB-SBIRT workflow attending to each tiered level of support.
- Supports and collaborates with their identified middle and/or high schools to complete a universal screen for (at minimum) one full classroom and/or grade as negotiated with the SB-SBIRT Manager using the Check Yourself web-based tool.
- Supports and collaborates with their identified middle and/or high schools to conduct brief interventions with students utilizing the SB-SBIRT model.
- Supports and collaborates with their identified middle and/or high schools to engage with parents/caregivers to participate in individual/family brief interventions or parent group sessions.
- Supports and collaborates with their identified middle and/or high schools to provide students with individualized referrals and follow-up as needed.

- Supports and collaborates with their identified middle and/or high schools to:
- Map and update a comprehensive referral network;
- Identify school staff or an outside partner to coordinate SB-SBIRT within each school building; and
- Set clear expectations including the clarification of roles and responsibilities to create a sustainable system.
- Ensures participating middle and/or high school SB-SBIRT practitioners and/or school counselors have access, attend, and participate in:
- The annual SBIRT Institute;
- The Middle and/or High School Learning Collaborative (every other month, or monthly respectively), where staff can brainstorm and address questions or concerns regarding implementation in the school building and information about the program can be disseminated regularly; and
- Other grant related trainings such as Motivational Interviewing to support in implementation of the SB SBIRT model.
- Identifies and assigns an SB-SBIRT district lead (or designee) to participate in:
- The annual SBIRT Institute;
- The Evaluation and Implementation Workgroup meetings three times a year to collaborate with participating districts regarding the progress of the evaluation and implementation activities, and
- The Data & Quality Assurance Workgroup to support districts in make sure their data is accurate, does not contain any student identifiable information and how data can be shared responsibly out with interested communities and partners.
- Reviews, develops and/or updates existing school planning, policies, and procedures that address suicide prevention, intervention and post-intervention consistent with the Washington State Youth Suicide Prevention Plan.
- Supports and collaborates with their identified middle and/or high schools to notify the County of all staff changes affecting the program within five business days of the resignation, termination, or any other change. A plan for replacing the staff person is submitted to the County within seven business days of the resignation, firing, or any other change. This plan includes timelines for replacing the staff person.
- Ensures identified middle and/or high schools available for onsite visit by the county if necessary and the on-site visit is held at the Provider's facility and/or service location for the purpose of observing the program and monitoring contract compliance.
- Maintains accountability for any services delegated to subcontractors.

The role of the SBIRT Interventionist is to:

- Provide liaison, information and referral, and collaboration with community-based organizations, school counselors and other resources;
- Provide consultation and make referrals regarding informal supportive services as needed;
- Assist with service connection, follow-up and documentation; and
- Maintain screening and brief intervention records within the web-based platform approved by the School District and County.

Evaluation Requirements:

Best Starts for Kids (BSK) and MIDD Behavioral Health Sales Tax are committed to being able to tell communities and stakeholders what happened as a result of this funding. The Provider names a person who leads evaluation activities for this contract. The Provider and the BSK Evaluation Team work collaboratively to track the strengths and challenges of implementing funded activities. The evaluation protocol and set of performance measures for the activities are co-developed and is intended to give Provider and BSK/MIDD leadership with useful information for decision-making, planning and program management.

- Engage in evaluation activities, including:
- Dedicate 10 percent of the award for evaluation into program staff time;
- Identify and assign an SBIRT district lead (or designee) to participate in scheduled Evaluation and Implementation Workgroup meetings to collaborate with participating districts regarding the progress of the evaluation and implementation activities.
- Establish and maintain data sharing agreement(s) to ensure collaboration and transmittal of data with King County and their provider(s);
- Participate in activities to support evaluation and learning which may include group meetings to share learning with other providers working on similar strategies, assistance with recruiting teens/parents for their feedback, or administration of surveys for evaluation data collection; and
- Provide additional data or information to King County staff and/or their evaluation provider(s) outside of the regular reporting schedule to respond to specific requests.
- Evaluation Plan

Work in collaboration with King County staff and/or their evaluation provider(s) to refine an Evaluation Plan during the contracting period. The Evaluation Plan uses a format to be supplied by King County or their Provider(s) and includes, at minimum: performance measures and reporting requirements. At least one of each type of performance measure (below) is included in the final Evaluation Plan. When there are multiple Providers working on a related strategy, the Evaluation Plan also includes at least one strategy-level performance measure.

- Quantity of service provided: How much did we do? *For Example:*
    - Percentage of learning collaborative meetings attended
    - Percentage of learning collaborative meetings attended
    - Number of students opted out by their caregiver
    - Percentage of Youth screened at school
    - Number of youth who received at least 1 brief intervention
    - Number of referrals made by type
- Quality of service provided. How well did we do it? *For Example:*
    - Percentage of Tier 2 and 3 youth who received at least 1 brief intervention
    - Percentage of youth given a referral that connected to services
- Quantity of clients that are better off: Is anyone better off? *For Example:*
    - Percentage of clients with improved health and well-being or with increased skills, knowledge or changed behaviors. For policy, systems, or environment projects, this is usually a narrative description of the change that a Provider has seen as a result of their work

King County is the final arbiter for the Evaluation Plan and any subsequent revisions. The Evaluation Plan is considered final after email confirmation of acceptance is received by both parties.

SB-SBIRT Eligibility Criteria	
Medicaid Status	N/A
Age Range	Ages 10-24
Authorization Needed	No
SB-SBIRT Reporting Requirements	
Monthly Reports	SB-SBIRT Financial Budget Report
Semi-annual Reports	SB-SBIRT Narrative Report SB-SBIRT Report in Tickit Health
Annual/Other Reports	SB-SBIRT Client Satisfaction Survey

10.34 School-Based SBIRT Evaluation

School-Based SBIRT Evaluation is conducted by the Provider for the novel School-Based Screening, Brief Intervention, and Referral To services/treatment; specifically (i) revising the High School (HS) screen and Brief Intervention report following the January-June 2022 pilot phase (ii) conducting a Process Evaluation of the HS SB-SBIRT implementation during its first year throughout the 2022-2023 school year and (iii) providing bi-annual performance measurements and ongoing quality assurance and improvement through the use and reflection of data on the SB-SBIRT Program. The HS pilot activities span through the summer of 2022 while the SB-SBIRT Program activities span until the end of 2025.

Program Specific Requirements

Task	SCRI Role	Evaluation Method	Timeframe
Develop summary of findings and present at the SB: SBIRT Institute	Lead	HS & MS Screening and BI Report Data	September annually
Develop agenda and co-lead the Implementation & Evaluation Workgroup Meetings	Co-lead	District Lead Feedback	3-4 meeting annually
Develop progress reports, performance measures of activities, achievements, challenges, and next steps	Lead	All Program Activities	Due Jan. 15 and July 15 of each evaluation year
Field questions from districts about the evaluation program only concerning data, screen and BI reports, and evaluation methods	Co-Lead with KC Staff	HS & MS Screening and Brief Intervention Reports	Continuous
Presentation consultation regarding evaluation results to King County staff	Assist		Ongoing
Conduct district data quality assurance meetings	Co-Lead w/ KC	CY Screening Data, BI Reports	3x annually

Clean individual district datasets used for data placemats, progress reports, and performance measures	Lead	CY Screening Data, SBIRT Reports	January and June annually
Revise SB-SBIRT Playbook	Lead	All Program Activities	Summer-Fall 2024
Analyze interventionist Motivational Interviewing (MI) competency data	Lead analysis	TBD	By Spring 2024
High School SB-SBIRT Program			
2022-2024			
Collect feedback from the High School Learning Collaborative meetings	Attend	HS CY Workgroup Meetings	1x per month thru 2024
Develop and Implement student follow-up surveys	Lead	HS Student Surveys	Develop: November-December, 2022 Implement: Jan-June, 2023, rolling basis per high school preference
Create Annual Data Placemats-High School	Lead	HS CY Screening Data, HS SB-SBIRT Reports	Year 4 (2021-2022): Send by November 1, 2022 Year 5 (2022-2023): August/September, 2023 Year 6 (2023-2024): August/September, 2024
Send out and collect feedback from high school staff and administrators re: SBIRT Program	Lead	High School Staff Survey	By May-June, 2024
Middle School SB-SBIRT Program			
2022-2024			
Create Annual Data Placements – Middle School	Lead	MS CY Screening Data, MS SB-SBIRT Reports	Year 4: send final copy November 1, 2022 Year 5: August/September, 2023 Year 6: August/September, 2024
Collect feedback from the Middle School Learning Collaborative	Attend	MS CY Workgroup Meetings	3x annually
Develop and Implement caregiver follow-up surveys	Lead	Caregiver Surveys (Post BI)	By March, 2024
Send out and collect feedback from middle school staff and administrators re: SBIRT Program	Lead	Middle School Staff Survey	TBD

Regular Progress Reviews
The Provider has regular email and phone contact and meets with BSK/MIDD staff monthly, or more frequently as needed, to review project status and provide a brief progress report on the agreed workplan. The Provider convenes and facilitates these meetings, including setting up agenda and sending out notes. The first meetings include developing a mutually agreed upon work plan to set deadlines and deliverables. The Provider participates in other BSK/MIDD evaluation meetings, as needed.

Materials Development
The Provider develops all materials necessary to complete the deliverables in this contract. This may include activities such as developing consent forms, surveys, invitations or information about interviews, reports, data visualizations, and data sharing agreements.

Institutional Review Board (IRB) review
The Provider will complete and submit all materials necessary to apply, receive, and maintain Institutional Review Board waiver or approval, as deemed applicable by the relevant IRB.

SB SBIRT Eligibility Criteria	
Medicaid Status	No
Age Range	11-18
Authorization Needed	No
Additional Criteria	Reside in King County
SB SBIRT Reporting Requirements	
Semi-annual Reports	• **SB SBIRT Semi-annual Progress Report:** This report will document and summarize the progress made on the agreed upon workplan over the past 6 months. The report will be delivered in a mutually agreed upon format.
Annual/Other Reports	• Data Placemats for both Middle and High School: • School Year 2022-2023 due September 1, 2023 • School Year 2023-2024 due September 1, 2024 • High School Process Evaluation Report: August 2023 • 2023 Performance Measures: January 2024 • 2024 Performance Measures: January 2025 • SB:SBIRT Playbook Revision Summer 2024

10.35 School-based Screening, Brief Intervention and Referral To Services (SB-SBIRT) – Community Prevention and Wellness Initiative (CPWI) Pilot Partnership

School-Based Screening and Brief Intervention and Referral To Services (SB-SBIRT) – Community Prevention and Wellness Initiative (CPWI) Pilot Partnership is an initiative, supported through Best Starts for Kids (BSK), for the 2019-2020 and 2020-2021 school years in which King County funds the 20% cash match requirement to Puget Sound Educational Service District (PSESD) for each of the following CPWI communities in King County:

- Auburn Prevention Coalition serving Cascade Middle School in Auburn School District
- Coalition for Drug-Free Youth serving Cascade Middle School and Evergreen High Schools in Highline Public Schools
- Healthy Youth Central Area Network serving Washington Middle School in Seattle Public Schools

- Southeast Seattle Prevention Education an Action through Community Empowerment Coalition serving Aki Kurose Middle School in Seattle Public Schools
- Southwest Seattle Prevention Alliance serving Denny International Middle School and Chief Seattle High School in Seattle Public Schools
- Vashon Alliance to Reduce Substance Abuse serving McMurray Middle School and Vashon Island High School in Vashon School District

PSESD is responsible for participating in the SB-SBIRT program, including providing staff to deliver required services. Specifically, PSESD ensures that, in addition to screening students as referenced in the 2019-2020 and 2020-2021 agreements between PSESD and the School District/ Fiscal Agent affiliated with CPWI, Student Assistance Professionals (SAPs) working in CPWI-identified middle schools participate in efforts to screen a minimum of one classroom using the Check Yourself screener, moving toward universal screening.

PSESD staff, including SAPs, work with the school district and identified middle school administration to determine workflow plan for follow up interventions then provide the plan to the Behavioral Health and Recovery Division (BHRD) prior to screening.

SAPs working in CPWI-identified high schools follow PSESD approved work plan, and use the Global Assessment of Identified Needs-Short Screener (GAIN-SS) Reclaiming Futures version.

In addition to all required SAP t233nsures/ meetings, PSESD ensuresg that SAPs in CPWI-identified schools attend SBIRT-related training/ events as required, which may include:

- SBIRT Institute
- Training on the screen and data collection system
- Motivational Interviewing
- Practitioner Workgroup, a hybrid of in-person and web-based monthly learning collaborative sessions
- Other grant related trainings

SB-SBIRT-CPWI Pilot Partnership Eligibility Criteria	
Medicaid Status	N/A
Age Range	10-14 primary focus; 15-18
Authorization Needed	No
Additional Criteria	None
SB-SBIRT-CPWI Pilot Partnership Reporting Requirements	
Monthly Report	Service Data and Budget Report
Quarterly Report	SB-SBIRT Data Report, as requested
Semi-annual Reports	• SB-SBIRT Narrative Report, as requested • SB-SBIRT Report in Tickit Health, as requested
Annual/ Other Reports	• SB-SBIRT Client Satisfaction Survey, as requested • SB-SBIRT Work Flow Plan for Follow Up Interventions

10.36 Supported Employment Program (SEP)

The Supported Employment Program (SEP) provides an evidence-based approach to help people with mental illness obtain and maintain competitive employment in the community. SEP is based on the Individual Placement and Support (IPS) model of care. In accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA), King County Behavioral Health SEP adheres to the eight principles of IPS fidelity as follows:

- **Open to anyone who wants to work.** Enrollment utilizes a principle of "zero exclusion," meaning individuals may not be turned away based on past hospitalizations, psychiatric symptoms, past or current level of functioning, and past work history, including a lack of work history.
- **Focused on competitive employment.** Competitive employment includes:
  - Part-time or full-time;
  - Performed in an integrated work/employment setting (i.e., employees with disabilities work with employees and/or customers without disabilities to the same degree that a person without a disability in the same type of job would experience);
  - Paid at or above the state minimum wage;
  - Open to recruitment by the general public; and
  - Provides the employee with a disability an opportunity to earn the same level of wages and benefits as other employees doing similar work who do not have a disability.
- **Involves rapid job search.** The Vocational Specialist and the participant begin the job search within thirty days of enrollment into the program to demonstrate optimism for the likelihood that the participant will become employed. Emphasis is on directly seeking jobs rather than focusing on pre-employment assessments, internships and trainings.
- **Targeted job development is provided**. Job development and job placement services include placement of a client into a paid integrated employment position. Job placement is accomplished when clients complete their first day of employment as defined by the employer. Job placement services may be appropriate for a client who needs a SEP to assist with job placement activities or to directly perform many aspects of the client's job placement activities such as:
  - Identifying job leads;
  - Conducting job searches;
  - Marketing the client to prospective employers;
  - Assistance with developing effective resumes;
  - Assistance with completing and submitting employment applications;
  - Preparing the client for job interviews;
  - Arranging for job-related disability accommodation needs; and
  - Performing job-creation activities to match a client's skills and abilities to a needed series of tasks as identified by the employer.
  - In addition to job development, job development logs are completed by Vocational Specialists for all face-to-face employer contacts and submitted to the supervisor on a weekly basis. Logged contacts should be limited to face-to-face contacts about potential employment opportunities with business representatives who have hiring authority. Contacts with secretaries, cashiers, security guards, or other employees at a business may be helpful but do not count for this purpose. Telephone and email contacts with a hiring manager do not count, nor do follow-along job support contacts with an employer for a person who is currently employed.

Supervisors should review logs with employment specialists during supervision to determine the quality of employer contacts and to help specialists plan for next steps.

- **Client preferences guide decisions.** An initial vocational assessment/career profile occurs over two to three sessions and is updated with information from subsequent work or work-related experiences. The vocational assessment is completed by SEP staff. It should include information from the mental health treatment team and, with permission, from family members, friends, and past employers. Information is not gathered to determine employability but to determine the type of job and supports that will be required to help ensure successful employment. At a minimum, the initial work-based vocational assessment includes the following information:
  - Employment goals, preferences, and interests of the client;
  - Client strengths and skills;
  - Client experiences including, but not limited to, work and educational background;
  - Client's current adjustment to the community;
  - Personal contacts; and
  - Supports available and needed.
- **Individualized long-term "follow along" supports are provided.** Also referred to as "Extended Support Services," follow along supports include individualized support services provided to employed clients to help ensure job retention. Follow along supports are individualized for each client based upon the job as well as the participant's preferences, needs, strengths, work history, and other relevant factors. These services may be provided by mental health and/or vocational staff on the job site, in the Provider's office, or in the community. Employer support, such as educational information and job accommodations related to a particular client/employee, are acceptable Extended Support Services. Client assistance may include but is not limited to: individual and group vocational counseling, benefits counseling, on-the-job coaching, off-the-job meetings to talk about work and employer supports, facilitating family meetings to discuss the job, help with training on how to travel to the job site, assistance with grooming, coordinating mental health services and treatment changes with mental health staff as they relate to work performance, and social skills training.
- **Integrated with the treatment team.** Vocational specialists include the behavioral health treatment team in applying strategies to engage and support participants including those individuals in the pre-contemplative, job seeking, and employed stages of employment. The treatment team includes but is not limited to psychiatrists, nurse practitioners, therapists, case/care managers, peers, substance use disorder Providers, housing Providers and Providers from other systems as applicable to the needs of the participant.
- **Benefits counseling is included.** Benefits counseling services include services provided to a client by a benefits specialist familiar with Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Social Security Administration (SSA), Medicaid, and Medicare regulations and income limits as they relate to client income. Benefits specialists should also be familiar with work incentives, Medicaid spenddowns, Healthcare for Workers with Disabilities (HWD), food stamps, housing subsidies and childcare benefits. Benefits counseling services are provided prior to a client receiving Division of Vocational Rehabilitation (DVR)-funded services. Services result from a written benefits plan that is updated as needed.
  - Service activities include vocational assessment and counseling; development of individualized job/career plans that include strengths, abilities, preferences, work history and desired outcomes; job development of competitive, integrated jobs in accordance with the career plan; assistance with resume development, interview skills, workplace "soft"/interpersonal skills, job placement and job retention supports; and internal or referral to external benefits counseling.

- Program design and service delivery should adhere to the IPS fidelity scale located here. Programs should strive to maintain an overall "good fidelity" rating (100-110 points in IPS rating scale) and upon request, demonstrate steps taken to improve IPS adherence if the fidelity rating is below "fair fidelity" (74-99 points in IPS rating scale.)

This program is funded by the MIDD Behavioral Health Sales Tax Plan Initiative RR-10- Behavioral Health Employment Services and Supported Employment. A portion of the total funding for SEP consists of a monthly base reimbursement for services. If specific participant level outcomes are achieved incentives-based funding is provided based on availability of funds and in accordance with the SEP Reimbursement Criteria document and its successors. All Providers must have a current Community Rehabilitation Program contract with the Department of Vocational Rehabilitation (DVR), make a timely request for all DVR services, and document the result of the request in order to be eligible for County reimbursement as DVR is the payer of first choice. DVR services include job placements, ninety-day job retentions, and Intensive Training Services. County funds will not duplicate, replace or supplant DVR funding or any other available employment funding including Medicaid funded supported employment through Foundational Community Supports (FCS) or its successors. Individuals receiving FCS supported employment services for less than six months prior to enrollment are not eligible to enroll in King County funded SE services. Further County reimbursement criteria are detailed in the Specialty Employment Program Reimbursement Criteria document and its successors.

Supported Employment Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults aged 18 Years or Older
Authorization Needed	Yes
Additional Criteria	Refer to IPS model of care fidelity scale here
Supported Employment Program Reporting Requirements	
Quarterly Reports	• Supported Employment Program Quarterly Outcomes Report • Supported Employment Program Quarterly Outcomes Supplemental Provider Report (as needed)
Annual/Other Reports	Provide specific information for the MIDD Annual Report as requested by the County.

10.37 Seven Challenges

Seven Challenges® (the Program) is a proprietary, copyrighted, and trademarked psychological mastery counseling program designed to treat adolescents with drug abuse and dependency problems. The Program consists of reading materials, journals, visual aids, group protocols, posters, group psychological approaches, evaluation instruments and models, counseling techniques, a training regimen, know-how, processes, and other technical and non-technical information.

Seven Challenges is responsible for quality assurance and consulting services to professional and staff personnel covered under the King County Behavioral Health and Recovery Division (BHRD) umbrella license, ("Providers") for the purpose of permitting and allowing such Providers to implement and use Seven Challenges in King County programs.

The Providers are responsible for providing Seven Challenges, at no charge, access to information and resources that permit Seven Challenges to accomplish the support described herein. Providers ensure trained clinicians have their own copy of required Seven Challenges materials to include the latest edition of the book entitled *The Seven Challenges*, together with the nine-volume journal set, *The Seven Challenges Manual,* one Seven Challenges poster, and one Working Sessions poster for use during the training and program. Providers participate in quarterly Seven Challenges fidelity and support meetings to include designated Seven Challenges Leaders. The goal of these meetings is to provide ongoing clinical and technical assistance to implement the Seven Challenges model.

Depending on King County funding allocation, the Providers are responsible for ordering required Seven Challenges materials and ensuring relevant staff receive needed Seven Challenges training (Seven Challenges Initial Training, Leader Training, and Refresher Training). Seven Challenges are responsible to coordinate with BHRD staff regarding funding availability then, upon King County approval, will ship Seven Challenges materials to the Providers and deliver the Seven Challenges training sessions.

Seven Challenges Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	Yes
Additional Criteria	Provider personnel covered under the BHRD umbrella license.
Seven Challenges Reporting Requirements	
Monthly Reports	Seven Challenges Monthly Report (including materials purchased and training sessions provided to the Providers).
Annual/Other Reports	Annual Fidelity and Support Meeting Summary for The Seven Challenges agencies, complete with recommendations for improved fidelity and supervision.

10.38 Standard Supportive Housing Rental Assistance

The Provider procures housing units for rental assistance that meet the minimum housing quality standards as established by the Department of Housing and Urban Development (HUD). SSH clients selected for rental assistance have an income at or below 30 percent Area Median Income (AMI) and pay no more than 30 percent of their income for rent and utilities. Rental assistance is used to pay rent for units that are priced no more than 10 percent above the Fair Market Rent (FMR) in King County as established by HUD. Rental assistance does not exceed $9,600 per unit per year, and can only be used for non-refundable deposits, rents, and utilities. The Provider may use rental assistance to hold a vacant unit for up to one month.

When a client graduates from the SSH program, the client is provided permanent subsidized housing. Program policies and procedures describe how SSH rental assistance funds are administered, including the client selection process, income eligibility, unit inspection process, and a process for determining client rent and utility payments. Program staff coordinate with the housing authorities and BHRD to procure additional rental assistance and housing resources.

Standard Supportive Housing (SSH) Rental Assistance Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Clients participating in the Provider's SSH program and meeting the income requirements outlined above are eligible for rental assistance resources.
Standard Supportive Housing (SSH) Rental Assistance Reporting Requirements	
Monthly Reports	Standard Supportive Housing Rental Subsidy Report

10.39 Workforce Development Plan

Training, technical assistance, learning collaborative and leadership services that assist King County in developing and implementing the King County Workforce Development Plan (KCWDP).

These activities are funded by the MIDD Behavioral Health Sales Tax Plan Initiatives #SI-04 *Workforce Development and* #PRI-01*Screening, Brief Intervention, and Referral to Treatment.*

KCWDP Goals:

- Increase culturally appropriate, trauma-informed behavioral health services.
- Increase and retain behavioral health staff.
- Enhance the skill sets of behavioral health staff.
- Increase the adoption of evidence-based practices.

KCWDP Objective:

- To provide training services to County-funded Providers to address current and future workforce system needs as defined in the KCWDP.

Program Requirements include:

- Operate within a trauma-informed, culturally responsive, recovery-oriented framework.

- Manage training logistics including registration, securing venues, catering, and certificates unless other arrangements have been agreed upon by both parties.
- Participate in the development of the KCWDP quarterly training calendar.
- Provide continuing credits for a wide range of clinical staff in the behavioral health and medical fields.
- Engage in quality management activities in collaboration with the Behavioral Health and Recovery Division (BHRD) Program Manager and KCWDP Coordinator. This includes strategies to improve attendance and evaluation feedback if needed, determining future and ongoing workforce development needs, assuring availability of trainings throughout the County, engaging underserved populations, and tailoring training content for a variety of learning styles and audiences utilizing active and receptive instructional activities to effectively teach concepts and skills.
- Coordinate training services with the KCWDP Coordinator.
- Participate in scheduled KCWDP coordination/planning meetings.
- Comply with the MIDD Evaluation Plan and the MIDD and Data Submission Plan:
  - Data are due 15 calendar days after the end of the month for which data are being reported, unless stated otherwise.
  - Non-compliance with evaluation data requirements may result in the withholding of payment for all associated contracted services.
- Deliverables are determined on a quarterly, semi-annual or annual basis with input from each KCWDP Provider that includes Provider-specific training, technical assistance, learning collaborative and/or leadership services that are to be provided.

Workforce Development Plan Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
Workforce Development Plan Reporting Requirements	
Monthly Reports	• Training evaluations and sign-in sheets must be submitted within five business days after a training is provided. • Workforce Development Professional Support Services Report, if applicable.

10.40 Emergency Department Utilization Management (EDUM) Behavioral Health Rapid Response Team

As part of providing Quality Coordinated Outpatient Care within the Mental Illness Drug Dependency (MIDD) strategy SI-03, an Emergency Department Utilization Management (EDUM) initiative has been developed. The goals of the initiative are to: (a) rapidly engage individuals experiencing frequent behavioral health-related ED visits into outpatient behavioral health care, and (b) reduce behavioral health-related avoidable ED visits. Rapid response team interventions are specifically aimed to improve rapid engagement in behavioral healthcare post ED-discharge and community stabilization. A small workgroup with Providers and key hospital and King County Integrated Care Network (KCICN) stakeholders is convened to determine final operational details.

The Provider:

- "Champions" a small workgroup in planning final operational details of the clinical model with support for coordinating the workgroup from KCICN and HMA in late 2018.
- Operates regionally positioned teams on First Hill (coordinating with Harborview, Swedish, Virginia Mason) and South King County (coordinating with St Francis, Multicare, Valley Medical, Highline).
- Forms a care team with funding calculated on the basis of 5.0 FTE staff and 0.50 FTE supervisor. At least one staff member has medical training – i.e., nurse or higher level. The team includes a peer support component.
- Conducts population-based systematic identification of super utilizers of ED in King County and monitors utilization over time using CMT's PreManage system.
- Provides rapid response and care coordination upon notification of a client's ED visit, with EDs, Managed Care Organization care coordinators, and BHAs engaging clients in care.
- Provides evidence-based interventions to reduce high ED use including transitional care, assertive community engagement, motivational interviewing, support (including peer support) for client engagement in treatment.

- Uses measurement-based treatment-to-target with systematic tracking, using a registry, of key outcomes and adjusting care when outcome goals are not achieved.

EDUM Rapid Response Teams Client Eligibility Criteria	
Medicaid Status	Medicaid eligible individuals are prioritized
Age Range	Adults at 18+
Authorization Needed	No
Additional C–iteria	• Are ED super-utilizers - having had 20 or more ED visits within the previous 12 months • Behavioral health disorder cannot be ruled out; and • Are willing to receive this service.
EDUM – Rapid Response Teams Reporting Requirements	

Monthly Reports	• Depending on decisions regarding program design and metrics for bonus payments, the Provider may need to submit monthly reports including, but not limited to the number of individuals who meet eligibility criteria who are: identified, approached, consented and served. The report is in an electronic format approved by the County to the BHRD Secure File Server according to the Secure File Transfer instructions.
	• BHRD develops (in consultation with the Provider) a monthly report that tracks the key metrics for the EDUM initiative:
	  • ED rate per 1000 Medicaid lives reduced
	  • ED utilization for clients served by the rapid response teams
	  • Follow-up after ED for mental Illness (increase within 7 and 30 days)
	  • Follow-up after ED for substance use disorders (increase within 7 and 30 days)

One-time report	The Provider submits a one-time-only report–after six months in operation - providing cumulative statistics for the contract period and a description of program activities, successes and challenges.

10.41 Zero Youth Detention Behavioral Health Pilot Project

Institute for Family Development (IFD) provides behavioral health services for “Becca Bill” (RCW 13.32A) petitioned youth and families identified and referred by Superior Court’s Family Court Services. In alignment with the goals and objectives of Zero Youth Detention (ZYD), this pilot aims to reduce low-level engagement with the juvenile legal system, prolonged system involvement and/or additional Court filings, especially for youth of color, by increasing timely access to evidence-based practices (EBP) and intensive therapeutic interventions such as Functional Family Therapy (FFT), Homebuilders (HB), and Parents and Children Together. The activities included in this scope are funded by the MIDD Behavioral Health Sales Tax Plan Initiative CD-02 Youth Detention Prevention Behavioral Health Engagement.

The Provider ensures that FFT, HB, and Parents and Children Together services are accessible, and meetings are scheduled at times and in locations convenient for enrolled youth and their families/caregivers. Accessibility includes but is not limited to; accommodation of work and school schedules, services provided in homes and/or local communities, and availability of concrete funds to meet basic needs.

The Provider ensures staff operate within a trauma-informed, culturally and racially equitable, and recovery-oriented framework.

Zero Youth Detention Pilot Project Eligibility Criteria	
Medicaid Status	Not Applicable
Age Range	Ages 12-18
Authorization Needed	None
Additional Criteria	Accept referrals solely made by King County Superior Courts Family Court Services
Zero Youth Detention Behavioral Health Pilot Project Reporting Requirements	
Monthly Reports	IFD Service Report

10.42 Wraparound

Wraparound is funded by the MIDD Behavioral Health Sales Tax Plan Initiatives: *CD-15 Wraparound for Youth and Families*.

Wraparound is a team-based planning process for non-Medicaid multi-system involved youth and their families that follows the established guidelines for high fidelity Wraparound. “Wraparound is commonly described as taking place across four phases of effort: Engagement and team preparation, Initial plan development, Implementation, and Transition. During the Wraparound process, a team of people who are relevant to the life of the child or youth (e.g., family members, members of the family’s social support network, service Providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, monitor the efficacy of the plan, and work towards success over time.” A hallmark of the Wraparound process is that it is driven by the perspectives of the family and the child or youth. The plan should reflect their goals and their ideas about what sorts of service and support strategies are most likely to be helpful to them in reaching their goals. For more information please see https://nwi.pdx.edu/

Effective January 1, 2022, there are three (3) agencies contracted to provide this service. Each is responsible to serve at minimum 10 and a maximum of 18 non-Medicaid youth and families at any point in time.

- MIDD Wraparound Providers: Maintains adherence to the NWI standards for providing high fidelity wraparound.
- Maintains staff in the role of coach(s) facilitator(s), parent and/or youth peer(s) in sufficient numbers to serve the minimum caseload.
- Maintains a minimum monthly caseload of 10 clients, with a maximum of 18.
- Records and reports pending, enrolled and discharged clients on a once per month basis to King County staff.
- Enrolls youth found eligible for MIDD Wraparound by King County ASO in accordance with King County procedures.

- Ensures that encounters are reported correctly and in a timely manner.
- Ensures that pertinent staff attend all County convened trainings, consultations and/or meetings for MIDD Wraparound.
- Assists each Child and Family Team with accessing flex funds, when necessary, in accordance with the King County Wraparound Flex Fund Policy.
- Adheres to the procedures for all CLIP referrals and discharges as defined in the Policies and Procedures of the CLIP Administration.

MIDD Wraparound Eligibility Criteria (Non-Medicaid)	
Medicaid Status	N/A
Age Range	0-21
Authorization Needed	Yes
Additional Criteria	• Not eligible for Medicaid • Actively participating in at least 2 of 6 specific child serving systems with a representative able/willing to participate. (Eligible systems include: outpatient mental health, outpatient substance use, Department of Child and Family Services, Juvenile Justice, Special Education, Developmental Disabilities Administration) • Agrees to participate in the program
Wraparound Reporting Requirements	
Monthly Reports	• Wraparound Data Outcome Tool and Caregiver Strain Questionnaire to CORE • Wraparound Monthly Invoice to include a list of KCIDs for clients served in each month • Wraparound Flex Fund Expenditure Report • Wraparound Pending Enrollees & Discharge report due 5th of each month

10.43 Zero Suicide Initiative Pilot Program

The Zero Suicide Initiative Pilot Program (ZSIPP) is a MIDD funded (PRI-06) training and support program for youth-serving medical and behavioral healthcare provider organizations that seek to work toward implementation of the Zero Suicide (ZS) program. The ZS program model is an evidence-based, comprehensive, and operationalized approach to suicide care for patients interacting with medical healthcare and behavioral health systems.[2] Youth-serving medical and behavioral healthcare systems are uniquely positioned to interact with patients for regular check-ups, emergency department visits, and when delivering behavioral healthcare.

Zero Suicide Institute (ZSI), part of the Education Development Center (EDC) provides ZSIPP training and facilitated support meetings for ZSIPP provider organizations.

Program Specific Requirements:

- Provider organization identifies a team of four individuals who fully participate in all ZSIPP activities. One team member is identified as the organization's ZS team lead. Team membership consists of at least one senior leader/manager who is responsible for and with decision making authority (e.g., CEO, COO, Medical Doctor, CIO, ED). Three additional team members are representatives from other areas such as electronic health records (EHR), quality improvement, assurance, risk management, patient care providers (e.g., case manager, psychologist, social worker, nurse, other), patient care supervisors, human resources, or a person with lived experience.
- Provider organization wholly supports the four-person teams to participate in all ZSIPP activities
- Provider organization team assess their organization's suicide care and identify opportunities for improvement by completing the Organizational Self Study (OSS).
- Provider organization team fully participates in ZSIPP activities:
    - One Pre and one Post Zero Suicide Academy (ZSA) meeting(s)
    - Two full 8-hour days ZSA training, and
    - Nine Community of Practice (CoP) learning community meetings, and

[2] The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care - PMC (nih.gov)

- May access coordinated technical assistance to support implementation efforts.

Provider Organization Team Deliverable Tasks	Date & Time	Role
2022		
Organizational Self-Study (Academy Pre-Requisite)	Complete Prior to Academy	Lead
Virtual Pre-Academy Meeting	November 29, 2022 (10 am PST - 11 am PST)	Participant
Virtual King County Zero Suicide Academy Day 1	December 6, , 2022 (8 am PST - 4 pm PST)	Participant
Virtual King County Zero Suicide Academy Day 2	December 7, 2022 (8 am PST - 4 pm PST)	Participant
2023		
Virtual Post-Academy Meeting	January 11, 2023 (10 am PST - 11 am PST)	Participant
Virtual (90-minute) Community of Practice Meeting	(10 am PST – 11:30 am PST) 1. January 24, 2023 2. February 21, 2023 3. March 21, 2023 4. April 25, 2023 5. May 23, 2023 6. June 27, 2023 7. July 25, 2023 8. August 22, 2023 9. September 26, 2023	Participant

Materials Development

Providers complete OSS prior to ZSA and are responsible for all materials necessary to complete deliverables.

Zero Suicide Initiative Pilot Program (ZSIPP) - Eligibility Criteria	
Medicaid Status	No
Age Range	Youth Serving up to age 24
Authorization Needed	No
Additional Criteria	Youth-Serving Medical or Behavioral Healthcare Clinical Service Organization Team membership requirement: one member from senior leadership or management who is responsible for and with decision making authority Four member ZSIPP provider organization team to fully participate in activities
Zero Suicide initiative Pilot Program - Reporting Requirements	
Monthly Reports	ZSIPP Narrative Report

11 Other Locally Funded Programs

11.1 Enhanced Shelter

Recovery Cafe uses the Recovery Cafe site, located at, 4202 6th Ave S, Seattle, WA 98108, as a temporary enhanced shelter with capacity up to 50 individuals. The site is open 24 hours a day, seven days a week. Pioneer Human Services (PHS) staffs the enhanced shelter.

Program Specific Requirements

Recovery Café allows PHS and Department of Community and Human Services (DCHS) staff access, including keys, to the Recovery Café site, allow PHS and DCHS to use up to six (6) parking spaces in the Recovery Café lot, provide all electricity, water and weekly trash collection.

Enhanced Shelter Reporting Requirements	
Monthly Reports	Enhanced Shelter documentation for incidentals (as applicable)

11.2 Evidence Based Practices

Evidence Based Practices provides training and consultation services for ongoing evidence based, emerging, and/or promising practices. This training is offered to service Providers to support individuals with involvement in the criminal legal system.

Evidence Based Practices Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults at 18 Years and Older
Authorization Needed	No
Additional Criteria	None
Evidence Based Practices Reporting Requirements	
Annual/Other Reports	A summary of trainings provided with an assessment of Provider understanding and recommendations of next steps.

11.3 Community Outreach and Advocacy Team (COAT)

The Community Outreach and Advocacy Team (COAT) provides an intensive, multi-disciplinary, community-based behavioral health treatment program as part of the continuum of care for the *Trueblood Phase III* funded services package. *Trueblood* class members are individuals who are now or have a history of waiting in jail for either court-ordered competency evaluation or court-ordered admission for inpatient evaluation or competency restoration services. *Trueblood Phase III* services include LEAD expansion, COAT, respite, and interim housing, specifically for individuals who have a history of using legal competency services or are identified as likely to have legal competency raised in future court proceedings if not for LEAD diversion.

COAT is a behavioral health team ancillary to LEAD, maintains staff to participant ration of no more than 1:20, and provides core behavioral health services as well as transitional and supplemental care coordination, mental health and co-occurring disorder treatment, and basic needs case management for participants who can utilize other outpatient behavioral health services. The team consists of mental health professionals, care coordinators, a psychiatric Provider, a nurse, and an occupational therapist who can provide flexible, intensive, and individualized care to enrolled participants. The COAT program utilizes evidence based and promising practices within a recovery-oriented system including assertive outreach and engagement, Motivational Interviewing, Integrated Dual Disorder Treatment or other co-occurring disorder interventions, a Harm Reduction orientation, Cognitive Behavioral Therapy, Psychiatric Rehabilitation, and Trauma Informed Care.

Crisis Housing Voucher

Crisis Housing Vouchers provide short-term housing to eligible individuals. These residential supports target individuals who are assessed to need more intensive support and stability immediately following a behavioral health crisis and are intended to increase the opportunity for stability while awaiting more permanent housing solutions. Providers administering Crisis Housing Vouchers will find a short-term housing placement, pay for the placement, and refer individuals to community-based supportive housing programs. Follow-up supports will be coordinated and provided by the community-based supportive housing program.

Individuals are eligible for Crisis Housing Vouchers if they are clinically assessed to be experiencing a behavioral health crisis, need supportive housing services, and are experiencing homelessness or are unstably housed. An individual is clinically assessed to be experiencing a behavioral health crisis if they are being referred from a crisis facility or if they have experienced a Crisis Event. A Crisis Event is defined as a period of time of engagement by crisis hourly staff with a person who is experiencing symptoms of a behavioral health disorder which currently outweigh their abilities to tolerate, minimize, or attend to those symptoms or other current circumstances, the person does not appear to meet involuntary detainment criteria under RCW 71.05, and the person is at a higher risk for victimization in the current situation or circumstance if they remain in the current situation or circumstance without respite. Individuals may experience more than one stay at a crisis facility or Crisis Event, therefore, their eligibility if based on the stay or event.

Crisis Housing Vouchers will be dispersed based on the need of the eligible individual. They initially cover a maximum of 14 days, but can be extended an additional 14 days at the discretion of the provider.

Crisis Housing Vouchers are intended to be utilized at:

- **Hotel**- An establishment that provides paid lodging on a short-term basis.
- **Motel**- An establishment that provides lodging and parking and in which the rooms are usually accessible from an outdoor parking area.
- **Family Member or Friend**- A verified family member or friend of the eligible individual that agrees to temporarily house them.
- **Other Housing Related Expenses**- On a case-by-case basis and with prior-approval, Crisis Housing Vouchers may be approved for other housing related expenses. Prior approval must be requested through the Crisis Housing Voucher Exception Request Form.

When a provider utilizes a Crisis Housing Voucher, a referral to a community-based supportive housing program also must occur.

- A referral to the community-based supportive housing program Forensic HARPS must occur for individuals who meet the following criteria:
    - Have had at least two contacts with the forensic mental system in the past 24 months, or were brought to a crisis diversion facility or brought to the attention of a mobile crisis responder team via arrest diversion in accordance with RCW 10.31.110;
    - Need assistance accessing independent living options and would benefit from short-term housing assistance beyond the 14-day vouchers;
    - Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Housing Voucher;

  - Are unstably housed;
  - Are not currently in the community outpatient competency restoration program; and
  - Do not meet Involuntary Treatment Act commitment criteria (RCW 71.05).

- If an individual is not eligible for Forensic HARPS, a referral must be made to another community-based supportive housing program. This can include, but is not limited to, Foundational Community Supports Supportive Housing, traditional HARPS programs, local coordinated entry systems, or other community-based supportive housing programs.

- Referrals must be made by or within the same day as Crisis Housing Voucher utilization.

- Referrals must be made via secure email, phone call, or fax.

Community Outreach and Advocacy Team (COAT) Eligibility Criteria	
Medicaid Status	N/A, but Medicaid can be used for outpatient services, if eligible
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Behavioral health condition and are a current or potential Trueblood class member. Identified eligible for the LEAD program by law enforcement partners and are willing or will be willing to sign the LEAD release of information with regard to status and progress in the program in order to update the prosecuting attorney and other identified stakeholders, and receive Trueblood Phase III complement of services**.**
Community Outreach and Advocacy Team (COAT) Reporting Requirements	
Monthly Reports	• COAT Monthly report as provided by the County • Crisis Housing Voucher Log-due the 5th of the month following the reporting period
Quarterly Reports	COAT Quarterly report as provided by the County
Annual/Other Reports	• One-time only report with a description and analysis of program activities, successes and challenges identified. • Any other requested reports by the County.

Attachments in this Section

- Attachment A: Crisis Housing Voucher Exception Request Form

11.4 COVID Fund- Federally Qualified Health Center (FQHC)

See requirements under* COVID Relief Fund*.

11.5 COVID Relief Fund

COVID Relief Fund (CFR) is funding that has been made available through the Coronavirus Relief Fund (CARES) Act to cover necessary operating expenditures incurred due to the public health emergency in respect to COVID-19. The CRF was established in section 5001 of the CARES Act, which makes CRF distribution available under section 601 (a) of the Social Security Act.

CRF allows Providers to meet the increased demand for services resulting from the COVID-19 emergency. In addition to expanding capacity to meet the increased need to provide these services to more individuals, this program provides funds to allow agencies to provide these services in a safe manner, including purchasing appropriate PPE, sanitization supplies, and equipment to allow for more remote provision of services.

These funds allow Providers to expand capacity to meet increased demand in a manner that complies with public health guidelines, through the following activities:

- Purchase the needed PPE, supplies janitorial costs, and other costs related to compliance with safety and sanitation protocols for behavioral health providers.
- Purchase and support increase IT infrastructure including telehealth operating systems, including hardware and software.
- Support non-reimbursable clinical services such as outreach and coordination that have become required due to COVID-19.
- Purchase and support telecommunication technology for clients so that at-risk vulnerable populations can access services remotely.
- COVID testing with prior approval

See Covid Scopes-Attachment A: Federal Terms and Conditions for details.

Support non-reimbursable clinical services may include, but is not limited to the following:

- Outreach and engagement to meet with harder to serve populations and to help individuals who need assistance learning how to use technology and telehealth
- Paying for staff's mileage when they previously would have used public transit
- Establishing extra office space to allow for proper social distancing
- Other expenses as approved by your Provider Relations/Contract Specialist

Reimbursement is contingent on available funding. Reimbursement is available for activities conducted and expenses incurred between March 1, 2020 and December 30, 2020.

Method of Payment:

- Reimbursement is made based on actual costs for eligible expenses outlined above.
- Receipts and payment documents must be submitted with the invoice.
- The amount requested for outreach/coordination should be equal to the staff time spent on that activity multiplied by their hourly salary.

Additional Requirements:

- The Provider attests that by submission of this invoice, they have not been reimbursed by any other fund source.

Attachments in this Section:

- Covid Scopes-Attachment A: Federal Terms and Conditions
- Covid Scopes-Attachment B: Certification

COVID Relief Fund Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	N/A
Additional Criteria	N/A
COVID Relief Fund Reporting Requirements	
Monthly Report	COVID Relief Fund Report

11.6 COVID CO-LEAD

The program described herein is funded through an allocation of the Coronavirus Relief Fund, as created in section 5001 of H.R. 748 of the CARES Act. The Provider agrees to administer the award consistent with this Provider Manual, in accordance with the applicable provisions of the CARES Act, any future applicable guidance issued by the U.S. Department of Treasury, and any other applicable federal provisions, as currently described in Attachment A. Any entity performing these services provides the County with certification found in Attachment B, that award funds were used for eligible expenditures. Award funds may only be used to pay or reimburse expenditures as described herein, consistent with Attachment A. No award funds may be used to pay or reimburse costs reimbursed under any other public or private program.

Co-LEAD is an adaptation of Seattle-King County's longstanding LEAD program and is one component of King County's response to the COVID-19 pandemic.

The goal of Co-LEAD is to ensure a health and human services response for individuals whose law violations are driven by behavioral health needs or extreme poverty at a moment in which, due to COVID-19, the need for alternatives to arrest and incarceration is uniquely great and law enforcement resources are unusually limited. Co-LEAD works to address this by providing intensive outreach, temporary housing, and short term supportive services including criminal legal system coordination—all via rapid response model—to adults in Burien and other designated service areas who are unsheltered and have a history of criminal legal system involvement.

Eligible use of funds and key activities include:

- Procuring temporary lodging, food, PPE, sanitation supplies, and other basic needs items
- Providing necessary staffing to ensure the lodging can be maintained
- Staffing to identify stabilization strategies including relief benefits and permanent housing, employment
- Outreach staffing to identify and engage participants and to coordinate with law enforcement to identifying eligible individuals ordinarily subject to enforcement and jail booking
- On-site medical care from a consulting doctor, including regular COVID testing for staff and participants
- Care coordination with behavioral health services inaccessible to this population due to COVID conditions

- Project management staffing
- With appropriate documentation, reasonable amounts for the portion of office space and administrative expenses attributable solely to the performance of services for this program
- Criminal legal system coordination regarding any pending or possible cases or warrants involving participants

Attachments in this Section:

- Covid Scopes-Attachment A: Federal Terms and Conditions
- Covid Scopes-Attachment B: Certification

Co-LEAD coordinates upstream with law enforcement to deploy temporary teams of intensive outreach responders (including behavioral health clinicians and medical Providers) and temporary housing resources (including motel rooms and on-site staff support) to serve adults living unsheltered in Burien and any other designated service areas. Program participants are identified as needing stabilization and support in the community and engaged via outreach responder teams. Participants are lodged temporarily in motels and hotels whenever viable and provided with short term services necessary to support compliance with public health measures which mitigate risk of COVID transmission (e.g. social distancing).

The Provider do the following:

- Provide project management, including subcontracting, to coordinate delivery of intensive outreach as well as triage and connection of referrals to case management and temporary housing.
- Ensure the provision of criminal legal system coordination for the purpose of tracking and/or mitigating any pending warrants and outstanding criminal cases
- Facilitate the targeted outreach and enrollment of adults living unsheltered, particularly those from historically marginalized communities (e.g. Black and Native communities, disabled, LGBTQIA, legal system involved, etc.)
- Secure hotel rooms that are reliably available through December 2020
- Ensure coordination with King County's Coordinated Entry for All (CEA) system by facilitating permanent housing screening & assessment of Co-LEAD participants
- Retain a Medical Director and ensure on-site response from said Medical Director for services including but not limited to: primary care, prescribing medication, connection and referral to medical specialists, and health coverage enrollment.
- Provide arrangements for on-site meal service and support participants in being able to prepare food in hotel kitchens whenever available
- Procure and distribute an adequate amount of personal protective equipment (PPE) and sanitation supplies
- Ensure individualized post-program transition planning for each participant that incorporates, at minimum, 1) connecting or reconnecting with community-based Providers who are able to provide long term services in the realm of behavioral health, primary care, and housing, and 2) connecting or reconnecting with supportive pro-social networks (e.g. families, clubs/activities, faith communities)
- Ensure the collection and timely submission of required data and documentation from all Co-LEAD Provider agencies, including subcontractors
- Serve a minimum of 60 individuals by December 30, 2020

- Fulfill the terms of the Co-LEAD contract in good faith, including seeking every reasonable effort to ensure maximal delivery of direct services

Co-LEAD Eligibility Criteria	
Medicaid Status	No
Age Range	Adults
Authorization Needed	No
Additional Criteria	Individuals must be living unsheltered in the King County (non-Seattle) catchment area and have a history of or be at risk of committing law violations. Referrals must be willing and able to sign a Release of Information (ROI) giving authorization to share information with law enforcement for care coordination purposes.
Co-LEAD Reporting Requirements	
Monthly Reports	• Monthly narrative report on project management and direct service delivery • Monthly client-level data submission through CORE and any additional reports required by PME Plan • Monthly documentation from subcontracted Providers that details the increased need for services as a result of the COVID-19 emergency (e.g., increased caseloads since COVID-19 emergency proclamation)
Annual/Other Reports	Any other reports requested by King County

11.7 COVID Just Care

The program described herein is funded through an allocation of the Coronavirus Relief Fund, as created in section 5001 of H.R. 748 of the CARES Act. The Provider agrees to administer the award consistent with this Provider Manual, in accordance with the applicable provisions of the CARES Act, any future applicable guidance issued by the U.S. Department of Treasury, and any other applicable federal provisions, as currently described in Attachment A. Any entity performing these services provides the County with certification found in Attachment B, that award funds were used for eligible expenditures. Award funds may only be used to pay or reimburse expenditures as described herein, consistent with Attachment A. No award funds may be used to pay or reimburse costs reimbursed under any other public or private program.

The Just Care program is one component of King County's response to the COVID-19 pandemic. The goal of Just Care is to reduce COVID's impact on homeless populations by providing temporary housing and wraparound supports to adults living unsheltered in the Pioneer Square and Chinatown/International District neighborhoods. By providing non-congregate temporary housing options, Just Care has the first order effect of preventing and/or reducing community transmission of COVID-19 and may also work to reduce the impact of tent encampment sweeps and other law enforcement responses to homelessness which carry their own public health risks, COVID and otherwise.

Eligible use of funds and key activities include:

- Procuring temporary lodging, food, PPE, sanitation supplies, and other basic needs items
- Providing necessary staffing to ensure the lodging can be maintained
- Staffing to identify stabilization strategies including relief benefits and permanent housing, employment
- Outreach staffing to identify and engage participants and to coordinate with law enforcement to identifying eligible individuals ordinarily subject to enforcement and jail booking
- On-site medical care from a consulting doctor, including regular COVID testing for staff and participants
- Care coordination with behavioral health services inaccessible to this population due to COVID conditions
- Project management staffing
- With appropriate documentation, reasonable amounts for the portion of office space and administrative expenses attributable solely to the performance of services for this program

Attachments in this Section:

- Covid Scopes-Attachment A: Federal Terms and Conditions
- Covid Scopes-Attachment B: Certification

Just Care deploys temporary teams of intensive outreach responders (including behavioral health clinicians and medical Providers) and temporary housing resources (including motel rooms and on-site staff support) to serve adults living unsheltered in the Pioneer Square and Chinatown/International District areas in Seattle. Program participants are identified as needing stabilization and support in the community and are lodged temporarily in motels and hotels whenever viable and provided with wraparound services necessary to support individuals in complying with the public health measure identified to mitigate risk of COVID transmission.

The Provider do the following:

- Provide project management, including subcontracting, to coordinate delivery of intensive outreach as well as triage and connection of referrals to case management and temporary housing.
- Ensure the provision of criminal legal system coordination for the purpose of tracking and/or mitigating any pending warrants and outstanding criminal cases
- Facilitate the targeted outreach and enrollment of adults living unsheltered, particularly those from historically marginalized communities (e.g. Black and Native communities, disabled, LGBTQIA, legal system involved, etc.)
- Secure hotel rooms that are reliably available through December 2020
- Ensure coordination with King County's Coordinated Entry for All (CEA) system by facilitating permanent housing screening & assessment of Just Care participants
- Retain a Medical Director and ensure on-site response from said Medical Director for services including but not limited to: primary care, prescribing medication, connection and referral to medical specialists, and health coverage enrollment.
- Provide arrangements for on-site meal service and support participants in being able to prepare food in hotel kitchens whenever available
- Procure and distribute an adequate amount of personal protective equipment (PPE) and sanitation supplies
- Ensure individualized post-program transition planning for each participant that incorporates, at minimum, 1) connecting or reconnecting with community-based Providers who are able to provide long term services in the realm of behavioral health, primary care, and housing, and 2) connecting or reconnecting with supportive pro-social networks (e.g. families, clubs/activities, faith communities)

- Ensure the collection and timely submission of required data and documentation from all Just Care Provider agencies, including subcontractors
- Serve a minimum of 125 individuals by December 30, 2020
- Fulfill the terms of the Just Care contract in good faith, including seeking every reasonable effort to ensure maximal delivery of direct services

Just Care Eligibility Criteria	
Medicaid Status	No
Age Range	Adults
Authorization Needed	No
Additional Criteria	Adults living unsheltered in program service areas of Pioneer Square (downtown Seattle) and Chinatown/International District.
Just Care Reporting Requirements	
Monthly Reports	• Monthly narrative report on project management and direct service delivery • Monthly client-level data submission through CORE and any additional reports required by PME Plan • Monthly documentation from subcontracted Providers that details the increased need for services as a result of the COVID-19 emergency (e.g., increased caseloads since COVID-19 emergency proclamation)
Annual/Other Reports	• Any other reports requested by King County

11.8 Family Intervention and Restorative Services (FIRS)

The Family Intervention and Restorative Services (FIRS) at the Judge Patricia H. Clark Children and Family Justice Center operates a non-secure, 24/7 respite facility, provides 24-hour line of site supervision, provides housing support services, and residential support services for eligible youth residing at the Children and Family Justice Center. The respite facility serves as a safe and temporary respite housing for the youth, while the family gets enrolled in social services. Staying at the respite facility and participating in the FIRS program is voluntary and available as resources allows. King County –Department of Community and Human Services (DCHS), King County Superior Court, and The Provider are collaborating to implement and operationalize a respite facility where eligible youth may stay when the family is experiencing juvenile domestic violence. King County –Department of Adult and Juvenile Detention (DAJD) and Superior Court are providing recently constructed building to be used as the respite facility, computer access, including printer use and internet access, language line access for translation services (as needed), linen, meal service, maintenance and repairs, utilities, and equipment to operate the respite facility safely and effectively. In addition, King County Superior Court is providing services staffed by juvenile probation counselors and Step-Up Social Workers.

The Provider conducts the following:

- Operates the seven-bed, 24/7 respite facility located at the Judge Patricia H. Clark Children and Family Justice Center for youth. This facility is non-secure and is a safe place for youth to stay while family intervention and restorative services are considered and arranged.
- Maintains at least two on-site staff at all times per Superior Court requirements.
- Provides at minimum, 1,450 hours of housing support services and residential support services, including structured programming, at the respite facility per month.
- Provides 24-hour line of site supervision, housing support services, and residential support services at the respite facility for 7 residents at any given time. Staffing includes 1.0 FTE Program Manager, 8.0 FTE Residential Youth Counselor, 0.33 Director, 0.25 FTE Data Support Specialist, and 1.0 FTE Residential Youth Counselor on-Call.
- Meets with King County DCHS to perform a mid-year budget review by no later than July 30 of each year.
- Case consult and coordinates with Superior Court's Juvenile Probation Counselors (JPC) and Step-Up Social Workers, where appropriate, surrounding a case management plan.
- Participates in regular meetings with King County Superior Court staff to improve program outcomes and indicators for the youth referred by the juvenile probation counselors.
- Provides culturally appropriate services and operates from a framework that supports recovery.

Family Intervention and Restorative Services (FIRS) Eligibility Criteria	
Medicaid Status	N/A
Age Range	12-17
Authorization Needed	N/A
Additional Criteria	Referred by Juvenile Probation Counselors
Family Intervention and Restorative Services (FIRS) Reporting Requirements	
Monthly Reports	• FIRS Expenditure of Actual Administrative and Program Service Report • FIRS State Report
Quarterly Reports	• N/A
Semi-annual Reports	• FIRS: Current respite facility/residency guidelines to King County DCHS and King County Superior Court by June 1, 2021
Annual/Other Reports	• FIRS Client Profile Report • FIRS client success stories and client photographs as well as more detailed information on housing stability outcomes and project budgets, as needed

11.9 Family Integrated Transitions

The Family Integrated Transitions (FIT) is a research-based program that provides intensive individual and family services to youth involved in the juvenile justice (JJ) system with mental health (MH) and substance use disorders (SUD). The goals of the FIT program include connecting the family with community supports, improving the MH status of the youth, and increasing prosocial behavior in order to lower the youth's risk of recidivism and use of alcohol and other drugs.

FIT uses the Multisystemic Therapy model with elements of Dialectical Behavior Therapy, Motivational Enhancement Therapy, and Relapse Prevention to serve a minimum of ten youth per clinician annually.

FIT clinicians provide services at a minimum of once weekly in the youth and family's home 24 hours a day, 7 days per week and access to face-to-face crisis response for each youth and their family for the duration of their enrollment in the FIT Program.

FIT services include:

- Assisting the youth participant in defining and identifying family and community;
- Conducting assessment(s) with each youth and family to determine interventions and the unique needs of each family, including what has worked and what has not worked for the youth and family;
- Preparing the family, utilizing education and encouragement strategies to increase trust and address resistance and/or unwillingness to participate;
- Defining and assembling the treatment team and/or community support;
- Developing a service plan with the youth and family that focuses on family strengths and sets goals in collaboration with youth and family members;
- Referring youth to inpatient short-term withdrawal management and psychiatric respite care with cross-discipline support when appropriate and if available;

Providing referrals for psychiatric evaluation to determine appropriate psychotropic medications, as well as monitoring and counseling to support understanding, acceptance, and adherence to the medication regimen;

- Providing incentives to youth and families as rewards for meeting goals and treatment accomplishments;
- Continuing to work with both the youth and family while youth is on probation revocation status: when a youth goes on absconder, runaway, or escape status, the Provider continues working with the family for 15 days; after 15 days, the case is terminated; and with advance approval of the KCSC, the youth and family may be allowed back in the program;
- Conducting structured graduation ceremonies for youth and family who complete the program; and
- Working with the youth and family to develop long-term linkages in the community to prepare them to transition from the program, including:
- Strategies to transition families to long-term treatment and natural supports,
- Parent-to-parent support strategies, and
- Self-help group linkages.

The FIT Team works collaboratively with the assigned probation staff to develop joint decision-making processes regarding revocations and/or respite care and provides weekly updates either in person or electronically on active cases with to assigned probation staff that includes dates of meetings, current goals and a Case Summary of Supervision and Consultation.

MST-FIT services are provided to youth and families with fidelity to the MST-FIT evidence-based model and MST Goals and Guidelines document.

Family Integrated Traditions (FIT) Eligibility Criteria	
Medicaid Status	N/A
Age Range	11-17.5 years
Authorization Needed	Yes
Additional Criteria	• Qualifying scores from the Risk Needs Assessment developed by the Washington Policy Institute and administered by KCSC, and other criteria established by KCSC; • Referral by staff designated by the KCSC; • Meet the clinical and diagnostic criteria for the FIT Program; and • Have a family stabilization placement.
Family Integrated Transitions (FIT) Reporting Requirements	
Monthly Reports	MST-FIT FTE Report

11.10 Functional Family Therapy

Functional Family Therapy (FFT) is an empirically grounded, family-based intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. All FFT services provided comply with the FFT fidelity model and are monitored by Washington State FFT Quality Assurance. The goals of FFT are to decrease involvement in the juvenile justice system by youth receiving services and increase family communication and mutual support.

Services are accessible at times and in locations that are convenient for enrolled youth and their families/guardians. Accessibility includes services accommodating work and school schedules, and services being provided in homes and/or local communities.

FFT helps family members become aware of what they desire from each other, identify possible solutions to family problems, and to develop behavior change strategies.

Services are provided with absolute compliance to all FFT protocols and quality assurance processes.

Each full-time therapist carries a minimum of eight Juvenile Court Services (JCS)-referred families on their caseload at any given time. Each therapist serves no fewer than 32 JCS-referred families per year.

A minimum of 75 percent of the families referred by JCS are engaged (has attended at least one session after intake) into FFT services.

The Provider completes services with a minimum of 75 percent of active (has completed their first session after intake) JCS-referred families per calendar year.

FFT services are terminated after 45 days if the family has not engaged in services.

Minimum numbers served and completed may be adjusted if referral rates or other factors impact the Provider's ability to meet this requirement. The Provider notifies the County if referral rates or other factors that impact the Provider's ability to meet these requirements.

Mechanisms for formal contact with JCS are developed and maintained and includes referral procedures, problem solving related to program operations, and regular meetings with JCS staff involved with specific youth.

The Provider participates in an oversight group comprised of County and service Provider staff and collaborates with the King County Juvenile Justice System, including judges and Juvenile Probation Counselors (JPCs) to assure court orders are followed.

The Provider informs JPCs about the progress of youth on their caseloads who are enrolled in the program.

The Provider participates in all research requirements, including consistent adherence to the FFT model.

The Provider develops and maintains positive interagency relationships, including with at a minimum: mental health, drug/alcohol, child welfare, and schools.

The Provider adheres to all quality assurance processes as defined by the FFT services including, but not limited to participation in:

- Introductory clinical training series in FFT when new therapists are hired;
- Annual booster trainings:
- All other trainings required by the JCS Project Manager;
- Weekly meetings including the Provider clinical lead and all therapists to discuss and coordinate cases;
- Bi-weekly case reviews;
- Regular data entry of case notes, client contacts, and other requirements into the FFT Clinical Services System (CSS); and
- Statewide quality assurance activities.

The Provider participates in quality improvement efforts as agreed upon by the Provider, JCS and BHRD:

- The Washington State FFT Quality Assurance monitors all FFT therapists statewide and initiates quality improvement efforts with therapists who are not competent in the FFT model.
- If quality improvement efforts fail, the Provider removes the non-competent FFT therapist from the position and replace the therapist.

FFT staff monitor the following metrics:

- Number of youth with decreased referrals to juvenile court following enrollment in services; or
- Number of youth with fewer days spent in detention following enrollment in services.
- Number of youth and their families exhibiting decreased risk factors or increased protective factors. At exit, families are assessed for their progress toward reducing family risk factors and improving family protective factors such as:
- Adults report increased family management or parenting skills;
- Parents report decreased barriers to being an effective parent; and/or

- Parents report increased positive communication with their child/children.

Functional Family Therapy Eligibility Criteria	
Medicaid Status	N/A
Age Range	11-18
Authorization Needed	Yes
Additional Criteria	• Eligibility is established by scores from the Risk Needs Assessment developed by the Washington State Institute for Public Policy and administered by JCS, and other criteria established by JCS. • Referrals to the FFT Program may only be made by staff designated by the JCS Project Manager. • Criteria whereby a referred youth may be refused or terminated are limited to those described below, and on a case by case basis, subject to approval by the JCS Project Manager. These criteria are: • The JPC does not want services and/or does not support the program; • The youth refuses to participate; • The caregiver refuses to participate; • The youth is on the run and/or a warrant is issued; • There is not enough time left in the period of probation; • Youth did not show up for any sessions; • Youth moved or is moving out of state; • Youth is in foster care or other placement less than 90 days or there is a plan for reunification in less than 120 days; • A Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSMV) diagnosis of Schizophrenia or Personality Disorder; • Youth in need of crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who meet the eligibility criteria may be referred into the FFT program; • Youth going into inpatient mental health services; • Youth diagnosed with a moderate or severe substance use disorder by a certified Substance Use Disorder Professional (SUDP); • Chemical Dependency Disposition Alternative (CDDA) youth; • Youth with Intelligent Quotient (IQ) scores of 69 or below; or • Youth participating in the Special Sex Offender Disposition Alternative (SSODA). • It is the responsibility of the Provider to immediately notify the JCS Project Manager and request a waiver if a youth has been referred who fits the exclusionary criteria shown above. • Priority of clients is as follows: • Juvenile offenders and their families as identified through the statewide Risk/Needs Assessment tool. • Youth are selected based on risk/needs scores, therapist availability, and other criteria as described in the FFT description.

Functional Family Therapy Reporting Requirements	
Monthly Reports	• FFT Report
Quarterly Reports	• FFT Client Demographic Report • FFT TOM/COM Summary Report
Semi-annual Reports	• FFT Data Elements Report

11.11 Infrastructure Development

Infrastructure Development projects aim to strengthen and expand Behavioral Health and Recovery Division (BHRD's) behavioral health network. These projects may include the acquisition of property, building renovation and remodeling, or other start-up costs to create permanent facilities necessary for operating and providing long-term behavioral health services.

For the purchase of land, buildings and/or remodeling, the Provider:

- Completes the following documents provided by BHRD: Promissory Note, Deed of Trust and Covenant Agreement.
- Submits a plan of activities that outlines the process and steps toward purchasing and/or remodeling the building at BHRD approved site. This plan is submitted by the date requested by BHRD.
- Executes and records a covenant in a form acceptable to the County requiring that behavioral health services specified in this manual is provided at the site for no less than 20 years. The Provider's obligation to provide such services extends beyond the termination date identified, notwithstanding any provision to the contrary, and is enforceable by the County until satisfied.
- Executes a Covenant Agreement (Covenant) and a Promissory Note (Note) in the approved principal amount. The terms and conditions of the Covenant and Note are incorporated into Provider's contract by reference. The Provider also obtains an American Land Title Association (ALTA) extended title insurance policy naming the County as beneficiary.
- Follows sound standard business practices to ensure that public dollars are appropriately spent, including but not limited to the following actions:
- Purchases no property in which a board member or staff person has any financial interest;
- Obtains a Member of Appraisal Institute (MAI), Senior Residential Appraiser (SRA), or Residential Member (RM) appraisal which complies with the Uniform Standards of Professional Appraisal Practices. If the original appraisal exceeds $15,000,000 or involves income property, the Provider obtains a review appraisal, unless the County waives this requirement upon review of the particular circumstances of the acquisition.
- Purchases American Land Title Association (ALTA) extended title insurance naming the County as beneficiary.
- Has the closing documents prepared by an attorney or escrow officer.
- Reviews the Cost Settlement Statement to make sure all costs are eligible. The following costs are eligible: recording fees, transfer taxes, documentation stamps, title certificates, other evidence of title, boundary surveys, penalty costs and charges for repayment of any preexisting recorded mortgage entered into in good faith encumbering the real property, and the pro rata portion of any prepaid real property taxes and other charges such as water, sewer and garbage allocable to the period subsequent to closing or possession, whichever is first.
- Participates in County convened meetings relevant to the purchase of purchase of land, buildings and/or remodeling.

Additional Terms:

- The Provider does not assign any portion of its rights or responsibilities under the Contract or transfer or assign any claim arising pursuant to the Contract, without the prior written consent of the County.
- No less than 60 days in advance of a proposed assignment, the Provider delivers to the County its request for consent to any such assignment, which includes information regarding the proposed assignee's mission, legal status, and qualifications to manage and operate the Premises and to ensure provision of the same level of services.
- Within 15 days after such request for consent assignment, the County may request additional information reasonably available to the Provider about the proposed assignee.
- The County reserves the right to approve the Provider's proposed assignee or to conduct a selection process before approving an assignee. Any assignment without prior written consent by the County will be void.
- For other infrastructure or start-up projects:
  - Approved expenses are paid on a cost reimbursement basis.
  - Refer to invoice for project specific detail.

Infrastructure Development Reporting Requirements	
Monthly Reports	As requested by BHRD per specific project
Quarterly Reports	As requested by BHRD per specific project
Semi-annual Reports	As requested by BHRD per specific project (i.e. status reports in electronic copy that describe the status of the facility purchase)
Annual/Other Reports	As requested BRHD per specific project, such as: updated plans and timelines for scheduled activities. Submit a copy of the appraisal(s) and purchase agreement to King County Housing and Community Development prior to requesting reimbursement for the cost of the real property acquisition. Submit a copy of the Cost Settlement Statement when requesting funds for real property acquisition.

11.12 LEAD Expansion for *Trueblood* Class Members

LEAD provides community-based care for people who commit law violations related to behavioral health issues or extreme poverty, as an alternative to law enforcement and incarceration. Services provided in LEAD expansion are in alignment with the Trueblood Phase III Grant. Trueblood class members are individuals who are now or have a history of waiting in jail for either court-ordered competency evaluation or court-ordered admission for inpatient evaluation or restoration services. To be eligible for Trueblood-specific capacity, individuals are screened for a history of competency services or elevated risk of future competency services based on a checklist of criteria including known diagnosis of a psychotic disorder or cognitive impairment such as a traumatic brain injury or developmental disability, and a history of recent psychiatric hospitalization, homelessness, and/or law enforcement encounters and jail bookings. The Trueblood Phase III service package is provided by a collaborative multi-agency team which includes psychiatric services, master level behavioral health clinicians, an occupational therapist and interim housing and housing supports.

Services include:

- Twenty-four hours, and seven days a week (24/7) screening and outreach response to arrest diversion referrals from law enforcement;
- Low barrier outreach and case management from harm reduction orientation;
- Assistance accessing basic needs resources;
- Criminal legal coordination by case managers and dedicated prosecutors within the Seattle City Attorney's Office and King County Prosecuting Attorney's Office;
- Housing navigation and housing retention support;
- Community relations responsive to community safety needs and concerns, to provide behavioral health, social service, and dispute resolution alternatives to law enforcement involvement; and
- Ongoing coordination and advocacy with criminal legal partners including law enforcement and courts, community and business organizations, and resources needed by participants.

Additional terms:

Trueblood diversion programs will collaborate and coordinate care with the Trueblood Settlement Agreement programs including Forensic Pathways in Transition from Homelessness (FPATH), Forensic Housing and Recovery Through Peer Services (FHARPS), Outpatient Competency Restoration (OCR), Forensic Navigators, crisis services, co-responders, and local partners.

All services shall be in compliance with ensuring confidentiality per HCA Confidential Information. See Confidential Information Security Requirements.

Sub-contracted providers maintain individual service records including:

- An assessment of an individual's needs as relevant to the service profile of that program (case management, housing, etc).
- An individualized service plan which reflects the individual's desires and goals and identifies specific strategies and objectives to address needs and goals, with regular revisions to the service plan as goals are met and needs change.
- Documentation of services provided and progress toward service plan goals.

LEAD Expansion for Trueblood Class Members Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes

Additional Criteria	• *Trueblood* class members and potential future members.
	• Residents of, or are experiencing homelessness in, King County, or were immediately prior to incarceration or another institutional stay.
	• Willing or will be willing to sign Releases of Information (ROIs) with regard to status and progress in the program in order to update the prosecuting attorney and other identified stakeholders, and receive any appropriate Trueblood Phase III compliment of services.
	• Meet one of the following criteria:
	  • Currently, have a history of, or are likely to end up waiting in jail for either court-ordered in-jail evaluation of competency to stand trial or court-ordered admission for inpatient evaluation or restoration services; or
	  • Eligible for the LEAD program as identified by law enforcement partners under expanded eligibility criteria.

LEAD Reporting Requirements	
Monthly Reports	• Staffing Report for all contracted and subcontracted agencies providing LEAD services. • Provider performance measures spreadsheet must be submitted to DCHS staff by the fifth of each month. • Community outreach activities. • Billing shall occur monthly at 1/12th of the total allocation; up to $388,969. • Trueblood Phase III report.
Quarterly Reports	• Summary Reports shall outline the efforts made to ensure the sustainability of the Trueblood Diversion programs, participation in community justice workgroups, partnerships made and sustained, and networking with other professionals who also serve Trueblood Class Members. Quarterly reports are due 10/15/2022 (for services provided between July 1, 2022 and September 30, 2022) and 1/15/2023 (for services provided between October 1, 2022 through December 31, 2022).
Annual/Other Reports	• Two vignettes from individuals served in the program • Annual report providing cumulative statistics for the contracted period and a description and analysis of program activities, successes and challenges identified. • All program staff including any new staff hired over the course of the year on the Trueblood Diversion programs must complete the two online trainings; “Intersection of Behavioral Health and Law” and DEI training “Enhancing Your Cultural Intelligence”. The training link will be provided by HCA. • Any other requested reports by the County.

Attachments in this section:

- Attachment B: Confidential Information Security Requirements

11.13 Medication-Assisted Treatment (MAT) Expansion

The Substance Abuse and Mental Health System Administration (SAMHSA) Medication-Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant funds the Medication-Assisted Treatment Expansion or MAT-EPIC project. MAT is the use of anti-craving medicine such as buprenorphine, in combination with behavioral therapy and support, to treat Opioid Use Disorders (OUD). The lack of prescribers and lack of support for existing prescribers contributes to the underutilization of MAT. The SAMHSA funded project increases Provider capacity to prescribe buprenorphine or naltrexone and during the contract year.

OUD is a chronic relapsing disease that can be effectively treated and managed, but there is no “one size fits all” approach. All practitioners working on the MAT project obtain a data waiver. The SAMHSA grant funds nurse care managers and navigators that allow the sites to serve new clients. The practitioner prescribes the medication while the nurses and other staff manage the care necessary to treat the complex needs of individuals with Opiate Use Disorder.

The project will:

- Develop outreach and engagement strategies to increase participation in, and access to treatment for diverse populations;
- Use innovative interventions to reach, engage, and retain clients in MAT-EPIC projects by providing services in locations where individuals with OUD already receive care;
- Refer and link patients for ongoing MAT-EPIC and other needed services, which will be offered at a needle exchange and at an “after hours” community health clinic;
- Screen all individuals with OUD for appropriateness for MAT-EPIC;
- Conduct a detailed clinical assessment to determine if clients meet the diagnostic criteria for OUD relative to MAT-EPIC, including a determination of opioid dependence, a history of opioid use, or a high risk of relapse;
- Conduct screening and assessment for co-occurring substance use and mental disorders and the delivery or coordination of any services determined to be necessary for the individual client to achieve and sustain recovery;
- Ensure all practitioners working on the MAT-EPIC grant obtain a data waiver;
- Check the state, county or local Prescription Drug Monitoring Program (PDMP) for each new client admission in compliance with rules and regulations;
- Provide MAT-EPIC using Food and Drug Administration (FDA) approved medications for the maintenance treatment of OUD in combination with comprehensive psychosocial services;
- Provide education, screening, care coordination, risk reduction interventions, testing and counseling for HIV/AIDS, hepatitis, and other infectious diseases for people with OUD who are receiving treatment;
- Provide support services designed to improve access to and retention in MAT-EPIC and facilitate long term recovery;
- Build funding mechanisms and service delivery models in order to provide a robust suite of MAT - EPIC and recovery support services that effectively identify, engage and retain individuals in OUD treatment and facilitate long term recovery;

- Establish and implement a plan to mitigate the risk of diversion and ensure the appropriate use/dose of medication by clients.

Medication-Assisted Treatment Expansion Eligibility Criteria	
Medicaid Status	Medicaid and non-Medicaid clients
Age Range	18 years and Older
Authorization Needed	No
Additional Criteria	None
Medication-Assisted Treatment Expansion Reporting Requirements	
Monthly Reports	• Government Performance and Results Act (GPRA) data (twice a month) • MAT Expansion Staffing Report
Annual/Other Reports	To be determined by SAMHSA-grant evaluator

11.14 Multisystemic Therapy

Multisystemic Therapy (MST) is an evidence-based model that provides intensive family- and community-based services in collaboration with KCSC that focuses on addressing all environmental systems that impact youth involved in the juvenile justice (JJ) system. MST clinicians provide services at a minimum of once weekly in the youth and family's home 24 hours a day, 7 days per week and access to face-to-face crisis response for each youth and their family for the duration of their enrollment in the MST Program.

MST services include: Serving at least 32 youth either on probation and/or who have completed the Risk Needs Assessment. Each MST therapist maintains an average caseload of four, no more than 6, cases; collaborating with Superior Court to develop and implement mechanisms for formal contact with KCSC; providing accessible services at times and in locations that are convenient to enrolled youth and their families/guardians and that services are available throughout the County; developing strengths-based, family-focused treatment plans reflective of the family's cultural beliefs and practices and designed to provide sustainable support to families after program termination; providing the Family Preservation Model and other therapeutic models identified during the MST Orientation Training and applying these models in the circumstances described as clinically appropriate; working with existing wraparound and/or family-centered teams that youth may be involved in; maintaining working relationships with the following systems: schools, drug/alcohol, mental health, child welfare, and other agencies or systems with which a youth is involved; identifying drug and alcohol treatment needs in the MST Treatment Plan and, where treatment is indicated, referring to a Substance Use Disorder Professional; participating in transition planning that assists youth and family members to become linked to appropriate service and treatment options in the event a youth and their family are not able to complete a course of MST treatment, at the completion of MST, or at termination from MST; ensuring that at least one MST staff is provided to represent the MST Team at all required meetings and court hearings; and adhering to at least the following quality assurance processes: MST Adherence Measure interviews conducted by an MST Inc. expert with each family enrolled in the program occurring after the second week of treatment and every four weeks thereafter for the duration of enrollment; weekly MST consultation provided by an MST Inc. expert pursuant to MST model adherence procedures; at least weekly clinical supervision and support to each staff providing MST services; and other statewide quality assurance activities, as directed by Behavioral Health and Recovery Division (BHRD) and the KCSC Project Manager.

MST services are provided to youth and families with fidelity to the MST evidence-based model and MST Goals and Guidelines document.

Multisystemic Therapy (MST) Eligibility Criteria	
Medicaid Status	N/A
Age Range	11-17.5 years
Authorization Needed	Yes

Additional Criteria	• Qualifying scores from the Risk Needs Assessment developed by the Washington Policy Institute and administered by KCSC, and other criteria established by KCSC;
	• Referral by staff designated by the KCSC; and
	• Have a family stabilization placement
	• Eligible youth who have referred must not be refused unless they meet the following exclusionary criteria:
	  • Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers;
	  • Youth in need of crisis stabilization because of active suicidal, homicidal, or psychotic behavior (once stable, youth who meet the eligibility criteria may be referred into the MST program);
	  • Youth participating in the Special Sex Offender Disposition Alternative (SSODA) Program; and Youth with Intelligence Quotient scores of 69 or below.

Multisystemic Therapy (MST) Reporting Requirements	
Monthly Reports	• MST FTE Report • MST City of Seattle Status Report
Annual/Other Reports	MST City of Seattle Annual Summary Demographic Report

11.15 Opioid Overdose Prevention Services

In coordination with the Heroin and Prescription Opiate Task force, Behavioral Health and Recovery Division (BHRD) is partnering with community services Providers to address the regions heroin and opioid epidemic. As a result, the Opiate Overdose Prevention Partnership is a collaboration between BHRD and community service Providers to prevent injury and death from opioid overdose. Partnership includes a wide variety of Providers including behavioral health, homeless housing, law enforcement, emergency medical services, etc. This project includes a two-pronged approach 1) Expand distribution of naloxone kits to individual using heroin and pharmaceutical opioids. 2) Provide naloxone kits for agency staff use.

The Provider may make available naloxone kits to Medicaid-funded clients who have an opioid use disorder. If the Provider does so, they will:

- Have a naloxone policy and procedure that address the guidelines for staff response to a suspected opiate overdose, staff training, client training, documentation standards related to staff administering naloxone to clients, and guidelines to monitor naloxone supplies and the ordering of naloxone kits;
- Ensure that staff and clients are trained in the use of naloxone kits;
- Submit an incident report via the DCHS Naloxone Portal within five working days that the naloxone kit was used to reverse a suspected opioid overdose; and

- Collaborate with the Providers existing pharmacy partner or Kelley-Ross and Assoc. Inc. to order naloxone kits for interested Medicaid clients.

Behavioral Health agencies that have a partnership with a pharmacy arrange standing orders to dispense naloxone so that clients can get naloxone as necessary. Behavioral health agencies that do not have an existing partnership with a pharmacy may enter into a Business Associate Agreement and make arrangements with Kelley-Ross and Associates Inc. to provide naloxone kits to interested BHRD enrolled Medicaid clients. Kelley-Ross prescribes and dispense naloxone kits to these clients.

Program website and forms located here.

11.16 Pre-Employment Transition Services

Pre-Employment Transition Services (Pre-ETS) are activities provided to students with disabilities while attending secondary or post-secondary education. Services include 1) Workplace Readiness Trainings 2) Self-Advocacy Trainings 3) Work-Based Learning Activities and 4) Work-Based Learning Experiences. These activities are contracted by the Department of Vocational Rehabilitation (DVR) with Department of Community and Human Services (DCHS) and consists of a partnership between the Youth Source Program within the Child, Youth and Young Adult Division, the Behavioral Health and Recovery Division (BHRD) and its designated subcontractors.

The goal of Pre-ETS is to assist students with disabilities to prepare for future employment by receiving the following:

- Training on workplace readiness such as “soft skills,” workplace behavior, and work culture/habits;
- Training on self-advocacy skills for workplace and interpersonal communications;
- Participating in work-based learning activities such as job site tours, job shadowing, and informational interviewing;
- Participating in short-term, paid, work-based learning experiences in an integrated employment setting.

The Provider delivers Pre-ETS in accordance with all requirements in the “Contract of Reference,” the DVR Pre-ETS contract with DCHS and its successors.

The Provider adheres to the service capacity limits below identified by BHRD for each service as noted in the DCHS/BHRD Pre-ETS contract.

Capacity limits on individual services are as follows:

- Workplace Readiness Training (WRT) to a maximum of 25 students, no more than 40 hours per student.
- Work Based Learning Activities to a maximum of 25 activities total per agency. More than one activity may be provided to each student. Students may choose from the following activities:
- Job Site Tour;
- Job Shadow Visit;
- Informational Interview;
- Paid Work-Based Learning Experiences, with a minimum of forty hours and a maximum of 120 hours of experience.

Pre-ETS services align with personal transition goals specified in the Individual Education Plan on file at the student’s educational institution. If the student is a customer of DVR, the pre-ETS goals also align with DVR’s Individual Plan for Employment.

At the completion of each training series, work-based learning activity and/or work-based learning experience, the Provider provides to the student: 1) a student certificate 2) a student portfolio 3) an opportunity to complete a student evaluation.

Pre-Employment Transition Services (PRE-ETS) Eligibility Criteria	
Medicaid Status	N/A
Age Range	Ages 16-21
Authorization Needed	Yes
Additional Criteria	Refer to DVR/DCHS Pre-ETS Contract
Pre-Employment Transition Services (PRE-ETS) Reporting Requirements	
Monthly Reports	• Pre-ETS DVR Monthly Report • Pre-ETS BHRD Monthly Report • Pre-ETS Provider-Supplemental Report (as needed)
Quarterly Reports	• Pre-ETS Quarterly Report
Annual/Other Reports	As requested

11.17 Sobering Adult Case Management

Sobering Adult Case Management (SACM) serves the Seattle community by assisting people who have ongoing issues with substance use through a partnership between King County BHRD and the City of Seattle. The majority of people served through SACM are experiencing homelessness and have multiple social, behavioral health, and medical conditions. SACM functions as a single-entry point into several systems for individuals who have complex physical and behavioral health concerns.

Case management provides service planning, referral to community resources, and individualized follow up to all identified clients. Case managers assist people in accessing services and engage clients to increase motivation for support and recovery. Case management responsibilities include file documentation and linkages to an array of publicly funded services, such as substance use disorder treatment, withdrawal management, housing, and staffing for people who are use services frequently.

Service Definitions

SACM services are defined as follows:

- *Case management* is defined as coordinating, referring, and assisting people who are using sobering services in accessing publicly funded resources to promote health, recovery, and stability. Examples include arranging intakes for mental health and substance use disorder treatment, guidance in completing housing applications, and help in obtaining documents needed to access benefits.
- *Referrals to housing* are a particular focus of SACM with the goal being to secure safe places for people to live. The housing application process generally involves answering questions and submitting documents to attain supportive, transitional, or permanent housing based on the person's needs.
- *Admission to withdrawal management* is defined as entrance to any withdrawal management program such as Valley Cities Recovery Place Seattle.

Annual Metrics

Performance in SACM is measured according to annual targets: milestones are included as part of the monthly base payment and performance commitments (PC) are incentivized. For SACM, the annual metrics are as follows:

- Milestone #1: 500 persons will receive case management to coordinate referrals and resources.
- Milestone #2: 100 persons will be referred to housing.
- PC #1: 24 persons will be admitted to withdrawal management services.

PC #1 is reimbursed monthly for each unit completed by the provider subject to an annual maximum.

Other SACM Requirements

The Provider maintains timely and accurate records which reflect service levels, participant characteristics and demographics, action taken to assist participants, and service outcomes and expenditures. The Provider must notify BHRD of all staffing changes affecting the program within five days and describe a plan for replacing the staff person within 10 days of the vacancy that includes timelines for replacing the staff person. The Provider may not require individuals to participate in religious activities such as prayer or religious services as a condition of receiving services with City funding.

Sobering Adult Case Management Eligibility Critieria	
Medicaid Status	N/A
Age Range	18 and older
Authorization Needed	No
Additional Criteria	Individuals are identified as people using sobering services
Sobering Adult Case Management Reporting Requirements	
Monthly Reports	Sobering Adult Case Management Monthly Status Report Sobering Adult Case Management Services Report
Quarterly Reports	Sobering Adult Case Management Quarterly Narrative Report
Annual/Other Reports	Sobering Adult Case Management Summary Demographic Report

11.18 South King County Housing First

South King County Housing First (SKCHF) Program is a housing program that serves 45 unduplicated adults in permanent supportive housing units. The Provider uses an integrated multi-disciplinary team approach, based on the Assertive Community Treatment (ACT) model, to provide outreach, supportive services, treatment services, employment services, and medical/health services to adults who are eligible for the Housing First Program. Eligible adults are rapidly placed in housing units upon program entry. Health, medical, and dental needs are assessed, and clients are referred to primary health care Providers when needed. The Provider assists clients with applications to determine eligibility for entitlement programs and aggressively works to convert non-Medicaid clients to Medicaid status. Clients are assessed for employment services and are referred as needed to a licenses employment Provider. The majority of services are provided in the community and caseloads do not exceed a ratio of one to 15 for direct service case management staff. Program staff meet weekly and review services for each client. Program staff receive training in Recovery and resiliency principles and practices, Motivational Interviewing, and Trauma-Informed services and supports.

Providers:

- Maintain collaborative working relationships with Providers who serve people experiencing homelessness in south King County.
- Provide a team that includes a substance use disorder professional and a paid peer counselor.
- Participate in planning and system change activities to improve services for the homeless in south King County.
- Participate in a program oversight committee convened by the Behavioral Health and Recovery Division (BHRD).
- Work with the King County Housing Authority, the County, suburban cities, and affordable housing Providers in order to maintain and increase housing resources and options for clients.
- Ensure Program Outcomes including:
  - Program clients who are housed have an 80 percent housing retention rate after six months;
  - Program clients who are not successful in their first housing placement are placed into another permanent housing unit; and
  - Program clients reduce their utilization of public safety and acute care resources within one year of placement into housing.

This program participates in the Safe Harbors Homeless Management Information System (HMIS) and program staff complete the Safe Harbors HMIS Provider/Program Set Up.

SKCHF Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 or older
Authorization Needed	No
Additional Criteria	Live in South King County
SKCHF Program Reporting Requirements	
Monthly Reports	South King County – Tenant Move-In Information Sheet for all housed clients. One Year/Move-Out Form as clients move out or reach their one-year stay in the program.

11.19 Ticket to Work

This program is an incentive-based employment program through the Social Security Administration (SSA) designed to increase the economic self-sufficiency of individuals who are receiving government financial assistance due to their disability and non-working status. Employment service Providers assist individuals with achieving and maintaining competitive jobs in the community. Once the individual achieves specific earned income levels, SSA provides “milestone payments” to the Provider for helping the individual achieve their employment outcomes. TTW services by the Provider are documented in order to receive payment for services rendered and include but are not limited to the following:

- Career Counseling: identifying individuals’ interests, talents, skills;
- Job Search Supports: Developing/improving job skills, resume writing, job interview tips, job search strategies;

- Long-term Support on the Job: Ongoing employment supports post placement based on individualized needs;
- Social Security Work Incentives Advisement: Agency staff provide benefits planning and work incentives guidance to all participants; and
- Financial Wellness: Providers have at least one certified benefits planner available to provide benefits counseling services to TTW participants throughout the contract period. Agency staff also provide a referral and linkage to internal or external financial literacy and/or education services to build financial wellness.

Additional services provided include:

- Participate in required TTW trainings and follow requirements of the American Dream Employment Network (ADEN), the contracted Employment Network of BHRD's TTW program;
- Respond to and make determinations of eligibility in a timely manner for referrals from BHRD to enroll mutually agreed upon individuals into TTW based on SSA guidelines:
- Provide services and document these contacts with enrolled TTW participants in the ADEN portal, at minimum, on a monthly basis; and
- Collect paycheck stubs for all participants throughout their first year of employment and as requested by BHRD.
- Dedicate a minimum of ten hours per week, by one staff or combined among staff, for service delivery and administration of TTW services, and increase the allocated staff time as the Provider's enrollments increase.
- Work collaboratively with BHRD, other behavioral health agencies, and the Department of Vocational Rehabilitation to address issues that may arise from a participant's assignment of a ticket when multiple agencies are eligible to provide TTW services.

Funding

- Funding of milestone payments is contingent upon funding from SSA and ADEN.
- Funding received by Providers through TTW is dedicated solely to employment related services, training and programming for TTW or the agency's broader employment related service offerings. Providers submit plans and demonstrate use of funds solely for employment related purposes as requested by BHRD.

Ticket to Work Eligibility Criteria	
Medicaid Status	N/A
Age Range	Ages 18-64
Authorization Needed	Yes
Additional Criteria	None
Ticket to Work Reporting Requirements	
Monthly Reports	Submission of individual service contacts as well as other requested documentation (i.e. paystubs) into the ADEN portal.
Annual/Other Reports	As requested.

11.20 Trauma Response to Adverse Childhood Experiences (TRACE)

The Provider provides an enhanced trauma-specific response through the existing Children's Crisis Outreach Response System (CCORS) team to eligible children, youth and/or family members who

have experienced a traumatic event and are referred by First Responders in the King County Electoral District 3. The trauma enhancements piloted in this are provided in accordance with the Best Starts for Kids (BSK) Trauma-Informed and Restorative Practices Initiative.

The program provides an enhancement of CCORS response services and allows for immediate access to CCORS staff by First Responders in King County Electoral District 3. CCORS staff is responsible for identifying and participating in training to enhance their skills in being responsive to population-based crises identified by First Responders. CCORS staff is also responsible for promoting their services and collaborating with First Responders and schools in District 3. Once a referral is made, the outreach team responds within 2 hours to provide face-to-face crisis stabilization services at the site of concern on a no-decline basis. The program also ensures that children or youth receiving a crisis response receive continuity of service through connecting with relevant ongoing community-based services.

Definitions:

- *Adverse Childhood Experiences (ACEs):* Stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders (SUD). ACEs are strongly related to the development and prevalence of a wide range of health problems throughout an individual's lifespan, including those associated with substance misuse.
- *First Responders* Personnel associated with District 3 located fire departments, law enforcement organizations, First Responder Chaplaincy Program and the emergency department at Evergreen Hospital.
- *King County Electoral District 3*: Encompasses King County geographic areas including the following cities and zip codes: Duvall: 98019, Fall City: 98024, North Bend: 98045, Snoqualmie: 98065, 98068, Bellevue: 98004, 98005, 98006, 98007, 98008, 98009, Bothell: 98011, 98028, 98041, Carnation: 98014, Hobart: 98025, Issaquah: 98029, 98075, Kirkland: 98033, 98034, 98083, Redmond: 98052, 98053, 98054, 98075, Sammamish: 98074, 98075, Skykomish: 98288 and Woodinville: 98072.
- *TRACE Response:* Non-Emergent Outreach (NEO): Outreach within 24 hours to children, youth and families for non-crisis situations,
- *Prevention & Early-Intervention:* Preventative consultation and meetings with First Responders and identified stakeholders to link children, youth and families with appropriate behavioral health resources and services.

TRACE Eligibility Criteria	
Medicaid Status	N/A
Age Range	3-17 years old
Authorization Needed	No
Additional Criteria	Any child or youth age 3-17 in King County Electoral District 3 who: • Has experienced an acute crisis situation or traumatic event; and • Is referred to the program through identified First Responder personnel and School Districts (Riverview and Snoqualmie Valley)
TRACE Reporting Requirements	
Monthly Reports	• TRACE Service Summary • TRACE Narrative Summary
Annual/Other Reports	TRACE Project Evaluation due January 31st.

11.21 Trueblood Phase III Interim Housing and Supports

Trueblood Phase III Interim Housing and Supports program is part of the continuum of care for the *Trueblood Phase III* funded services including LEAD expansion to individuals who are receiving or at risk of receiving legal competency services in the criminal legal system. This program provides interim cluster-based housing and housing support specialists with the goal of providing supports for a minimum of 16 participants at any given time.

Trueblood Phase III Interim Housing and Supports Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Identified as eligible for the LEAD program by law enforcement partners; or Currently enrolled in the Legal Intervention and Network of Care Program (LINC).
Trueblood Phase III Interim Housing and Supports Reporting Requirements	
Monthly Reports	Trueblood Phase III Status Report
Annual/Other Reports	• One-time only report providing cumulative statistics for the contract period and a description and analysis of program activities, successes and challenges. • Any other requested reports by the County

11.22 Washington Recovery Alliance (WRA)

Washington Recovery Alliance (WRA) is a statewide, grassroots organization comprised of individuals in recovery from addiction and mental health conditions, families impacted by behavioral health conditions, and recovery community organizations driving change in two spheres related to behavioral health recovery: public policy and public understanding. WRA supports the cultivation of a well-organized group of community advocates working on behalf of behavioral health recovery and in partnership with King County. The King County Chapter of the WRA works collaboratively with community sector representatives of the Coalition to organize and train the recovery community and advocates to more effectively address and reduce the stigma often associated with behavioral health disorders and advance the recovery movement in King County.

WRA ensures all services and activities are designed and delivered in a manner sensitive to the needs of all cultural groups and ethnic minorities. WRA initiates actions to ensure or improve access, retention, and cultural relevance of recovery services, for cultural groups and other diverse populations in need of recovery services.

WRA develops a sustainability plan to ensure the continued viability of this body of work.

WRA develops and maintains a social media campaign to improve community understanding of mental health and substance abuse issues and detail any continuing maintenance.

WRA plans and executes a campaign to support individuals to open up around being in recovery from a mental illness or substance use disorder in an effort to reduce social stigma.

WRA works collaboratively with behavioral health Providers and other public entities to host recovery events throughout the year, including during recovery month in September. These campaign efforts document the connections and partnerships developed, the number of individuals participating in recovery events, and an annual summary of recovery events.

WRA creates public events and documents the number of events that have taken place, a description of the events created and the total number of individuals that participate.

WRA is developing a speaker's bureau of individuals in recovery who would receive training and coaching on telling their recovery stories and incorporating it into their social media campaign so that community partners are aware of it.

Washington Recovery Alliance (WRA)	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
Washington Recovery Alliance (WRA)	
Annual/Other Reports	• WRA Social Media Campaign Report • WRA Recovery Events Report • WRA Recovery Coalition Sustainability Report

11.23 Washington State Emergency COVID-19 (WASEC) Non-Medicaid Medication-Assisted Treatment (MAT)

The WASEC Non-Medicaid Medication-Assisted Treatment (MAT) Program is funded by a SAMHSA/HCA grant to expand access to behavioral health treatment in response to the COVID-19 pandemic. The program provides MAT services for individuals who are not eligible for Medicaid coverage.

The WASEC Non-Medicaid MAT Program will intake and provide Medication-Assisted Treatment to at least 60 individuals who are not eligible for Medicaid coverage. Government Performance and Results Act (GPRA) data collection and submission through SAMHSA's Performance & Accountability Reporting System (SPARS) is required. A GPRA intake is required upon intake and a follow-up at six months after the intake date.

- Grant funds cannot be used to supplant current funding of existing activities.
- Ensure Eligible Individuals are eligible to receive treatment services provided through funding by this grant.
- Ensure that staff are trained on the required GPRA data collection process within ninety (90) days of the date the contract was executed.
- Ensure that each individual receiving treatment services funded through the grant works with staff that provide various social service interventions including, but not limited to: managing referrals, completing required data collection, developing and managing recovery care plans, peer services, recovery coaching, skill development support, and discharge planning.
- Provide sufficient staffing to implement and supervise the provision of WASEC Grant services, including but not limited to, ensuring public accountability and community standards, for the provision of publicly-funded social services.
- Ensure that services to Eligible Individuals are not denied to any individual regardless of:
- The individual's drug(s) of choice;
- The fact that an individual is taking medically-prescribed medications; and

- The fact that an individual is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen
- Serve all Eligible Individual Washington State residents who are transient and require services, subject to available funds and service availability.
- Regarding Services and Activities to Ethnic Minorities and Diverse Populations:
- Ensure all services and activities provided are designed and delivered in a manner sensitive to the needs of all ethnic minorities and diverse populations.
- Initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention or other appropriate service, for ethnic minorities and other diverse populations in need of treatment and prevention services as identified in their needs assessment.
- Take the initiative to strengthen working relationship with other agencies serving these populations.

Data Collection:

- Ensure that data is collected and submitted through SPARS on all WASEC Grant services, as required by HCA.
- Ensure that the GPRA intake interview data is collected and entered into the SPARS as required by SAMHSA and the WASEC Grant for all individuals receiving grant funding.
- Ensure that at least eighty percent (80%) of individuals that receive treatment services complete a six (6) month follow-up GPRA survey.
- Ensure that all discharged individuals receive a GPRA discharge interview or administrative discharge.

WASEC Recovery Supports Systems Program Eligibility Criteria	
Medicaid Status	Individual must be not eligible for Medicaid in order to receive services
Age Range	N/A
Authorization Needed	No
Additional Criteria	N/A
WASEC Recovery Supports Systems Program Reporting Requirements	
Monthly Reports	• WASEC Non-Medicaid Medication-Assisted Treatment Program Monthly Report
Annual/Other Reports	• WASEC GPRA intake for each individual receiving services upon intake • WASEC GPRA follow-up at six month after each individual's intake date • WASEC Non-Medicaid Medication-Assisted Treatment Program Annual Report

12 American Rescue Plan Act (ARPA)/Coronavirus Local Fiscal Recovery Fund (CLFR)

American Rescue Plan Act (ARPA)/Coronavirus Local Fiscal Recovery Fund

American Rescue Plan Act (ARPA)/Coronavirus Local Fiscal Recovery Fund (CLFR) funds were signed into law in 2021 to support the country's recovery from the COVID-19 pandemic. Through ARPA/CLFR, the U.S. Department of the Treasury (Treasury) allocated more than $350 billion to state, local, territorial, and Tribal governments across the country to "rebuild a stronger and more equitable economy as the country recovers."

All recipients of Federal ARPA funds must comply with the following federal and pass-through requirements:

- Treasury's Final Rule
- Treasury's Frequently Asked Questions
- Federal Recipient Compliance and Reporting Responsibilities
- Attachment A, Federal Terms and Conditions
- Any future applicable rules and guidance
- Code of Federal Regulations, including:
  - 2 C.F.R. § 200
  - 2 C.F.R. § 200.303
  - 2 C.F.R. § 200.331 – 200.332
  - 2 C.F.R Subpart F
  - 2 C.F.R. § 200.425

Program Specific Requirements

Expenses paid for by ARPA funds cannot also be paid by any other funds. ARPA Funds may be used in conjunction with other federal funding sources, provided that the costs are eligible costs under each source program and are compliant with all other related statutory and regulatory requirements and policies. Providers must comply with applicable reporting requirements for all sources of funds supporting the ARPA projects, and with any requirements and restrictions on the use of funds from the supplemental funding sources and the ARPA program.

Invoice Method of Payment

Level of documentation will vary depending on the risk assessment of the funded provider. The Provider submits a Billing Invoice Package (BIP) monthly, which consists of an invoice statement and a detailed general ledger report (expenditure listing) of actual expenditures for the invoice period. The provider submits all supporting documents for the invoiced expenditures for any general ledger detail line item depending on the Federal Risk Assessment category:

- High Risk Assessment: All expenditures
- Medium Risk Assessment: Expenditures over $250
- Low Risk Assessment: Expenditures over $500

Providers work with their King County Scope Leads to identify appropriate supporting documentation of expenditures.

Attachments in this Section:

Attachment A: ARPA Federal Award Terms and Conditions

12.1 Behavioral Health Services at Health through Housing Facilities and Permanent Supportive Housing Sites

Behavioral Health Services at Health through Housing (HtH) Facilities and Permanent Supportive Housing (PSH) Sites programs provide mobile, behavioral health intervention services in HtH Facilities and selected PSH Sites across King County. Interventions include the following:

- Screening/intake
- Behavioral health assessment/evaluation
- Case management
- Peer support
- Crisis intervention
- Counseling services
- Prescribing psychiatric medication and evaluation
- Providing access to Buprenorphine and Naltrexone and short-term maintenance, overdose prevention
- Assistance with linkage to additional behavioral health treatment and recovery supports.

Program Specific Requirements:

Mobile behavioral health team clinicians provide 24/7, face-to-face services at HtH facilities or targeted PSH sites where the individual is located and will respond and provide outreach for all referrals that meet eligibility criteria on a no-decline basis.

HtH and PSH teams are comprised of the following:

- Certified Peer Counselors and Peer Counselors in Training
- Case Manager
- Licensed Master's Level Mental Health Professional
- Licensed Substance Use Disorder Professional
- Master's Level Clinical Supervisor
- Psychiatric and Buprenorphine Waivered Medical Staff.

The teams utilize validated tools and evidence-based practices to assess for safety and individual needs. Residents are referred to ongoing long term treatment modalities and/or medication management, as appropriate.

For specific ARPA and documentation requirements, see Provider Manual Section American Rescue Plan Act (ARPA)/Coronavirus Local Fiscal Recovery Fund (CLFR).

Behavioral Health Services at HtH Facilities and PSH Sites Eligibility Criteria	
Medicaid Status	N/A. Serves individuals regardless of Medicaid status.
Age Range	N/A
Authorization Needed	No
Additional Criteria	Guests/residents of designated HtH Facilities and PSH Sites.
Behavioral Health Services at HtH Facilities and PSH Sites Reporting Requirements	
Monthly Reports	• BH Services at HtH and PSH Sites Individual Needs Assessment Report • BH Services at HtH and PSH Sites Client Follow Up Contact Report • BH Services at HtH and PSH Sites Narrative Report

12.2 Expand Peer Support for Behavioral Health Services Program (EPS)

The Expand Peer Support for Behavioral Health Services Program (EPS) is funded through the American Rescue Plan Act (ARPA) to address the increased need for community-based behavioral health peer support services as a result of the COVID-19 pandemic. Contracted community-based organizations (CBO) provide recovery-oriented and trauma informed peer support services in a one-on-one and/or group setting, and during times that meet the needs of those being served. EPS providers complete documentation for individuals receiving services, including type of service and, as applicable, program agreements and recovery plans. For specific ARPA and documentation requirements, see Provider Manual Section American Rescue Plan Act (ARPA)/Coronavirus Local Fiscal Recovery Fund (CLFR).

EPS activities include:

- Peer mentoring or coaching
- Recovery resource connecting
- Facilitating and leading groups
- Helping individuals build Community and social support networks

Program Specific Requirements

Peer Support workers demonstrate Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Peer Workers in Behavioral Health Services Core Competencies for Peer Workers in Behavioral Health Services (samhsa.gov)

- Supervisors follow the *National Practice Guidelines for Peer Specialists and Supervisors* and are trained or experienced with providing critical supervision functions, including administration, support, education, advocacy, and evaluation.

Eligible Funding Uses. Reimbursement for program service delivery can be made in accordance with the cost principles found in 2 CFR 200 Subpart E. Eligible funding uses include:

- Salary and benefits to employ Peer Support Workers (with supervisory oversite),
- Salary and benefits for supervisory staff to provide the required oversight for employed Peer Support Workers and/or Peer Support volunteers,

--OR--

- Fee-for-service payment for Peer Support services provided by employed Peer Support Workers. A fee-for-service **cannot** be charged if:

    a. The employed Peer Support Worker's salary and benefits are funded by the *Expand Peer Support for Behavio*ral Health Services Program or through another funding source,
    b. Peer Support services are provided by volunteers or non-employed individuals that receive a stipend.

Additional funding uses include:

- Costs associated with staff recruitment and community outreach to publicize the increased availability of Peer Support services including online and print materials.
- Administrative costs related to administering the program consistent with 2 CFR Part 200. Refer to Provider Manual Section American Rescue Plan Act (ARPA)/Coronavirus Local Fiscal Recovery Fund (CLFR).

Expand Peer Support for Behavioral Health Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	All
Authorization Needed	No
Additional Criteria	• Peer Support workers must receive supervisory oversight • Program participant must be a resident of King County • Program participant must self-identify as having a behavioral health condition and/or be a family member of someone with a behavioral health condition • Program participation must be voluntary
Expand Peer Support for Behavioral Health Services Reporting Requirements	
Monthly Reports	Monthly reports as specific to recipient, see Provider Manual Section American Rescue Plan Act (ARPA)/Coronavirus Local Fiscal Recovery Fund (CLFR).
Quarterly Reports	To be decided with Program Lead
Semiannual Reports	To be decided with Program Lead
Annual/Other Reports	• EPS 18-month final report • Any other reports requested by BHRD

13 Quality Management

The Provider is responsible for providing quality services and abiding by appropriate quality standards as necessary for quality improvement and assurance. The Provider works with Behavioral Health and Recovery Division (BHRD) as needed to make adjustments to service methodologies and procedures to ensure quality, performance, and client satisfaction.

The Provider reviews their Quality Management Plan at least annually. Such review incorporates updates and quality initiatives in line with the organization's quality goals. The Provider is responsible for maintaining this documentation internally. A revised date is imprinted on the document, indicating the last date of update. This documentation may be requested by BHRD during identified opportunities for quality review or improvement and during the development of performance plans.

13.1 Grievances and Complaints

A grievance is an expression of dissatisfaction about any matter other than an action or adverse benefit determination. Actions and adverse benefit determinations are authorization decisions about services.

Examples of possible subjects for grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the individual's or client's rights. Termination of a Subcontract is not grounds for an appeal, Administrative Hearing, or a Grievance for the client if similar services are immediately available in the service area.

Clients and Individuals may choose to file a grievance with the funder of their services at any time.

- Non-Medicaid funded individuals and clients may file a grievance at King County Behavioral Health Administrative Services Organization (BH-ASO), and
- Medicaid-funded clients may file grievances at their MCO.

Providers may resolve complaints directly and are responsible for the following:

- Handling complaints through implementation of their individual policies and procedures.
- Ensuring that non-Medicaid funded individuals and clients are aware of their right to file a grievance with the BH-ASO, and that Medicaid-funded clients are aware of their right to file a grievance with their MCO. MCO and BH-ASO contact information for filing a grievance is included on individual and client rights publications, as well as agency policies and procedures.
- Providing relevant information to Behavioral Health and Recovery Division (BHRD) or MCOs to assist in effectively investigating and resolving grievances filed with the BH-ASO or with an MCO, if requested.
- Participating in evaluating the complaint/grievance system as requested.

Contact information for individuals or clients to file a grievance:

Organization	Phone number
Amerigroup	1-800-600-4441
Community Health Plan of Washington	1-800-440-1561
Coordinated Care of Washington	1-877-644-4613
Molina Healthcare of Washington, Inc.	1-800-869-7165
United Healthcare Community Plan	1-877-542-8997
King County Behavioral Health and Recovery Division/BH-ASO	1-800-790-8049

13.2 Critical Incidents Program and Reporting Requirements

All Programs establish a Critical Incident Management System consistent with all applicable laws and include policies and procedures for identification of incidents, reporting protocols, oversight responsibilities, and for incorporation into its Quality Management plan.

Critical Incidents and Quality Management

Providers maintain appropriate policies and procedures outlining response, and follow-up to Critical Incidents. Providers maintain a Critical Incident Committee consisting of appropriate clinical staff, quality improvement staff, and/or supervisors as necessary for the review and analysis of any causal factors for Critical Incidents.

Providers track critical incidents, identify trends, and address any patterns or trends identified that negatively affect individual and client safety or outcomes.

Providers increase intervention for clients when incident behavior escalates in severity or frequency.

Examples of appropriate care and critical incident follow-up include, but are not limited to:

- Regularly scheduled internal reviews at a Critical Incident Committee to identify any contributing factors and/or strategies to prevent future similar occurrences and to direct agency protocol changes.
- Timely follow up and documentation procedures for the incident itself, which could include, but are not limited to: referrals to additional services, referral for involuntary treatment, reporting to Law Enforcement, Critical Incident reporting to appropriate funding source(s), APS or CPS notification, and/or a Duty to Warn notification.
- Addressing high risk behaviors in crisis and treatment plans, including individualized strategies to manage risk.
- Ongoing assessment and frequent reassessment of risk, as needed.
- Steps or individual action plan created to minimize future harm.
- Increased frequency of contact based on acuity and risk.
- Increased support around safety planning, SUD support, and relapse prevention, as indicated.
- Increased outreach and contact with collaterals, as indicated.
- Use of clinical supervision and consultation with the treatment team and other partners to strategize how to best support the individual.
- Consistent documentation of all services provided including risk assessment, interventions, contact with collaterals, and outreach and engagement efforts.

Critical Incident (CI) Reporting Criteria for non-Medicaid and Medicaid funded individuals or programs

Providers submit an individual Critical Incident Report for the following incidents that occur:

- Incidents that occur to an individual:
  - **Abuse, neglect, or sexual/financial exploitation perpetrated by staff,** that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), Federally Qualified Health Center (FQHC), or by independent behavioral health Provider
  - **Physical or sexual assault perpetrated by another client,** that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agenices), or FQHC
  - **Death*** that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health Provider, **OR** Death where possible relationship with mental illness or substance use, or their treatment cannot be initially ruled out.
- By an Individual with a behavioral health diagnosis, or history of behavioral health treatment within the previous 365 days. Acts allegedly committed, to include:
  - Homicide or attempted homicide
  - Arson
  - Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death
  - Kidnapping
  - Sexual assault
- Unauthorized leave from a behavioral health facility during an involuntary detention
- Any event involving an individual that has attracted or is likely to attract media coverage *(*Provider includes the link to the source of the media, if available)
- Incidents posing a credible threat to an individual's safety
- Suicide and attempted suicide
- Poisoning/overdoses unintentional or intention unknown

Please note that reporting requirements are subject to change based on Health Care Authority contract requirements, recommendations from stakeholders, or through Behavioral Health Administrative Services Organization (*BH-ASO) quality assurance and improvement process learnings.*

Reporting this information to King County BHRD does not discharge the Contractor from completing any mandatory reporting requirements including, but not limited to, notifying DOH, law enforcement, Residential Care Services, and other protective services as necessary.

Reporting Critical Incidents for BH-ASO or Locally Funded Programs

Providers must report Critical Incidents no later than one (1) business day from when the Provider becomes aware of the incident.

Notes:

- If the client is served in PACT, *report all unexpected deaths to King County Behavioral Health and Recovery Division (BHRD) regardless of facility or funding/payer status.*
- Any media related incidents should be reported to the BH-ASO as soon as possible, and not to exceed one (1) business day.

- If the Provider is a subcontractor, the form should also be sent to the contracting agency.

Organization	Contact/Phone Number	CI Reporting Form
King County Behavioral Health and Recovery Division/BH-ASO	E-mail: BHRDCriticalIncidents@kingcounty.gov Phone: (206) 263-9000 Fax: (206) 296-0583	Attachment A: BHRD Critical Incidents Form

Reporting Critical Incidents for Medicaid Funded Programs

Providers must report Critical Incidents no later than one (1) business day from when the Provider becomes aware of the incident.

Providers report critical incidents to the MCO where the Medicaid Client is enrolled.

Notes:

- If the client is served in PACT, report the critical incident to both the Medicaid Client's MCO, as well as the BH-ASO.
- If the Provider is a subcontractor, the form should also be sent to the contracting agency.
- If the individual has Medicaid and is only enrolled in BH-ASO or Locally Funded services/programs, send the Critical Incident Report to King County BHRD.

Organization	Contact/Phone Number	Link to CI Reporting Form
Amerigroup (P1: AMG)	E-mail: QMNotification@anthem.com Phone: 1-800-600-4441 Fax: 1-855-292-3770	WAWA_CAID_AMGCriticalIncidentReportForm.pdf (amerigroup.com)
Community Health Plan of WA (P1: CHPW)	E-mail: Critical.Incidents@chpw.org Phone: 1-800-440-1561 Fax: (206) 652-7056	CHPW_Critical_Incidents_Form_Updated 12_13_2019
Coordinated Care (P1: CCC)	E-mail: wa_qocci_reporting@centene.com Phone: 1-877-644-4613 Fax: 1-866-270-1885	CCW_Critial_Incident_Notification_Form.ashx (kingcounty.gov)
Molina Healthcare (P1: MHC)	E-mail: MHW_Critical_Incidents@MolinaHealthcare.com Phone: 1-800-869-7165 Fax: 1-800-767-7188	Universal CI Reporting Form MHW FINAL 3.31.2021 (003).pdf
United Healthcare Community Plan (P1: UHC)	E-mail: wa_criticalinc@uhc.com Phone: 1-877-542-8997 Fax: 1-844-680-9871	https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/wa/provider-info/WA-Critical-Incident-Report-Form.pdf

Reporting Documentation Requirements

The Provider ensures the following information is included on the Critical Incident Form submitted:

- The date the Provider became aware of the incident;
- A description of the incident
- The name of the facility where the incident occurred, or a description of the location;
- The name(s) and age(s) of individuals involved in the incident;
- The name(s) and title(s) of facility personnel or other staff involved;
- The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement;
- The individual's location at the time of the report if known (i.e. home, jail, hospital, unknown, etc.) and actions taken by the Provider to locate the individuals or clients if their location is unknown;
- Actions planned or taken by the Provider to minimize harm resulting from the incident; and
- Any legally required notifications made by the Provider.
- In the case of a death of an individual verification from official sources that includes the date, name and title of the sources. When official verification cannot be made, the Provider reports a description of all attempts to retrieve it.

Providers also provides documents and information to facilitate any investigation deemed necessary by the MCO or ASO.

Annual Quality Reviews for Critical Incidents of BH-ASO or Locally Funded Programs

Annually, the BH-ASO conducts quality reviews of selected Critical Incidents. Providers collaborate with BH-ASO staff to review critical incidents as needed. Reviews focus on risk, safety, and quality of services using the BH-ASO Critical Incident Review Guide and take place during annual clinical site visits or at an alternative agreed upon time.

Provider is expected to respond to requests in a timely manner regarding all inquiries related to Critical Incidents. Items flagged as high importance are to be expedited as requested based on timelines stated within the inquiry.

Review Process for Medicaid Funded Programs

The review process may vary depending on the MCO involved. Providers can expect to collaborate with either MCO or BH-ASO staff to review selected critical incidents.

Provider is expected to respond to requests in a timely manner regarding all inquiries related to Critical Incidents. Items flagged as high importance are to be expedited as requested based on timelines stated within the inquiry.

Attachments in this Section:

- Attachment A: BHRD Critical Incidents Form

14 Provider Resource Guide

14.1 Behavioral Health Administrative Services Organization (BH-ASO) and King County Integrated Care Network (KCICN) Provider Resource Guide

The purpose of the Provider Resource Guide is to help behavioral health providers and agencies pursue clinical excellence in serving our community. The Provider Resource Guide includes both academic resources and guidelines, as well as quick reference materials and therapeutic tools. BHRD encourages the use of this document to assist provider staff in their day-to-day activities.
The BH-ASO Medial Director works with BHRD clinical staff, as well as provider agencies, to create and regularly review the Provider Resource Guide. Materials in the Provider Resource Guide are based on:

- The needs of clients and families in the communities served by provider agencies,
- Valid and reliable clinical scientific evidence, and
- Principles from the King County Equity and Social Justice Strategic Plan

Providers are responsible for:

- Maintaining awareness of the Provider Resource Guide and sharing it with staff when appropriate.

Attachments in this Section:

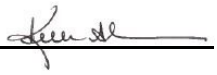
Attachment A 2023 Provider Resource Guide

Appendix A: Behavioral Health Administrative Services Organization (BH-ASO) Policies and Procedures

1.0 POLICY TITLE: BH-ASO Policies and Procedures

1.1 Officially Adopted: October 2, 2018

1.2 Effective Date: January 1, 2019

1.3 Signed: 

Kelli Nomura, BHRD Administrator

When the King County Integrated Care Network (KCICN) and the Behavioral Health Administrative Services Organization (BH-ASO) share the same requirements, the King County entity responsible for meeting or overseeing those requirements are referred to as the Behavioral Health and Recovery Division (BHRD).

2.0 PURPOSE: To describe BH-ASO specific policies and procedures within the King County Regional Service Area. Medically necessary services means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR ACCESS TO SERVICES:

3.1 BH-ASO priority populations include persons in crisis and individuals funded by sources other than Medicaid, included but not limited to, Mental Health and Substance Abuse Block Grants, Criminal Justice Treatment Act, and those in services funded by State General Funds.

3.1.1 Within available resources, the King County BH-ASO prioritizes services to the populations listed, who meet medical necessity, in the following priority order:

A. Pregnant women who inject drugs

B. Pregnant women with substance use disorders

C. Women with dependent children

D. People who inject drugs

3.1.2 The following are additional priority populations, in no particular order:

A. Postpartum Women (up to 1 year, regardless of pregnancy outcome)

B. People transitioning from residential care to outpatient care

C. Youth

D. People with criminal convictions

3.1.3 For non-crisis behavioral health services funded by General Fund-State, within available resources, priority is given to clients who meet financial eligibility, and meet one of the following criteria:

A. Are uninsured;

B. Have insurance, but are unable to pay the co-pay or deductible for services;

C. Are using excessive Crisis Services due to inability to access non-crisis behavioral health services; and

D. Have more than five (5) visits over a six (6) month period to an emergency department, detox facility, or sobering center due to a substance use disorder (SUD).

3.2 Financial Eligibility

3.2.1 Medicaid Eligibility

A. Outpatient benefit authorizations that are approved (status "AA") are evaluated for Medicaid eligibility throughout the authorization period and six months beyond the expiration date. A combination of ProviderOne data and Managed Care Organization (MCO) data are used to determine a client's Medicaid eligibility.

The Medicaid eligibility status in the Behavioral Health and Recovery Division (BHRD) Information System (IS) will match ProviderOne with four exceptions:

1. As Medicaid eligibility for KCICN is established through managed care organization (MCO) Data provided by the contracted MCOs, if there is a discrepancy between an MCO's system and ProviderOne, an agency can inform the KCICN, and KCICN staff will work with MCO to correct the inconsistency.

2. Clients in foster care or a confidential address program.

   A client in foster care or a confidential address program is considered King County BH-ASO Medicaid-eligible if the Provider indicates that the client is in this type of program and if the client qualifies for BH-ASO coverage in another BH-ASO.

3. Clients living in border zip codes.

   Special processing is in place for cases where the client lives in a border zip code – these are zip codes that belong to two different counties. When determining Medicaid coverage, we first check MCO Data supplied by the applicable MCO to verify both Medicaid coverage and if the client is attributed to the KCICN. If the client is covered by Medicaid and attributed to KCICN, then enrollment in behavioral health services can move forward. If the client is covered by Medicaid, but not attributed to KCICN, then KCICN will seek attribution with the MCO. Following attribution, client enrollment can move forward. If a client is covered by Medicaid and an MCO is unable to attribute the client to KCICN, then the client cannot be enrolled in KCICN outpatient services unless the client is eligible for coverage under non-Medicaid funds.

4. Clients moving to King County mid-month.

   This exception applies to new authorization requests that are on hold (in unauthorized "UA" status) due to a discrepancy between agency and

ProviderOne Medicaid eligibility data.

The BH-ASO will receive full 834 eligibility tables to King County monthly with the 834 “adds” and “deletions” coming to the ASO daily. The BH-ASO will track 834 eligibility table the “adds” and “deletions” to assure that information about changes in MCO enrollment occurring midmonth is recorded in the data system and utilized to avoid any gaps in service. This information is available to the Providers through the Extended Client Look-up System (ECLS). Providers are informed of this process and the need to utilize the ECLS for mid-month eligibility changes through KC’s Information System Advisory Committee (ISAC). KC intends to provide daily updates to the Providers on all mid-month eligibility changes through the KC IT system in 2019 which will eliminate the need for Providers to use ECLS for this purpose.

When an authorization request is received, King County BH-ASO and KCICN will compare the agency-supplied Medicaid coverage data with the MCO-supplied Medicaid coverage data. If there is a discrepancy, the authorization will not be approved and will be placed on hold. While the authorization is on hold, the discrepancy will be re-evaluated each time BHRD receives updated MCO data (typically on a daily basis). If the discrepancy is resolved, the authorization will be approved. If the discrepancy remains through the end of the month following the month of the authorization start date, the authorization will be cancelled.

If a client moves to King County mid-month, that month will never show King County as the BH-ASO in the ProviderOne system. To address this, BHRD will apply the following month’s BH-ASO coverage to the previous (partial) month. In order for this to happen:

a. The agency must indicate that the client lived in King County in the partial month;

b. There must be King County BH-ASO coverage for the first full month; and

c. There must be non-King County BH-ASO coverage for the partial month.

B. Effect of Change in Medicaid Coverage or Circumstances

1. Continuity of Care due to change in Medicaid Coverage or Circumstance

a. BHRD does not require clients to enter service on the 1st of the month. If a client experiences a change in Medicaid Coverage, MCO, or circumstance mid-month, BHRD staff will work with Providers to bridge funding sources in order to maintain or establish medically necessary care for the client.

2. Authorizations that started as Medicaid-funded

a. Loss of Medicaid coverage: Payments for months without Medicaid coverage are suspended (resulting in a negative adjustment). Note when a client loses Medicaid coverage, payments are suspended, but the authorization is not cancelled, even if there is no coverage for the first month of the authorization.

b. Gain of Medicaid coverage: Payments for months that are now covered, but were previously suspended, are reinstated (resulting in a positive adjustment).

3. Authorizations that started as non-Medicaid funded

    a. Loss of Medicaid coverage: There is no effect on payments.

    b. Gain of Medicaid coverage: A payment adjustment is made to reflect the change in funding source. The adjustment will only affect the payment amount if there is a difference between Medicaid and non-Medicaid case rates.

    c. The Provider will verify and document the individual's Medicaid eligibility when accepted into services and at every service thereafter. An individual receiving both Medicaid and Medicare will be eligible for King County BH-ASO or KCICN services as a Medicaid client who has a third-party resource.

3.2.2 Medicare Eligibility

Individuals receiving Medicare (but not Medicaid) are eligible as individuals not covered by Medicaid who have a third-party resource. An individual with Medicare, and a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB), is one of the priority populations to receive any outpatient behavioral health non-Medicaid service.

3.2.3 Non-Medicaid Eligibility

A. An individual not covered by Medicaid who is a resident of King County may be eligible for an outpatient benefit if:

    1. The following individuals meet financial eligibility criteria at every non-crisis encounter:

        a. Eligible children are those individuals younger than 18 who have a family income of less than 300 percent of the federal poverty level;

        b. Eligible adults are those individuals age 18 or older who have a family income of less than 220 percent of federal poverty level; and

    2. The individual meets clinical eligibility criteria and priorities.

        a. Actual authorization to a non-Medicaid outpatient benefit is dependent upon the availability of King County BH-ASO financial resources.

        b. An individual with health insurance that appears to cover the individual's care needs may be denied a non-Medicaid benefit even when resources are available.

3.2.4 Financial Eligibility Documenting and Reporting Requirements

A. Client diagnosis must meet state and federal regulations, and justification for all diagnoses must be maintained in the agency records.

B. For clients up to age six: the Provider may use the DC:0-5 diagnosis instead of DSM-5. However, the crosswalk tables in the Data Dictionary must then be used to crosswalk the DC:0-5 diagnosis to ICD-10-CM codes.

C. Whenever any diagnosis is corrected or changed, the agency must resubmit all applicable current DSM-5 or ICD-10-CM diagnostic codes. The most recent set of diagnoses is considered the correct and complete set of diagnoses for the client.

D. See the Data Dictionary on Diagnoses for additional detail on the reporting of diagnoses information to BHRD Information System (IS).

3.2.5 Individuals with Washington Apple Health who do not qualify for KCICN services but may qualify for services through their Washington Apple Health Provider will be referred to that Provider and given additional assistance as needed to facilitate the referral.

3.2.6 Priorities for individuals who do not have Medicaid ("non-Medicaid") and will be funded by local funding.

A. Must be a resident of King County.

B. Income cannot be greater than 220 percent of federal poverty level for a single adult or family, as is appropriate to the individual's living situation. Income cannot be greater than 300 percent federal poverty level for children.

C. The individual may not be covered by any other health insurance, aside from Medicare in some instances where their income is such that they may not be reasonably expected to meet their spenddown.

D. The following table describes first and second priority populations for the use of non-Medicaid resources for routine MH outpatient benefits.

Criteria	First Priority for MH Benefits	Second Priority
State Hospital Discharge	• Being discharged from Western State Hospital (WSH) within next 60 days or was discharged within last 30 days; • A Medicaid application is pending; and • Adult referred by hospital liaison.	
	• Being discharged from Children's Long-term Inpatient Facility within next 60 days or was discharged within last 30 days; and • A Medicaid application is pending.	
Release from Incarceration	Will be released from WA State prison (except ORCSP, or juvenile rehabilitation facility) within next 30 days or was released within last 30 days; and LOCUS/CALOCUS score of at least 14-16; and A Medicaid application is pending.	

Criteria	First Priority for MH Benefits	Second Priority
Extraordinary Treatment Plan	Individual has a current non-Medicaid outpatient benefit; and Is receiving Extraordinary Treatment Plan (ETP) funds.	
Housing	Individual is residing in Standard Supportive Housing or Intensive Supportive Housing program or Shelter-Plus Care; and Will lose housing if MH services are not continued; Individual is residing in Long Term Rehabilitation or Supervised Living facility; and Is stepping down to the SSH program.	
Community Inpatient Hospital Discharge (includes E&Ts)	Individual is being discharged within next 30 days or was discharged within last 30 days from inpatient stay.	
		Individual is being discharged within next 30 days; A Medicaid application is pending; and Hospital discharge social worker has received pre-approval from BHRD clinical specialist prior to discharge.
		Or, see below on Frequent Admissions/ Detentions/Incarcerations.
Chronically Homeless		Individual is experiencing chronic homelessness (see Definitions); and LOCUS/CALOCUS score of at least 14-16.
Discharge from PACT	Individual is being discharged from PACT within the next 60 days; and Has received prior approval by the BHRD PACT Committee. A second year of benefits may be authorized, totaling two years of benefits since discharged from PACT.	
High Level of Care for All Ages		CALOCUS score is 17-19; LOCUS score is 17-19; and

Criteria	First Priority for MH Benefits	Second Priority
Medium Level of Care for Children and Older Adults		Children; or Older adults; and
King County Residents without Medicaid or other insurance		Individuals without Medicaid or other insurance; Children of Individuals without Medicaid or other insurance; and LOCUS/CALOCUS score is at least 14-16.
Medicare Qualifiers		Qualified Medicare Beneficiary (QMB); Specified Low-Income Medicare Beneficiary (SLMB); Qualified Individual (QI-1) Medicaid benefit; and LOCUS/CALOCUS score is at least 14-16
Current Non-Medicaid Benefit with Medicaid Application Pending		Currently enrolled in a non-Medicaid benefit; Not enrolled in a non-Medicaid benefit prior to current benefit; Does not meet other non-Medicaid eligibility conditions; and Has a Medicaid application submitted but not yet approved.
Frequent Admissions/ Detentions/ Incarcerations		Individual has had at least two admissions to any single facility or two admissions to any combination of the facilities below within the year previous to the referral date: • Any psychiatric stay. • Jail/youth detention – any stay that is recorded in a KC Department of Adult and Juvenile Detention database. LOCUS/CALOCUS score is at least 14-16. Referrals from Youth Detention must be made by the children's justice liaison. Referrals from the KC Correctional Facility must be made by the MH Court Liaison.

Criteria	First Priority for MH Benefits	Second Priority
		Referral from a suburban city jail by a criminal justice liaison. Individual meets the above frequent use criteria. LOCUS/CALOCUS score is at least 14-16

E. The following table describes the enhanced criteria for second priority populations for a mental health non-Medicaid outpatient benefit. These enhanced criteria are reviewed on an ongoing basis and contingent upon available funding.

Criteria	Enhanced Second Priority
Single Admission/ Detention/ Incarceration	Individual has been admitted to psychiatric inpatient services or jail or youth detention; LOCUS/CALOCUS score of at least 14-16; Admission occurred in the 12 months prior to the authorization request date.
Medium level of care for all Ages	Individual meets the criteria for a mental health outpatient medium level of care.
Homeless	Individual is homeless according to the BHRD data dictionary definition of homeless under the residential arrangement code; LOCUS/CALOCUS score of at least 14-16.

F. The following table describes first priority populations for the use of non-Medicaid resources for routine SUD outpatient benefits.

Criteria	First Priority for SUD outpatient benefits
People leaving SUD residential treatment service including secure detox	Admission to residential treatment occurred within six months of request for authorization; and Has an ASAM level of 1.0 or 2.1.
Pregnant or Post-Partum Women	Has an ASAM level of 1.0 or 2.1.
IV drug users	Is diagnosed with an opioid use disorder; Is identified as an IV drug user; and Has an ASAM level of 1.0 or 2.1.
People who have high utilization of sobering, Detox, EDs, jail and/or a history of multiple DUIs	Individual has had at least two admissions to any single facility or two admissions to any combination of the facilities below within the year previous to the referral date: 1. Detox, Sobering, or Emergency Departments (EDs); 2. Jail/youth detention – any stay that is recorded in a KC Department of Adult and Juvenile Detention database; 3. Drug Court involvement where CJTA is the payer; Has an ASAM level of 1.0 or 2.1.

Criteria	First Priority for SUD outpatient benefits
People who are military veterans	Has an ASAM level of 1.0 or 2.1. Reports participation in military service.

G. Second priority benefits are funded as resources permit.

H. For mental health agencies that get a quarterly allocation, first priority benefits can be funded using the allocation or using the BHRD Clinical Specialist's non-Medicaid fund source, at the discretion of the agency. The Non-Medicaid Mental Health Outpatient Request Form (with quarterly allocation) must be submitted.

- The allocation takes into account the expenditures for non-Medicaid benefits year to date, to account for any benefits authorized through the exception procedure or due to spenddown status.

I. For mental health agencies without a quarterly allocation, both first and second priority benefits are drawn from the BHRD Clinical Specialist's non-Medicaid fund source. The Non-Medicaid Outpatient Request Form (without a quarterly allocation) must be submitted.

3.3 For SUD agencies, first priority benefits are drawn from the BHRD Clinical Specialist's non-Medicaid fund source. Non-Medicaid Outpatient Request Form (without quarterly allocation) must be submitted for all non-Medicaid SUD benefit requests.

3.3.1 Medication-Assisted Treatment (MAT) in an Opioid Treatment Program (OTP)

Medication-Assisted Treatment (MAT) currently consists of the provision of daily doses of an opiate agonist (methadone) or partial agonist (buprenorphine) and an array of outpatient treatment services designed to address an individual's opioid use disorder provided by qualified opiate treatment Providers. This policy currently addresses only the dispensing programs in King County. In the future, this policy may also address other forms of MAT.

Benefit Characteristics.

A. MAT services are authorized for an open-ended benefit period.

B. The provision of daily medication dosing either on site at the agency's dispensary, by the provision of take-home medication (carries), or by courtesy dosing at approved off-site locations.

C. During the benefit, the full array of MAT outpatient services is available to the client, according to need and mutually negotiated goals of treatment.

Availability of MAT Services

A. Intake Appointment and initiation of services complies with Managed Care CFR's, and WAC 246-341-0610 or its successors.

B. A client is offered, by the Provider, a choice of behavioral health care Providers within the agency (see Section 03: Client Services and Service Notifications).

C. When MAT services are determined to be appropriate, but not immediately available, individuals receive Interim Services via the King County Needle Exchange.

1. Interim Services: A centralized waiting list for interim services is kept by Public Health – Seattle & King County (PHSKC) Needle Exchange. The Needle Exchange provides case management, overdose prevention, and admission support services while the client is on the waitlist.

a. Pregnant women are provided with comprehensive assessment services within 48 hours of referral and treatment services no later than seven days after the assessment has been completed. Waiting List Interim Services must commence upon request for services when comprehensive services are not immediately available.

3.4 Mental Health Continuing Stay Criteria

3.4.1 Clients must meet medical necessity at the time of benefit renewal and must be seen within 28 days before and after the benefit begins.

3.5 Termination of Outpatient Services

3.5.1 Termination of a benefit occurs when an authorization for services is ended prior to the original expiration date.

3.5.2 A terminated benefit is payable to the date of termination.

A. For the required terminations below, the date of the termination is the date of the event, unless otherwise specified.

B. When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped.

3.5.3 A Provider must submit to the Behavioral Health and Recovery Division (BHRD) Information System (IS) a request to terminate a benefit under the following circumstances:

A. The client dies;

B. The client moves out of the County;

C. The client has been in the hospital [including State hospitals, community hospitals, or Children's Long-term Inpatient Programs (CLIP) facilities for 30 days and will not be discharged within an additional 60 days. The effective date of the submitted termination must be 30 days from the date of admission. A new or continued authorization for outpatient services may be requested when a client will be discharged within 60 days. Note that whenever a client's Medicaid status is suspended, any requirements to terminate a benefit due to loss of active coverage also apply;

D. The client has been in prison, jail, Juvenile Rehabilitation Administration (JRA) facilities, or juvenile detention for 30 days and release will not be occurring within an additional 30 days. The effective date of the submitted termination must be 30 days from the date of detention. A new or continued authorization for outpatient services

may be requested when a client will be released within 30 days. Note that whenever a client's Medicaid status is suspended, any requirements to terminate a benefit due to loss of active coverage also apply; and

E. The client is enrolled in the Program of All-inclusive Care for the Elderly (PACE).

3.5.4 A Provider may submit to the BHRD IS a request to terminate a benefit at any time based on significant changes in the client's clinical profile and needs. Reasons for this optional termination include:

A. Successful completion of the ISP where treatment goals have been met;

B. Inability to provide services to a client where factors other than those under the control of the Provider make the provision of care impossible;

C. The client no longer meets outpatient level of care criteria and has been transitioned to and enrolled in an allied system. When appropriate, it is expected that the client will be referred, and enrollment verified in another system for continued care; and

D. The client gains enough resources during the benefit to be treated as a private-pay client.

3.5.5 If a benefit is being terminated because a client is transferring to a new Provider, the original Provider must continue to provide services for the client until it receives an electronic notification of the termination of the benefit. The original Provider will not initiate termination of the benefit.

3.6 Extraordinary Treatment Plan (ETP) approval requests

3.6.1 When a client has treatment needs that exceed the most service-intensive benefit within the BHRD outpatient or residential levels of care, an ETP funding request may be made to BHRD. ETP funds are provided only as resources permit. Requests for ETP funding will be submitted in accord with Attachment H.

Attachments in this Section:

- Attachment A: Non-Medicaid Outpatient Request Form (without quarterly allocation)
- Attachment B: Non-Medicaid Mental Health Outpatient Request Form (with quarterly allocation)

4.0 POLICIES/PROCEDURES/RESPONSIBILITIES FOR OUTPATIENT SERVICES:

4.1 Services

4.1.1 For all age groups, regardless of funding source, the state plan modalities are available as described in Attachment I, State Plan Modalities.

4.1.2 Coordination of care with primary care Providers and other treatment Providers

A. For individuals receiving outpatient services, the following information must be requested from the individual and the responses documented:

1. The name of any current primary medical care Provider;

2. Any current physical health concerns; and

3. Current medications and any related concerns.

B. For individuals receiving Substance Use Disorder (SUD) services, release of information must be compliant with 42 CFR, part 2.

C. Behavioral Health and Recovery Division (BHRD) Provider agencies ensure that each client's primary care Provider and other treatment Provider (if any) are informed of the name of the BHRD Provider agency and how best to contact the client's behavioral health care Provider and psychiatrist or psychiatric ARNP. Specific staff names need not be mentioned.

D. Should the client change primary care or other treatment Providers, the new Providers is contacted by the BHRD Provider Agency with the contact information as above.

E. Providers need not provide the above information when:

1. The client requests the information not be sent and the BHRD Provider Agency concurs with this request, or

2. The fact that the agency is providing services and the procedures for contacting the agency are implicit in shared documentation, such as entries by the agency in a nursing home record, shared medical records within an organization that provides both primary care and behavioral health care, or shared databases regularly used by clinicians, such as the Mental Health Integrated Tracking System (MHITS).

F. For individuals without a primary care Provider, the BHRD Provider Agency documents efforts to assist the individual in establishing care with one.

4.1.3 The following are also available:

A. Interpreter services, including sign language interpretation and other services for clients who are sensory-impaired (see Section 03: Client Rights and Service Notifications and HCA Interpreter Service Program here

B. Health screen referrals;

C. All authorized clients who have physical health needs must be referred to a qualified professional for a health screen if they have not been screened within the past year. For individuals over the age of 60, a referral for screening are made if the individual has not been screened within the past 90 days. These referrals must be recorded in the client's chart;

D. Employment and vocational services for those of employment age (16-65 years of age), according to Washington Administrative Code (WAC) 246-341-0736 or its successor;

E. Residential and housing services for adults, according to WAC 246-341-0722or its successor;

F. Co-Occurring Disorder Screening (see Attachment J);

G. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings for children and youth.

H. Intake evaluation must:

1. Meet WAC 246-341-1126 and WAC 246-341-0610 requirements;

2. Be performed by an MHP, as defined in Revised Code of Washington (RCW) 71.05.020, or by a certified Substance Use Disorder Professional (SUDP) as defined by WAC 246-811-010; and

3. Must include:

a. Current substance use including any SUD diagnoses and treatment status (Global Appraisal of Individual Needs Short Screener [GAIN-SS]);

b. An identification of risk of harm to self and/or others, including suicide/homicide;

c. Note: A referral for provision of emergency/crisis services, consistent with WAC 246-341 or its successor, must be made if indicated in the risk assessment.

d. Whether the individual is under the supervision of the Department of Corrections (DOC); and

e. A recommendation of a course of treatment that:

i. Addresses the presenting problem(s); and

ii. Identifies the use of one or more state plan modalities.

I. An intake evaluation is not required prior to the provision of:

4. Crisis services;

5. Withdrawal management services;

6. Stabilization services; or

7. Rehabilitation case management services.

4.1.4 Individual Service Plan (ISP) development and review

A. Development of the ISP must:

1. Meet WAC 246-341-1126 and WAC 246-341-0620 requirements;

2. ISP must be in place by the end of the first session (individual or group) following the assessment/intake.

3. Be client-driven and strengths-based;

4. Meet the individual's unique behavioral health needs; and

5. Be developed in collaboration with the individual or with the individual's parent or other legal representative if applicable.

a. Updates must reflect:

i. Any changes in the individual's treatment needs or as requested by the individual, or their parent or other legal representative if applicable;

ii. An assessment of current strengths and needs; and

iii. Input from other health, education, social service, and justice agencies, as appropriate and consistent with privacy requirements;

6. Identify any changes that have occurred since the previous assessment (or intake). With the individual's consent or the consent of their parent or other legal representative if applicable;

a. Coordinate with any systems or organizations the individual identifies as being relevant to the individual’s treatment; and

b. This includes coordination with any individualized family service plan (IFSP) when serving children under three years of age.

4.1.5 Clinical record content

A. The licensed behavioral health agency must maintain a clinical record for each individual served in a manner consistent with WAC 246-341, or any successors.

1. Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with Chapters 26.44 and 74.34 RCW has occurred;

2. Documentation that the individual, or their parent or other legal representative if applicable, are informed about the benefits and possible side effects of any medications prescribed for the individual in language that is understandable;

3. The following information must be requested from the individual and the responses documented:

a. History of any substance use/misuse and treatment, including tobacco use;

b. Any disabilities or special needs:

c. When intellectual disabilities are identified in children and youth, include goals that focus on restoration to typical functioning;

d. Previous history of use of inpatient or outpatient services and/or medications to treat a mental health (MH) condition; and

e. Information about past or current trauma and abuse;

4. If the Provider believes the client has a clinical need that the individual does not wish to address, this is documented and available for ISP revision.

a. Crisis services for clients receiving any behavioral health outpatient benefit.

b. In all cases, client need must determine response time. Crisis services may be either emergent or urgent. (See definitions in Section 04: Crisis Services Level of Care.)

c. All behavioral health outpatient Providers must ensure crisis services 24 hours a day, 365 days a year to all clients authorized to a behavioral health outpatient level of care. This includes clients assigned to a Provider, regardless of whether the Provider has previously provided services to the client. These includes:

5. Phone crisis services. This service is always considered emergent. Requirements for these services include:

   a. If the Provider has a voice mail system or answering machine, the first information conveyed must be how to access emergency assistance;

   b. Providing clients access to qualified clinicians without placing the client on hold or having to call another number;

   c. There is immediate access to interpreter services and to individuals who are proficient in the use of TDD or alternate languages to serve individuals who are deaf or hard of hearing; and

   d. The phone assistance offered should provide as needed basic information and referral services to appropriate mental health and substance use disorders, social and health services, as well as assistance in identifying community resources and natural supports.

6. Other crisis services to be provided by all agencies contracted to provide behavioral health outpatient services. This includes clients assigned to a Provider, regardless of whether the Provider has previously provided services to the client.:

   a. Outreach and stabilization services in clients' homes or other appropriate places in the community.

   b. Service coordination and discharge planning with the staff of the hospital diversion or crisis stabilization placements, for clients placed in those beds.

   c. Medication consultation.

   d. Procedures to coordinate with the regular treatment staff by the next working day, if the crisis service is provided outside regular business hours.

   e. Access to the client's crisis plan and advance directive, if applicable.

   f. If a client has a Wellness Recovery Action Plan (WRAP) and has requested a copy be available to crisis services staff, there is access to the client's WRAP.

7. The crisis intervention staff are qualified to provide crisis services.

   a. The qualifications include:

      i. Training in crisis triage and management for individuals of all ages and behavioral health conditions, including severe mental illnesses, substance use disorders, and co-occurring disorders;

      ii. A minimum of a bachelor's degree in a related field or an equivalent combination of education and experience;

iii. Mental Health Professional (MHP) credential or supervised by an MHP (or a child MH specialist when appropriate);

iv. Documented receipt of annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030 (or its successors)

v. Knowledgeable about community resources and utilization of natural supports;

vi. Proficient in assisting callers to identify and utilize their natural supports; and

vii. Skilled in assisting people to problem-solve and use their own strengths, resiliencies, and coping skills to reduce distress.

b. The services may be provided either directly or through a contract or agreement with another behavioral health outpatient Provider to provide the services. If the outpatient Provider subcontracts all or part of its crisis services, it must ensure that the subcontractor is providing services according to these policies and procedures.

c. All Providers must inform clients authorized to a behavioral health outpatient level of care about the crisis services available to them, including after-hours crisis support and the availability of other alternatives to inpatient hospitalization.

i. Providers educate clients and/or individuals who have legal responsibility for the client about when and how to use the designated crisis number. Providers provide this same information to families and/or other natural supports as appropriate.

ii. Providers supply their clients with necessary crisis information. This information is also posted at the Provider's clinical site(s).

iii. Clients are educated about how to access psychiatric inpatient services, should such services be necessary.

d. Clients participate in the development of a Crisis Plan (see Attachment H Crisis Plan Form). Where appropriate, family members, significant others, behavioral health specialists, and/or other relevant parties and/or cultural consultants are also involved in the Crisis Plan development.

All Crisis Plans are in the standardized format provided in Attachment H. If desired, providers can utilize other formats; other formats must include all data elements found in Attachment H and be approved by King County.

4.1.6 Services for an individual in a hospital ED

A. Providers respond to all hospital EDs for any individual:

B. Enrolled with the Provider, regardless of whether the Provider has previously provided services to the client; or

C. Assigned to the Provider and on an LRO. (See Section 4.1.8).

1. Upon the request of hospital ED staff, the Provider gives a telephone response as soon as possible and within two hours of the request;

2. Providers give all information that might assist ED staff in resolving the emergency without a hospitalization. This information includes:

    a. Any crisis plan, advance directive, and/or WRAP plan;

    b. Information on how the individual may obtain crisis outpatient services, including medication services, on the next business day; and

    c. Other interventions and resources that can support diversion from hospitalization (such as daily contacts, use of a diversion bed, medication adjustments and/or implementation of the individuals WRAP plan)

3. Phone contact with the ED includes the option for the Provider to speak directly with the individual to develop a plan for resolving the emergency without hospitalization.

D. If the above activities do not resolve the emergency, the Provider continues efforts as follows:

1. Hospital ED and Provider review all diversion options prior to recommending any hospitalization. Least restrictive options that allow individuals to remain in the community and connected to their support networks are preferred.

    a. If both the ED and Provider staff recommend admission, no outreach is needed, and the hospital will proceed with the admission.

    b. If neither the ED nor the Provider staff recommend admission, the Provider and ED will jointly develop a diversion plan (or one currently in place will be revised). No outreach is needed.

    c. If the ED recommends an admission but the Provider does not, the Provider will develop and implement any needed diversion plan. Unless the ED indicates otherwise, the Provider will go to the hospital to review and implement the diversion plan.

    d. If the Provider recommends an admission but the ED does not, Provider goes to the ED and provide input to the ED to pursue the admission.

        i. If more data is needed to determine whether hospitalization is indicated, or if the ED or Provider need more information about the individual's

clinical status and trajectory, the Provider evaluates the individual directly in the ED to help clarify the next clinical steps.

e. If at any time, the ED refers the client for an evaluation for a civil commitment, the Provider goes to the ED, if not already there.

f. If the Provider recommends the commitment, before leaving the ED, the Provider staff calls the Designated Crisis Responders (DCRs) to offer assistance with declarations and any other activities to support CCS staff.

g. If the Provider does not recommend the commitment, the Provider staff need not complete a declaration for the detention.

E. Whenever outreach to the ED is given, the Provider documents the assessment, recommendations, and all other activities. If the hospital does not allow the Provider to enter documentation on the hospital's forms, the written documentation is given to the ED on Provider letterhead.

4.1.7 Services for a client prior to and following a hospitalization

A. For clients authorized to the behavioral health outpatient level of care, Providers are responsible for:

1. Providing timely services, including but not limited to medication services, for those clients potentially in need of a hospitalization, if it appears such services are an appropriate alternative;

2. Identifying and referring individuals in need of hospitalization;

3. Coordinating with the hospital as follows:

a. Active involvement of Provider staff is expected to take place during a hospital admission process.

i. Provider staff may be asked to individually evaluate the client prior to a potential admission. At a minimum, current clinical information should be provided, such as the current crisis plan, the ISP, and any current mental health advance directive;

ii. When the assigned Provider agency staff individual does not respond to a request for information within an hour, the MHP evaluating the client for admission may contact the supervisor or agency clinical director to obtain the needed assistance;

b. If not done during the admission process, the Provider makes contact with the inpatient team within 24 hours of notification of admission (including weekends) to provide any needed clinical information;

c. If the client has been admitted or transferred to WSH, in addition to providing the above information to the hospital, the same information is provided to the adult inpatient and residential liaison;

d. If clinically indicated, the Provider has a face-to-face contact with the client within three working days;

e. The Provider contacts the inpatient team within three working days to discuss treatment planning;

f. The Provider notifies the client's outpatient psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP), if any, so that individual may contact the inpatient team to discuss treatment planning;

g. The Provider has ongoing face-to-face or telephone contact with the client and inpatient team while the client is hospitalized; and

h. The Provider actively assists in discharge planning, including helping the inpatient team determine the appropriate discharge date and updating the ISP and crisis plan. When appropriate, the Provider (and/or liaisons) assists in the development of a less restrictive court order (LRO) in order to enable the client to return to the community.

4. For clients on psychiatric medications, scheduling prior to the client's discharge a medication management appointment to occur within the time frame negotiated with the hospital.

5. For referred individuals who are not yet authorized to a mental health outpatient level of care but who are eligible for BHRD services, BHRD Providers are responsible for:

6. Providing timely assessment, enrollment, and care on discharge which includes, at a minimum, providing a face-to-face direct service within seven calendar days following discharge, and, for clients on psychiatric medications, scheduling prior to the client's discharge a medication management appointment to occur within the time frame negotiated with the hospital;

7. In addition to the above, for clients referred from WSH;

a. At the request of the adult inpatient and residential liaison, enrolling the referred client prior to discharge and actively participating in discharge planning; or

b. For those clients whose discharge is too imminent to allow time for on-site enrollment, providing outreach and engagement services to ensure that the client receives timely follow-up care, even if the initial scheduled appointments are not kept.

B. Hospitals who need additional assistance from a Provider may contact that Provider's clinical director or a supervisor at the agency phone number or the BHRD Client Services staff at 1-800-790-8049.

4.1.8 Services for a client on a "less restrictive" court order

A. Providers are expected to provide, or monitor the provision of, court-ordered services, for both Medicaid-covered and non-Medicaid-covered clients assigned to their agency who are on a Less Restrictive court order (LRO). Providers may refuse to accept the LRO on origination of the LRO if the Provider agency and the court have mutually agreed that the Provider agency is not appropriate to be assigned the LRO. Once a Provider has agreed to provide, or monitor the provision of, court-ordered services for a client, it is the responsibility of the Provider to carry on with the obligations the Provider agreed to for the duration of the court order. If

the client needs to transfer care during the duration of the LRO, the Provider agency is required to contact the court to request an amended LRO. The Provider agency is still expected to continue care for the client until the amended LRO goes into effect.

B. Services are provided according to the requirements in WAC 246-341-0805 or its successor.

NOTE: The following programs offer LRO services:

- Adult Outpatient Medicaid and Adult Outpatient MIDD
- Progressive Assertive Community Treatment, PACT
- New Journeys - First Episode Psychosis
- Intensive and Standard Supportive Housing
- Residential Services – Long Term Rehabilitation, LTR
- WSH Intensive Community Support Program
- Expanding Community Services Intensive Community Support and Recovery Program
- Homeless Outreach Stabilization and Transition Project - Intensive Case Management, HOST
- SUD Outpatient Medicaid and SUD Outpatient MIDD

4.1.9 Medication Evaluation Services

A. Each Provider agency ensures 24-hours-per-day access to a psychiatrist, physician, physician assistant, or ARNP (all of whom have at least one (1) years' experience in the direct treatment of individuals who have a mental or emotional disorder) for consultation to the client's assigned clinician or on-call Provider staff.

B. All clients authorized for an outpatient benefit has access to a psychiatrist or psychiatric ARNP for a face-to-face evaluation within 24 hours of an urgent clinical need.

4.1.10 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

A. The federal and state requirements of EPSDT for the Medicaid children's population is met through the provision of outpatient services.

B. Providers ensure face-to-face intake evaluations are completed for all children newly authorized to BHRD outpatient services.

1. Each EPSDT child referred by a health Provider is contacted to confirm whether services are being requested by the individual or the individual authorized to consent to treatment for that individual.

   a. The Provider maintains documentation of its efforts to confirm whether the individual or individual authorized to consent to treatment for the individual requests, declines, or does not respond to efforts within 10 working days to confirm whether these services are being requested.

b. If services are requested, an appointment for a behavioral health intake evaluation must be offered no later than 10 working days from the confirmed request for services by the family or youth.

2. If circumstances occur that prevent the completion of the behavioral health intake evaluation within this time period, a written description is placed in the clinical record documenting the problem(s) encountered, the remedial action(s) to be taken, and a specific timeline to ensure completion of the assessment.

C. For children covered by Medicaid, Providers are required to respond to referrals from primary medical care Providers. This includes:

3. A written notice replying to the Physician, ARNP, Physician Assistant, trained public health nurse, or RN who made the EPSDT referral. This notice includes at least the date of the intake and diagnosis; and

4. If the child or family does not identify a medical care Provider, the Provider informs the family of the EPSDT rights.

4.1.11 If the child or family does not identify a medical care Provider, the Provider informs the family of the EPSDT rights.

4.1.12 Vocational Services

Providers will:

A. Either provide employment services, refer clients for employment services, and/or support clients in maintaining employment.

B. Provide the client with information about how employment will affect his/her income and benefits or refer to an external Provider such as Plan to Work for benefits counseling.

C. Refer the client to the outpatient Provider's own employment program, one of the Specialty Employment Program (SEP) Providers, or to a community employment service Provider such as the Department of Vocational Rehabilitation, local WorkSource Centers, or the Medicaid-funded Supported Employment Program through the Foundational Community Supports Program for a vocational assessment, if the client expresses an interest in employment.

D. Coordinate outpatient treatment services with vocational services provided by the Provider's employment program or the SEP.

E. Document coordination of outpatient services with employment services, including progress towards goals for all clients referred or engaged in an employment program.

4.2 Documentation requirements for outpatient encounters

4.2.1 All clinical services must be recorded in the clinical record with the:

A. Date of service;

B. Service description consistent with procedure code (i.e., CPT or HCPCS) and modifier (if applicable) submitted to BHRD IS;

C. Service location;

D. Service duration and/or unit;

E. Primary diagnosis clinician is treating during encounter;

F. Clinician taxonomy number;

G. Clinician's individual National Provider Identifier (NPI) number;

H. Signature of the clinician providing the service, verifiable against a printed name (name or signature may be generated by the electronic medical record); and

I. Clinician's credentials.

4.2.2 Documentation occurs for each unit of service provided.

4.2.3 The entry must provide enough information to justify the service code.

4.2.4 The entry must be legible to someone other than the writer.

4.2.5 Progress notes reference the client's current clinical status and response to the ISP.

4.2.6 Documentation of crisis services

A. Documentation must include the date and time each request for a crisis response was received, the date and time of each response was provided, and an indication of whether or not the response was face-to-face.

B. Documentation must demonstrate that emergent crisis services are provided within two hours of the request for such services.

C. Documentation must demonstrate that urgent crisis services are provided within 24 hours of the request for such services.

4.3 Management of Service Utilization

4.3.1 Providers have a comprehensive utilization management process that identifies patterns of service utilization by all clients, and includes strategies to ensure that the right services are provided at the right time in the right place (e.g., type, duration, intensity, and frequency).

4.3.2 Providers review the agency-specific outpatient service utilization reports provided by BHRD to identify service utilization patterns for all behavioral health outpatient benefits. Providers determine if the services or the benefit level should be changed to reflect the increased or decreased needs of the individual client.

4.3.3 Providers develop and implement protocols for the utilization management of their clients who are frequently served by other costly systems, such as residential services, emergency room utilization, inpatient psychiatric care or jail.

4.3.4 BHRD tracks these clients and work with Providers to decrease subsequent need for these services, such as developing and implementing relapse prevention plans, client-centered crisis plans, and to mitigate crisis service utilization. This may include joint Providers; managed care organizations, and BHRD care conferences. Such care conferences must include the client and informal and/or formal supports as appropriate.

If the participation of the client is believed to be clinically contraindicated, the justification for this must be documented.

4.3.5 BHRD produces a regular High Utilizer Report of individuals who have had three or more BHRD-authorized psychiatric hospitalizations or residential SUD admissions in the preceding 12 months.

A. The report includes the client's outpatient Provider.

B. Individuals who are not authorized with an outpatient Provider are identified on the report separately.

C. Provider-specific client lists are shared quarterly with each Provider's clinical director.

D. Providers participate in BHRD approved quality improvement initiatives.

E. 4.3.6 Provider agencies use Collective Ambulatory (formerly PreManage) to conduct emergency department (ED) and hospital utilization management for all clients in ongoing outpatient or specialty mental health and substance use disorder programs.

5.0 FINANCIAL BUSINESS RULES:

5.1 Payment

5.1.1 Providers are paid for the delivery of outpatient services according to a case rate model, with the exception of Medication-Assisted Treatment (MAT).

5.1.2 Case rate Providers are prepaid monthly.

A. For services to clients with ongoing benefits, Providers receive the monthly case rate for that client at the start of the month for services to be provided during that month.

B. For services to new clients or to clients ending services, adjustments to payment may be applied retroactively.

C. Additional adjustments may occur as needed.

5.1.3 Providers are paid for the delivery of MAT services according to a dose day payment model.

A. MAT Providers are paid monthly.

1. For clients with an open MAT benefit, Providers receive monthly payments for; 1) each dose day encounter provided during the current month and adjustments made to the previous three months 2) peer support service encounters submitted during the current month for the period of the past 12 months.

2. Additional adjustments may occur as needed upon BHRD approval.

5.1.4 In general, Behavioral Health and Recovery Division (BHRD) expects that if a client is also receiving intensive behavioral health care services reimbursed through another funding source (for example, the state Children's Administration), no greater than a mental health outpatient medium level of care.

5.1.5 Stacked Benefits

A. The “Program Overlap Rules” document provides details on which programs can overlap and under what conditions. This document is available in the ISAC Notebook.

B. A client is limited to one mental health outpatient benefit and one SUD outpatient benefit authorization at a time. The Provider holding the authorization receives the case rate for the client and is responsible for coordinating all care.

5.1.6 Payment of subcontractors

A. If a Provider chooses to have a credentialed subcontractor provide services to an authorized client, it is the responsibility of the Provider and subcontractor to negotiate payment for services.

APPENDIX B: Delegation Agreement for Contracted Crisis Services

King County Behavioral Health Administrative Services Organization (BH-ASO) delegates to specific agencies certain activities or services necessary to support and facilitate the provision of behavioral health, recovery, or crisis services to residents of King County and surrounding areas. In addition, the BH-ASO recognizes the importance in maintaining responsibility and appropriate structures and mechanisms to oversee delegated activities. The following content serves as a reference and resource for King County BH-ASO delegate: Crisis Connections.

Monitoring and Oversight of Delegated Activities

BH-ASO delegates to contracted agencies specific activities and/or services necessary to support and facilitate the provision of behavioral health, recovery, or crisis services to residents of King County and surrounding areas. BH-ASO partners with their delegated agencies to review and analyze the performance of delegated entities. This allows BH-ASO to track and monitor the quality of services being performed by the delegated entity, as well as the effectiveness of any interventions or corrective actions.

Pre-Delegation Evaluation:

- BHRD evaluates the delegate's capacity to meet any National Committee for Quality Assurance (NCQA) or Washington Administrative Code (WAC) requirements within the prescribed look-back period prior to implementing delegation
- Examples of pre-delegation evaluation can include but are not limited to: site visit, telephone consultation, documentation review, committee meetings, and virtual review.

Ongoing Review and Evaluation of Delegated Activities:

- Annually, BH-ASO reviews its delegate's policies and procedures related to delegated activities or functions.
- Annually, BH-ASO audits delegate files against NCQA or WAC quality and client safety standards for each year that delegation has been in effect.
- Annually, BH-ASO evaluates delegate performance against NCQA or WAC standards for delegated activities.
- Semi-annually, BH-ASO evaluates regular reports applicable to delegated activities.

Corrective Action Plans:

- For delegation agreements that have been in effect for more than 12 months, at least once in each of the past 2 years BHRD follow-ups on opportunities for improvement.
- BH-ASO uses information from its delegation evaluation, ongoing reports, and/or annual evaluation to identify areas of improvement.
- If a delegate fails to meet any of its responsibilities outlined in the Delegation Agreement, including NCQA accreditation or WAC standards, BH-ASO works with the delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If delegate does not take corrective action, or fails to meet improvement goals, BH-ASO reserves the right to revise the contract or delegation agreement and scope or revoke the contract or delegation agreement altogether.

Delegation Agreement/Delegation Grid

The purpose of the following grid is to specify the responsibilities of the King County Integrated Care Network Provider, Crisis Connections ("Delegate") with respect to the specific activities that are Delegated: Utilization Management, Quality Improvement, WACs. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Contract. The grid below applies to the delegation of Behavioral Health Utilization Management, Quality Improvement, and WACs for Crisis Services by King County BH-ASO to Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by King County BH-ASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which King County BH-ASO evaluates Delegate's performance and the remedies available to King County BH-ASO if Delegate does not fulfill its obligations.

Process of Evaluating Delegate's Performance:

King County BH-ASO requires routine reports and documentation as listed in the delegation grid and uses this documentation to evaluate Delegate performance on an ongoing basis. In addition, King County BH-ASO will:

- Conduct an annual audit to ensure all Delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Delegate to implement corrective action plans if the Delegate does not fully meet Compliance Requirements.

If King County BH-ASO determines that Delegate has failed to adequately perform the Delegated activities, King County BH-ASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Delegate.

Ongoing performance of accredited Delegate is evaluated through the semi-annual and routine monitoring of reports. King County BH-ASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans:

If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, King County BH-ASO works with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, King County BH-ASO reserves the right to revise the delegation agreement and scope or revoke the delegation agreement altogether.

UTILIZATION MANAGEMENT (UM) DELEGATION GRID			
Function	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**King County BH-ASO Activities**
UM program applies objective and evidence-based criteria and takes individual circumstances and local delivery system into account when determining the medical appropriateness of health care services, makes criteria available, and is consistent in the application of criteria. [UM 2]	• Uses written decision-making criteria that are objective and based on medical evidence [UM 2.A.1] • Has policies for applying the criteria based on individual needs. [UM 2.A.2] • States in writing how practitioners can obtain UM criteria and makes them available upon request [UM 2.B.1, 2.B.2] • Evaluates consistency with which health care professionals involved in UM apply criteria in decision-making and acts on opportunities to improve consistency. [UM 2.C.1, 2.C.2]	Reports Inter-Rater Reliability (IRR) scores to Manager of Delegation on an annual basis. The report can be submitted electronically or hardcopy.	Manager of Delegation receives and reviews the IRR scores.
Members and practitioners can access staff to discuss UM issues *[UM 3]*	• Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. *[UM 3.A.1]* • Staff can receive inbound communication regarding UM issues after normal business hours. *[UM 3.A.2]* • Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. *[UM 3.A.3]* • TDD/TTY services for members who need them. *[UM 3.A.4]* • Language assistance for members to discuss UM issues. *[UM 3.A.5]*	None.	Manager of Delegation oversees services to ensure they meet standards during annual audit.

UM decisions are made by qualified health professionals. *[UM 4]*	• Has appropriately licensed professionals supervise all medical necessity decisions and specifies type of UM personnel responsible for each level of UM decision making. *[UM 4.A.1 and 4.A.2]* • Has professionals with required education, training or professional experience in medical or clinical practice with current active license who review denials of care based on medical necessity. *[UM 4.B.1, 4.B.2]* • Has physician or appropriate behavioral healthcare practitioner review any behavioral healthcare denial of care based on medical necessity. *[UM 4.D, ASO contract, 11.1.7]* • Has written procedures for using board-certified consultants and provides evidence of use of board-certified for medical necessity review. *[UM 4.F.1 and 4.F.2]*	None.	Manager of Delegation oversees services meet standards during annual audit.
UM decisions are made in a timely manner to minimize any disruption in the provision of healthcare. *[UM 5]* *[ASO contract, 11.4.3.3]*	• For urgent concurrent review, the organization acknowledges receipt for services within two (2) hours and provides a decision and notification within twelve (12) hours of receipt of request. *[ASO contract, 11.4.3.3]* • For post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request and gives electronic or written notification of the decision to practitioners and members within 2 calendar days of the decision. *[ASO contract, 11.4.3.3]*	Reports timeliness of behavioral health decision making to Manager of Delegation on a semi-annual basis. The report can be submitted electronically or hardcopy.	Manager of Delegation receives and reviews compliance during the annual file review.

CRISIS LINE TELEPHONE ACCESS DELEGATION GRID			
Function	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**King County BH-ASO Activities**
Behavioral Health Telephone Access *[ASO Contract, Exhibit E]*	Shows a telephone abandonment rate within 5 percent.	Submission to King County BH-ASO a monthly summary report. Reports provided in electronic or hard copy.	Manager of Delegation receives and reviews monthly reports for performance review.
Behavioral Health Telephone Access *[ASO Contract, Exhibit E]*	Shows that telephones are answered by a live voice within 30 seconds.	Submission to King County BH-ASO a monthly summary report. Reports provided in electronic or hard copy.	Manager of Delegation receives and reviews monthly reports for performance review.
Call Center Reports *[ASO Contract, Exhibit E*	Crisis Line Call Center Reports to include: Caller demographics	Submission to King County BH-ASO staff monthly.	The BH-ASO analyzes information to assist in improving the crisis response system.
Call Center Reports *[ASO Contract, Exhibit E]*	Crisis Line Call Center Reports to include: • Analysis of calls, callers, dispositions, origin of call (e.g. home, emergency room, community, Provider), referral sources and other relevant information to make recommendations and assist in improving the crisis response system.	Submission to King County BH-ASO staff daily.	The BH-ASO analyzes information to assist in improving the crisis response system.
246-341-0900 Crisis mental health (MH) services—	<u>Agency staff requirements:</u> • All crisis mental health services are provided by, or under the supervision of, a mental health professional;	Applicable policies and procedures for agency staff requirements and record content and documentation requirements. Evidence of current qualifications of MHPs and	Manager of Delegation receives and reviews the policies and procedures, protocols,

General	• Each staff member working directly with an individual receiving any crisis mental health service in WAC 246-341-0905 through 246-341-0920 receives:
	  • Clinical supervision from a mental health professional and/or an independent practitioner licensed by department of health; and
	  • Annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030. The staff member's individual record must document the training.
	• Staff access to consultation with one of the following professionals who has at least one year's experience in the direct treatment of individuals who have a mental or emotional disorder:
	  • A psychiatrist;
	  • A physician; or
	  • An advanced registered nurse practitioner (ARNP) who has prescriptive authority.
		clinical supervisors.
		Documentation of violence prevention training.
		List of current professional consultants.
		Documentation audit process and results of annual documentation audits for compliance with record content and documentation requirements, and documentation of any corrective actions taken on identified opportunities for improvement.
			documentation and reports.

246-341-0905 Crisis mental health services—Telephone support services	Mental health telephone support services are services provided as a means of first contact to an individual in crisis. These services may include de-escalation and referral. The agency must: • Respond to crisis calls twenty-four-hours-a-day, seven-days-a week; • Have a written protocol for the referral of an individual to a voluntary or involuntary treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated crisis responder; • Assure communication and coordination with the individual's mental health care Provider, if indicated and appropriate.	Applicable policies and procedures and protocols. Monthly Summary Call logs	Manager of Delegation receives and reviews the policies and procedures, protocols, documentation and reports including monthly summary call logs.

Definitions

Action	The denial or limited authorization of a contracted service based on medical necessity.
Acute Withdrawal Management	Services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Medically monitored withdrawal management provides medical care and physician supervision for withdrawal from alcohol or other drugs.
Addiction	Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.
Administrative Hearing	An adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW or the Agency's hearings rules found in Chapter 182 WAC.
Adjustment	A process whereby changes to Provider payments are made as a result of policy decision.
Adult	A person who is 18 years of age or older.
Adult Crisis Services	Specialized adult crisis services for adults 18 or older who are not enrolled in the King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) outpatient or residential services. The service provides next day appointments (NDAs) and follow-up care, both in and out of facility, until the crisis has stabilized.
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, relating to the provision of health care, when the individual is incapacitated (WAC 182-501-0125).
Advocacy Service	A service for clients and family members primarily staffed by current or former family members who provide assistance with questions, complaints, and/or grievances.
Agency	For purposes of the King County Integrated Care Network (KCICN) and Behavioral Health-Administrative Service Organization (BH-ASO), this refers to licensed community behavioral health centers credentialed to provide behavioral health services to KCICN and/or BH-ASO clients and families; also called a Provider.
Agreement	The King County Integrated Care Network (KCICN) Base Provider Agreement entered into between Behavioral Health and Recovery Division (BHRD) and Provider, including all attachments and incorporated documents or materials.
Alcohol and Other Drug (AOD) Screen	A process designed to identify people who have or who are at risk of having a substance use disorder (SUD). The process evaluates substance use, which contributes to illness, injury, or other long-term morbidity and/or mortality.

Allied System	An organization in close relationship to the behavioral health system responsible for the provision of services (that are not classified as behavioral health services) to clients and families.
Allied System Provider	An agency or person representing an allied system that provides direct services to clients and their families.
American Society of Addiction Medicine (ASAM)	A professional medical society dedicated to increasing access and improving the quality of addiction treatment.
American Society of Addiction Medicine (ASAM) Criteria	Admission, continued stay, transfer and discharge criteria for individuals with addiction and co-occurring conditions as published by ASAM.
Appeal	A request for review of an action.
Appeal Process	The Provider's procedures for reviewing an action.
Assertive Engagement	Regular outreach and engagement efforts intended to connect with and keep individuals engaged in services. Examples of this include, but are not limited to: letters, phone calls, offering flexible appointment times, community outreach, home visits, etc.
Authorization	The activity by the King County Integrated Care Network (KCICN) and Behavioral Health-Administrative Services Organization (BH-ASO) in which a level of care or a specific service is determined to be medically necessary.
Available Resources	Funds appropriated for the purpose of providing behavioral health programs. This includes federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated by the Legislature.
Bed Day	Any day in residence at a residential behavioral health treatment program, excluding the day of discharge.
Behavioral Health Administrative Services Organization (BH-ASO)	An entity designated by the Health Care Authority (HCA) to administer behavioral health services and programs, including crisis services for residents in a defined Regional Services Area. The BH-ASO administers crisis services for all residents in its defined service area, regardless of ability to pay, including Medicaid eligible clients. Behavioral Health and Recovery Division (BHRD) has been designated to serve as the BH-ASO for the King County Regional Service Area.
Behavioral Health	Mental health and substance use disorder (SUD) conditions and related services.
Behavioral Health Crisis Services (Crisis Services)	Providing evaluation and short term treatment and other services to individuals with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the individual's health or safety.

Behavioral Health and Recovery Division (BHRD)	A division within King County's Department of Community and Human Services (DCHS) responsible for oversight and provision of behavioral healthcare services encompassing Behavioral Health-Administrative Services Organization (BH-ASO) and King County Integrated Care Network (KCICN). KCICN and BH-ASO are referred to as "BHRD" in this document where the requirements are relative to both entities.
Behavioral Health and Recovery Division (BHRD) Information System (IS)	The Behavioral Health Information System (BHIS) refers to the total electronic information system and network used by the state, King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO), and contract Providers to collect, store, and disseminate information concerning client participation in behavioral health services.
Behavioral Health Administration (BHA)	The Division of Behavioral Health (DBHR) is part of the Behavioral Health Administration (BHA). DBHR and BHA are part of the Washington State Department of Social and Health Services (DSHS). BHA funds and oversees quality services for youth substance abuse prevention and intervention, inpatient treatment, outpatient treatment and recovery support to people with addiction and mental health needs. BHA's core services focus on individual support, health care quality and costs, and administration.
Breach	The acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of PHI, with the exclusions and exceptions listed in 45 C.F.R. § 164.402.
Brief Intervention	A time limited, structured behavioral intervention using techniques such as evidence-based motivational interviewing, and referral to treatment services when indicated. Services may be provided at sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.
Business Hours	8:00 am to 5:00 pm Pacific Time, Monday through Friday.
Capacity Management	A system for identifying treatment capacity for individuals who cannot be admitted and a mechanism for matching individuals to treatment programs with sufficient capacity.
Care Coordination	A process-oriented activity to facilitate ongoing communication and collaboration to address the multiple needs of an individual to achieve optimal health and wellness outcomes. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved Providers and agencies, organizing, facilitating and participating in team meetings, and providing for continuity of care by creating linkages to and managing transitions between levels of care.
Case Management	Services provided to assist clients in gaining access to needed medical, social, education, and other services. Does not include direct treatment services in this sub element. This covers case planning, case consultation and referral services, and other support services for the purpose of engaging and retaining clients in treatment or maintaining clients in treatment. This does not include treatment planning activities. See SERI Encounter Reporting Instructions (SERI) for encountering requirements.

Case Rate	A payment level approved for each person authorized for an outpatient or residential benefit payable to a Provider. Rates are based on a medical necessity assessment that determines a service intensity level. Rates are further adjusted based on age group (child or adult) and for cultural and language differentials.
Center for Medicare and Medicaid Services (CMS)	An administrative agency of the United States government, responsible for administering the Medicare program.
Certified Peer Counselor (CPC)	An individual that identifies as a consumer of behavioral health services or a parent or legal guardian of a child who has received behavioral health services that has met the Division of Behavioral Health and Recovery's (DBHR) training and testing requirements. When employed in a Medicaid funded agency, CPCs also hold an agency affiliated counselor credential from the Department of Health (DOH). CPCs draw upon their lived experiences to help their peers find hope and make progress toward accomplishing their recovery goals.
Chemical Dependency Disposition Alternative (CDDA)	Juvenile alternative sentencing program offering substance use disorder (SUD) treatment in lieu of more restrictive detention alternatives.
Child and Family Team	A group chosen by the child, youth, and/or family who will support them to meet their needs across life domains. The team is comprised of members who continue to support the family when professionals are no longer involved.
Child/Adolescent	An individual less than 18 years of age, also known as adolescent, juvenile, or minor.
Child and Family Team (CFT)	A group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family's care plan, address unmet needs, and work toward the family's vision and team mission.
Children's Crisis Outreach Response System (CCORS)	King County's CCORS provides crisis services to children, youth and families in King County who are not already enrolled in the publicly funded King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO). CCORS also provides limited services to children and youth who are currently enrolled in the KCICN. CCORS serves about 800 children, youth and families a year. CCORS builds on the family's and youth's strengths to provide creative and flexible solutions that focus on teaching and modeling parenting and problem-solving skills to manage behavior and avoid out of home placement. CCORS helps families achieve stability, helps prevent future crises, and helps children remain in their home.
Children's Long-Term Inpatient Program (CLIP)	A medically based treatment approach, available to all Washington State residents, ages 5 to 18 years of age, providing 24 hour psychiatric treatment in a highly structured setting designed to assess, treat, and stabilize youth diagnosed with psychiatric and behavioral disorders.
Children's Program	A behavioral health program that can serve people up to 21 years of age.

Chronically Homeless	A person who has either been continually homeless for a year or has had at least four episodes of homelessness in the past three years.
Client	A person who has been determined to meet both financial eligibility and medical necessity criteria and has been authorized for any Behavioral Health and Recovery Division (BHRD) funded services.
Client Services	A King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO) staff unit that accepts calls and correspondence from clients, potential clients, and family members; answers questions regarding benefits, eligibility, access to care; and receives and attempts to resolve complaints and grievances.
Clinical Indicators	Include, but are not limited to, inability to maintain abstinence from alcohol or other non-prescribed drugs, positive drug screens, individual report of a subsequent alcohol/drug arrest, individual leaves program against program advice, unexcused absences from treatment, lack of participation in self-help groups, and lack of individual progress in any part of the treatment plan.
Clinical Review	Review of services provided to a client in order to evaluate the quality of care and the impact on the outcome of treatment and/or to verify medical necessity.
Code of Federal Regulations (CFR)	The codification of the general and permanent rules and Regulations, sometimes called administrative law, published in the Federal Register by the executive departments and agencies of the federal government of the United States.
Community Mental Health Agency (CMHA)	A behavioral health agency that is licensed by the state of Washington and certified to provide mental health services
Community Outreach, Intervention and Referral Services	Providing individuals, the general public and community organizations with information on substance use disorders (SUDs), the impact of SUDs on families, treatment of SUDs, and treatment resources that may be available, includes responding to telephonic inquiries and other information activities. Also includes referral to assessment, treatment, interim services, and other appropriate support services.
Community-Based	Service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible and that safely promote client and family integration into home and community life.
Complaint	Any client expression of dissatisfaction that is resolved to the client's satisfaction through simple, first-level dialog. If not resolved to the client's satisfaction, the client has the option to escalate to the level of a formal Grievance with the funder of the services..
Confidentiality	An ethical principle, codified by state and federal statutes, that a behavioral health professional may not reveal any information disclosed in the course of behavioral health treatment, including the fact of providing treatment, unless authorized by law.
Conjoint Counseling	A planned therapeutic or counseling activity specific to substance use disorder provided by a Substance Use Disorder Professional (SUDP) or SUD Trainee (SUDPT) under the supervision of a SUDP to a client and one or more of his/her family by one or more therapists.

Continued Stay Criteria	The minimum criteria to receive an additional authorization for a specific level of care.
Continuity of Care	The provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one (1) setting as the individual transitions between: facility to home; facility to facility; Providers or service areas; managed care Contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include but are not limited to: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings or emergency departments, to home or other health care settings such as outpatient settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice to another; and from substance use care to primary and/or mental health care.
Contract	A written agreement between Behavioral Health and Recovery Division (BHRD), including the King County Integrated Care Network (KCICN) or Behavioral Health-Administrative Services Organization (BH-ASO), and a contracted Provider agency. This includes any exhibits, documents, and materials incorporated by reference.
Contractor	The individual or entity performing services pursuant to a contract and includes the Contractor's owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, officers, directors, partners, employees, and/or agents
Contracted Services	Services that are to be provided by the Contractor under the terms of a Contract within Available Resources.
Co-Occurring Disorder (COD)	A condition in which an individual has a simultaneous major mental disorder and a coexisting substance use disorder (SUD).
Corrective Action Plan (CAP)	A written plan, specifying Provider requirements to correct identified deficiencies, the plan may include a timeline for such action and consequences of lack of action.
Cost Reimbursement	The contractor is reimbursed for actual costs up to the maximum consideration allowed in the contract.
Covered Services	Health care services that are medically necessary, are within the normal scope of practice and licensure of Provider, and are covered under contract exhibits between King County Integrated Care Network (KCICN), Behavioral Health Administrative Services Organization (BH-ASO) and Providers.
Criminal Justice Treatment Account (CJTA)	An account created by the state for expenditure on substance use disorder (SUD) treatment and treatment support services for offenders with a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b) the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program (RCW 71.24.580).

Crisis Response	Interventions provided to stabilize an individual to reduce behavioral health crisis.
Crisis Service	A response to urgent and emergent behavioral health needs of persons in the community. The goal of this service is to stabilize the individual and family in the least restrictive setting appropriate to their needs, considering strengths, resources, and choice. Interventions are age and developmentally appropriate and contribute to and support the individual's innate resiliency and recovery.
Crisis Services with Next Day Appointment (NDA) Services	Providing emergency interventions for alcohol or drug related crisis to include, on a short-term basis, general assessment of the individual's condition and/or an interview for diagnostic or therapeutic purposes which may or may not lead to ongoing treatment. Also includes referral to assessment, treatment, interim services, and other appropriate support services. Does not include the costs of ongoing therapeutic services.
Crisis Stabilization Placement	Short-term intervention to help children, youth, and families not otherwise enrolled in King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) services, through a crisis. Interventions include beds that are available for children requiring immediate out-of-home placements who lack family or natural resources to safely rely upon. *See Inpatient Diversion Beds.*
Critical Incident	A situation or occurrence that places a client at risk for potential harm or causes harm to a client. Examples include homicide (attempted or completed), suicide (attempted or completed), the unexpected death of a client, or the abuse, neglect, or exploitation of a client by an employee or volunteer.
Cultural Competence	The ability to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of cultural competent care include striving to overcome cultural, language, and communications barriers, providing an environment in which individuals from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options, encouraging individuals to express their spiritual beliefs and cultural practices, and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. See Washington Administrative Code (WAC) Chapter 246-341-0200.
Cultural Differential	An adjustment in the case rate for each outpatient benefit to support services to clients who are ethnic minorities, sexual minorities, deaf or hard of hearing or non-facility-based medically compromised homebound individuals. The cultural differential payment rate is based on being a member of any one or more of these groups; the payment is not additive if the client belongs to more than one group.
Culture	An integrated pattern of human behavior, which includes and is not limited to: thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and the expected behaviors of a racial, ethnic, religious, social, or political group; the ability to transmit the above to succeeding generations; and dynamic in nature.

Day Support	An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Individuals to promote improved functioning or a restoration to a previous higher level of functioning
Deaf	A hearing impairment of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication, and gestures.
Department of Children, Youth and Families (DCYF)	The Washington State agency responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.
Department of Community and Human Services (DCHS)	A King County Department that manages a range of programs and services to help King County's most vulnerable residents and strengthen the communities. DCHS includes 5 divisions: • Adult Services • Behavioral Health and Recovery • Children Youth and Young Adults, • Developmental Disabilities and Early Childhood Supports • Housing, Homelessness and Community Development
Department of Social and Health Services (DSHS)	The Washington State agency responsible for providing a broad array of health care and social services.
Developmental Disabilities Administration (DDA)	Washington State agency that is responsible for providing a safe, high-quality, array of home, community and facility-based residential services and employment support for Washington citizens with disabilities.
Designated Crisis Responder (DCR)	A person designated by the county or other authority authorized in rule, to perform the civil commitment duties described in Chapters 71.05 RCW and 71.34 RCW.
Division of Behavioral Health and Recovery (DBHR):	The Health Care Authority (HCA) behavioral health division that administers state only, federal grants, and Medicaid funded behavioral health programs in community settings.
Diverted Juvenile Offender	Any alleged juvenile offender who has entered into a diversion agreement with a superior court diversion unit and who is still under the supervision of such unit. This term also includes a juvenile over 18 years of age who entered into an agreement prior to the 18th birthday as provided in Revised Code of Washington (RCW) 13.04.080 (12).
Dose Day	A Medication-Assisted Treatment (MAT) all-inclusive rate for face-to-face bundled services which include drug/alcohol assessment, daily methadone dose, urinalysis testing, vocational rehabilitation services, individual counseling, group counseling, family therapy, family planning session, counseling and education for pregnant patients, Human Immunodeficiency Virus (HIV) screening, counseling, and testing referral, and case-management. Only one billing per day per client is allowable. Missed doses or days without any of the listed activity are not billable as actual dose days.

Drug Court	A specialty court that has judicially supervised court dockets that handle the cases of non-violent substance abusing offenders under the adult, juvenile, family and tribal justice systems. Drug Courts operate under a specialized model in which the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities work together to help non-violent offenders find restoration in recovery and become productive citizens.
Dually Certified Staff	Staff that are licensed as both mental health and substance use disorder (SUD) professionals.
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	The federally mandated program for Medicaid children under age 21 which directs that all children at or below the poverty level be screened for health problems (including mental health) and provided with appropriate services to treat any identified medical issues.
Electroconvulsive therapy (ECT)	A medical procedure used for severe mental health disorders that involves a brief electrical stimulation of the brain while the patient is under anesthesia.
Elope/Elopement	An unauthorized departure of a client from a 24 hour care setting.
Emergent Care	Emergent care are those services that, if not provided, would likely result in the need for crisis intervention or hospitalization due to imminent concerns about potential danger to self, others, or grave disability. Emergency crisis services must be initiated within two hours of the initial request from any source. Examples include phone crisis services, Crisis and Commitment Services (CCS), Children's Crisis Outreach Response System (CCORS) services, inpatient diversion beds, and crisis stabilization services.
Emergency Services	Inpatient and outpatient contracted services furnished by a Provider qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.
Enrollee	A Medicaid or non-Medicaid recipient.
Ethnic minority	For the purpose of qualifying for the cultural differential case rate, ethnic minority means a person who self identifies as any of the following: African American/Other Black; Asian American/Pacific Islander; Native American; Hispanic; or Other/Mixed Race.

Evaluation and Treatment	Services provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric disorder. Services are provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD) facilities) licensed and certified by Department of Health (DOH) to provide medically necessary evaluation and treatment to the Individual who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses, and other Mental Health Professionals, and discharge planning to ensure continuity of mental health care. Treatment may include nursing care, individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented. This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric or co-occurring substance use disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for Room and Board. The Health Care Authority (HCA) authorizes exceptions for involuntary length of stay beyond a fourteen (14) day commitment.
Evaluation and Treatment (E&T) Facility	Any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental health diagnosis r, and which is licensed or certified as such by the department". (RCW 71.05.020)
Evidenced-Based Practices	A program or practice that has been tested where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.
Excluded Individuals or Entities	Individuals or entities that have been placed in non-eligible participant status under Medicare, Medicaid, and other federal or state health care programs. Exclusions may occur due to Office of Inspector General sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the state Medicaid agency.
Expanded Substance Use Disorder (SUD) Assessment	A comprehensive interview with the parent, and a minimum of two collateral contacts, resulting in a standardized written report that includes, at a minimum: the presenting problem, a basic psychosocial history including past and present drug/alcohol use (type, frequency, and duration of use), life effects of usage, substance abuse diagnosis, specific treatment recommendations and estimated time frames for completion, other services needed to initiate, establish, or maintain recovery such as mental health or domestic violence services, diagnostic instruments used in the assessment process, and the results of the assessment urinalysis (UA). A minimum of two collateral contacts are made and included.

Extended Client Lookup System (ECLS)	The Behavioral Health and Recovery Division (BHRD) Information System (IS) application that allows authorized users to access information on individuals to determine if they are receiving services from King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO) Providers.
Extraordinary Treatment Plan (ETP)	A plan for services when a client has treatment needs that exceed the most service-intensive benefit within the King County Integrated Care Network (KCICN) or Behavioral Health–Administrative Services Organization (BH-ASO) outpatient or residential levels of care.
Facility	"Facility" means but is not limited to: a hospital, an inpatient rehabilitation center, Long-Term and Acute Care (LTAC) center, behavioral health facility, skilled nursing facility, and nursing home.
Fair Hearing	A hearing before the Washington State Office of Administrative Hearings.
Family	A group of individuals who support the client emotionally, physically, and/or financially. A family is defined by its members and each family defines itself. A family can include individuals of various ages who are biologically related, related by marriage, or not related at all but who provide a significant level of support to the youth or primary caregiver.
Family-Centered	The principle that promotes that the family voice is heard and integrated throughout policy, program development, and service delivery. Services have moved from family-as-client to family-as-partner. Services are "done with" the family, rather than "done to" the family.
Family Integrated Transitions Program (FIT)	Two programs, one funded through the State Juvenile Rehabilitation Administration (JRA) is for youth transitioning from incarceration at a JRA facility to the community; the other is funded through Superior Court for youth transitioning from the local detention facility to the community.
Family Partnership	Contributing to a joint venture with the child and family-usually sharing its risks and benefits. Requires joint decision-making power and the shared distribution of benefits or losses.
Family Preservation Model	A service delivery model that incorporates service provision to the family, services targeted to families with children at risk for out-of-home placement and/or incarceration, services flexibly tailored to meet the needs of families within the context of their culture, and staff carrying small caseloads in order to provide highly intense, time-limited services.
Family Preservation Model	A service delivery model that incorporates service provision to the family, services targeted to families with children at risk for out-of-home placement and/or incarceration, services flexibly tailored to meet the needs of families within the context of their culture, and staff carrying small caseloads in order to provide highly intense, time-limited services.
Family Support	In the substance use context, involves information, education, intervention, and other supportive services, provided in a group or individual setting, to individuals who have significant individual relationships (e.g. sibling, child, parent or spouse) with a person with a substance use disorder not currently in treatment. Does not include services to significant others of an individual currently in treatment.

Family Treatment	Behavioral health counseling provided by or under the supervision of a Mental Health Professional for the direct benefit of an Individual. Service is provided with family members and/or other relevant persons in attendance as active participants.
Federally Qualified Health Center (FQHC):	A community-based organization that provides comprehensive primary care and preventive care, including health, dental, and behavioral health services to people of all ages, regardless of their ability to pay or health insurance status.
Financial Exploitation	The illegal or improper use of the property, income, resources, or trust funds of a vulnerable adult by any person for any person's profit or advantage per state statute.
First Responders	Police, sheriff, fire, emergency, medical and hospital emergency rooms, and 911 call centers.
Flag	An indicator that identifies client-centered circumstances or situations that have implications for utilization management or financial management. Flags could: 1. Include indicators that trigger the payment of the cultural differential case rate; 2. Identify individuals who are high users of inpatient or crisis services; or 3. Identify individuals who have an unusual service pattern.

Fraud, Waste and Abuse	Fraud: An intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Waste: The expenditure or allocation of resources or provision of services significantly in excess of need. Waste need not necessarily involve an element of private use or of individual gain, but invariably signifies poor management resulting in the misuse of resources Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary cost to the King County Integrated Care Network (KCICN) and Behavioral Health Administrative Service Organization (BH-ASO). Fraud, Waste, and Abuse can include but not be limited to: • Billing for or reporting of services not performed • Phantom individuals • Double-billing or reporting • Unnecessary services • Kickbacks • Upcoding (in a fee-for-service payment model) • Unbundling (in a fee-for-service payment model) • Falsification of health care Provider credentials • Falsification of Provider financial solvency • Intentional improper billing • Related party contracting • Incentives that limit services or referral • Embezzlement and theft • Billing Medicaid enrollees for Medicaid covered services • Using an inefficient or improperly trained coder whose inefficiency creates errors such as upcoding or double billing • Neglecting to properly examine service records and as a result claiming a service or services when the individual was not seen by the Provider • Incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls Continuing to provide a service when the individual is no longer benefiting from the service
Frequent Use	A criterion for a non-Medicaid benefit, meaning at least two uses of any single resource or two uses of any combination of resources within the year previous to the referral date.
GAIN-I	Global Assessment of Individual Needs – Initial (GAIN-I). Standardized clinical assessments for diagnosis, placement, and treatment planning.

GAIN-M90	Global Assessment of Individual Needs – Monitoring 90 Days (GAIN-M90). A quarterly follow up to the Global Assessment of Individual Needs – Initial (GAIN-I) that is used for monitoring change in clinical status, service utilization, and cost to society.
GAIN-SS	Global Assessment of Individual Needs – Short Screener (GAIN-SS). The screening tool for conducting the integrated comprehensive screening for coordinating substance use disorder (SUD) and mental health issues.
Community Relations Plan	A plan created by a treatment Provider to document community relations efforts and community contacts, evaluate these efforts and contacts over time, and address outstanding problems and deficiencies (WAC 246-341-1005).
Grievance	An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Individual's rights.
Grievance System	The overall system that includes Grievances and Appeals handled by BHRD BH-ASO or the MCOs and access to the Administrative Hearing Processes
Guidelines	A set of statements used to determine a course of action. A guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice. Guidelines are not binding and are not enforced.
Habilitation and Rehabilitation	Teaching individuals new skills or assisting individuals to relearn skills they once had but lost as the result of a disease.
Hard of Hearing	A hearing impairment resulting in a functional loss, but not to the extent the individual must depend primarily upon visual or tactile communication. The hearing loss should be a significant factor in the symptoms of the behavioral health issue (e.g., increasing anxiety, suspiciousness, or isolation), in the person's level of functioning, or in the provision of treatment.
Health Care Authority (HCA)	The Washington State Health Care Authority, any division, section, office, unit or other entity of HCA or any of the officers or other officials lawfully representing HCA.
Health Care Professional	A physician or any of the following acting within his or her scope of practice; an applied behavior analyst, certified registered dietician, naturopath, podiatrist, optometrist, optician, osteopath, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner or clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed midwife, licensed clinical social worker, licensed mental health counselor, licensed marriage and family therapist, registered respiratory therapist, pharmacist, and certified respiratory therapy technician.
Health Care Provider (HCP)	A Primary Care Provider, Mental Health Professional or Substance Use Disorder Professional.

Health Plan	A plan that undertakes to arrange for the provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse for any part of the cost for those services, in return for a prepaid or periodic charge paid by for or on behalf subscribers or enrollees.
High Intensity Treatment	Intensive levels of service provided to individuals who require a multi-disciplinary treatment team in the community that is available upon demand twenty-four hours per day, seven days per week.
Homeless	Persons who lack a fixed, regular, and adequate night-time residence or have a primary nighttime residence that is: 1. A supervised publicly or privately-operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelter and transitional housing for the mentally ill); 2. An institution that provides temporary residence for individuals; or 3. A public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.
Homeless Outreach, Stabilization and Transition (HOST) Project	A project that provides outreach and engagement, intensive stabilization, transition to ongoing services, and reengagement into services for persons who are mentally ill and homeless.
Housing Services	Minor renovation, expansion, and repair of housing, planning of housing, technical assistance in applying for housing assistance, improving the coordination of housing services, security deposits – the costs associated with matching eligible homeless individuals with appropriate housing situations, and one-time rental payment to prevent eviction.
Individual	Any person in the regional service area (RSA) regardless of income, ability to pay, insurance status, or county of residence; in regards to non-crisis services it is understood to mean a person who has applied for, is eligible for, or has received General Funds State/ Federal Block Grant (GFS)/FBG services funded by Behavioral Health and Recovery Division (BHRD).
Individual Service Plan (ISP)	An action plan mutually developed by the Provider with the client and others providing supports to the client that describes the services and supports (per Washington Administrative Code (WAC) 246-341-0425 with client goals and steps to achieve recovery.
Individuals with Intellectual or Developmental Disability (I/DD):	People with a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.
Initial Crisis Outreach	A crisis service provided by the Designated Crisis Responders (DCR)s 24 hours a day, 7 days a week. These are one-time-only contacts, provided face-to-face in community-based settings for persons in crisis for whom a mental health diagnosis cannot be ruled out.
Inpatient	Publicly funded behavioral health services in an inpatient facility, including evaluation and treatment (E&T) facilities.

Inpatient Diversion Beds	A short-stay crisis bed in a residential facility that provides 24-hour staff supervision. The goal is to avert immediate voluntary or involuntary hospitalization for those persons who need very short-term supervision during times of emotional crisis in order to ensure their safety or the safety of others.
Institution for Mental Diseases (IMD)	A hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.
Intake Evaluation (Mental Health)	An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except Crisis Services, Stabilization Services, and free-standing evaluation and treatment.
Intake (SUD)	The process of completing program admission paperwork with a new client. This service is provided by a SUDP or SUDPT under the supervision of a SUDP, after an individual's initial assessment is complete and once the individual is informed of their assessment results and consents to treatment. Intake processing includes all practices listed in applicable sections of WAC 246-341 or its successor. (This service is billable through ProviderOne, but not reimbursable through King County).
Integrated Dual Disorder Treatment (IDDT)	An evidence-based practice recognized by the United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) to be effective in the recovery process for consumers with COD. In IDDT, the same clinicians or team of clinicians work in one setting and provide mental health and substance abuse interventions in fully coordinated service delivery. Critical elements of IDDT include assertive outreach, motivational interventions, and a comprehensive, staged, client-centered approach to recovery.
Intensive Inpatient Residential Treatment Services	A concentrated program of substance use disorder (SUD) treatment, individual and group counseling, education, and related activities including room and board in a twenty-four (24) hour-a-day supervised facility in accordance with Chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 3.5).
Intensive Outpatient Substance Use Disorder (SUD) Treatment	Services provided in a non-residential intensive patient centered outpatient program for treatment of SUD (The service as described satisfies the level of intensity in ASAM Level 2.1).
Interim Services	Services to Individuals who are currently waiting to enter a treatment program to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. Such services are provided until the individual is admitted to a treatment program. Services include referral for prenatal care for a pregnant patient, brief screening activities, the development of a service plan, individual or group contacts to assist the Individual directly or by way of referral in meeting their basic needs, updates to advise them of treatment availability, and information to prepare them for treatment, counseling, education, and referral regarding HIV and tuberculosis (TB) education, if necessary referral to treatment for HIV and TB.
Intravenous Drug Use	Using a needle and syringe to illicitly inject substances such as heroin or cocaine into your body for the purpose of getting intoxicated.

Involuntary Treatment Act (ITA)	State laws that allow for individuals to be committed by court order to a Facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to seventy-two (72) hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05.180, RCW 71.05.230 and RCW 71.05.290).
Involuntary Treatment/ Commitment	Evaluation and action ordered by a Designated Crisis Responder (DCR) and/or a Superior Court Judge for persons with a behavioral health disorder who have demonstrated behavior that is dangerous to self or others; or have substantially harmed someone else's property; or are so gravely disabled that they are unable to provide for basic needs and are not receiving essential care for health and safety.
ITA Detained Person	Any person seen face-to-face under the provision of the Involuntary Treatment Act (ITA), Chapters 71.05 or 71.34 Revised Code of Washington (RCW), and subsequently detained for inpatient psychiatric treatment.
Juvenile Drug Court	A specific juvenile court docket, dedicated to a heightened and intensified emphasis on therapy and accountability, as described by the U.S. Department of Justice, Bureau of Justice Assistance in the monograph, Juvenile Drug Courts: Strategies in Practice, March 2003.
Juvenile Offender	Any offender under the jurisdiction of juvenile court who is under the chronological age of eighteen years and who has not been previously transferred to adult court.
King County Family Treatment Court (FTC)	A post-adjudication program established to address issues related to a child's dependency status due to parental substance abuse.
King County Integrated Care Network (KCICN)	Alliance formed by participating Providers and Behavioral Health and Recovery Division (BHRD) to operate a clinically integrated behavioral health network that provides the full range of Medicaid State Plan Services and contract with the Washington State Health Care Authority (HCA) designated Medicaid managed care organizations (MCOs) for the King County Regional Service Area. KCICN is a reference to the entities entering into this Agreement, and neither this Agreement nor any other understanding among participants is intended to create a separate legal entity.
Levels of Care	The organization of services into groups that reflect differences in the intensity of client need and the best way to deliver services that respond to that need. A set of guidelines for placement, continued stay and transfer or discharge of individuals with behavioral health conditions.
Locally Funded Programs	County and City Funded Services which include: All MIDD Behavioral Health Sales Tax program, Supported Employment Services (SEP), and Education and Workforce Development.

Long-Term Care Residential Substance Use Disorder (SUD) Services	The care and treatment of chronically impaired Individuals diagnosed with substance use disorder (SUD) who also have impaired self-maintenance capabilities who reside in a twenty-four (24) hour-a-day, supervised facility in accordance with Chapter 246- 341 WAC (The service as described satisfies the level of intensity in ASAM Level 3.3).
Long-Term Rehabilitation (LTR)	A 24-hour supervised residential treatment program for adults who: 1. Require 24-hour supervision; 2. Do not require extensive medical care; 3. Have a severe functional or behavioral impairment as a result of a psychiatric disorder; and/or 4. Do not follow or do not have effective medications.
Low-Income Individual	An individual greater than 18 years old whose gross household monthly income does not exceed the monthly income determined by 220% of the Federal Poverty Guidelines as eligible for low-income services. These individuals are eligible to receive services partially supported by County Community Services. An individual younger than 18 years old who have a family income of less than 300% of the federal poverty level.
Managed Care	An integrated system managing access and intensity and duration of care through defined standards, expected outcomes, quality indicators, and planned expenditures. A prepaid, comprehensive system of medical and behavioral health care delivery including preventive, primary, specialty, and ancillary health services.
Managed Care Organization (MCO)	An organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contract with Health Care Authority (HCA) under a comprehensive risk contract to provide prepaid health care services to eligible HCA individuals under HCA managed care programs
Managed Care Organization (MCO) Policy and Procedures	The MCO's compilation of operating policies, standards, and procedures for Participating Providers including, but not limited to, MCO's requirements for claims submission and payment, credentialing/re-credentialing, utilization review/management, case management, quality assurance/improvement, advance directives, Client rights, grievances and appeals.
Managed Care Organization (MCO) Provider Manual	The purpose for the Managed Care Policy Manual is to provide a reference for the administration of the Medicaid managed care program and to provide direction to the MCOs and other entities providing service under managed care.
Materials	Any promotional activity or communication with an Individual that is intended to "brand" a Provider's name or organization. Materials include written, oral, in-person (telephonic or face-to-face) or electronic methods of communication, including email, text messaging, and social media (i.e. Facebook, Instagram, and Twitter).
Medicaid Apple (Medicaid Expanded)	An individual who has become eligible and is receiving Title XIX benefits after the open enrollment date of October 1, 2013.
Medicaid Classic	An individual who has become eligible and is receiving Title XIX benefits prior to the open enrollment date of October 1, 2013.

Medicaid Recipient	An individual who is currently enrolled in the Medicaid program.
Medically Necessary/Medical Necessity	A requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all (WAC 182-500-0070).
Medication-Assisted Treatment (MAT)	Provision of treatment services and medication management (methadone, etc.) to individuals addicted to opiates. Treatment is defined as follows: 1. Assessment; 2. Treatment services to individuals with an opioid use disorder; 3. Prescribing and dispensing of methadone or other Department of Social and Health Services (DSHS) Division of Behavioral Health (DBHR)-approved substitute drug in opiate substitute programs approved in accordance with Washington Administrative Code (WAC) 246-341 or its successor. Both withdrawal management and maintenance are included. Physical exams, clinical evaluations, individual or group therapy for the primary individual and their family or significant others, guidance counseling, and educational and vocational information. MAT is also referred to as Opiate Substitution Treatment (OST).
Medication Management	The prescribing and/or administering and reviewing of medications and their side effects. This service is rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with primary therapists, and/or case managers, but includes only minimal psychotherapy.
Medication Monitoring	Face-to-face, one-on-one cueing, observing, and encouraging an Individual to take medications as prescribed. This activity may take place at any location and for as long as it is clinically necessary.
Mental Health Advance Directive	A written document in which the Individual makes a declaration of instructions, or preferences, or appoints an agent to make decisions on behalf of the Individual regarding the Individual's mental health treatment that is consistent with Chapter 71.32 RCW.
Mental Health Block Grant (MHBG)	Funds granted by the Secretary of the Department of Health and Human Services (DHHS), through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), to states to establish or expand an organized community-based system for providing mental health services for adults with Serious Mental Illness (SMI) and children who are seriously emotionally disturbed (SED).
Mental Health Court	A specialized court for misdemeanor defendants with mental illness. Defendants work with a team of specialists, including a judge, prosecutor, defender, court monitor, treatment Provider and probation officer, to receive court-ordered treatment as a diversion from prosecution or as a sentencing alternative.

Mental Health Professional	A psychiatrist, psychologist, psychiatric nurse, psychiatric nurse practitioner, physician assistant supervised by a psychiatrist, or social worker as defined in Chapters 71.05 and 71.34 RCW; 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. Such persons have, in addition, at least two (2) years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional; A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986; A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate. A person who has an approved exception to perform the duties of a Mental Health Professional; or A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional.
MIDD Behavioral Health Sales Tax	A Behavioral Health Sales Tax Fund. King County's MIDD is a countywide 0.1% sales tax generating an about $134 million per two-year biennium, specifically for programs and services for people living with or at risk of behavioral health conditions. King County's MIDD is managed and operated by the King County Department of Community and Human Services' Behavioral Health and Recovery Division.
Moral Reconation Therapy (MRT)	A systematic treatment strategy that seeks to decrease recidivism among adult criminal offenders by increasing moral reasoning. This cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments.
Multi-System Involved	Any person who is receiving services from or is formally involved with more than one service system. Typically, individuals would be involved with the behavioral health system and at least one other system like the criminal justice system and/or the child welfare system.
Multisystemic Therapy (MST)	MST is an empirically proven program that provides intensive family-based treatment addressing the known determinants of serious antisocial behavior in adolescents and their families. Only staff designated by the King County Superior Court Project Manager may make referrals to the MST Program.
The National Committee for Quality Assurance (NCQA)	An independent 501(c)(3) nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
Natural Supports	Any person or organization contributing to positive outcomes that is not a formal treatment or intervention service or any supports provided by individuals or organizations in the family's own community, kinship, social, or spiritual networks.

Medically Compromised Client	A person considered to be "medically compromised homebound" has a chronic medical condition, physical or psychiatric, which causes significant disability such that the individual is (1) unable to leave home, or (2) if leaving home is possible, this occurs infrequently, is usually for the purpose of receiving medical care, and requires considerable effort, supervision, or assistance. Because of this difficulty or inability to leave home, the medically compromised homebound individual is unable to utilize services if provided only in a clinic.
Non-Medicaid	A type of funding that can include state, county, federal funds, etc.). Non-Medicaid behavioral health services are available as resources permit.
Notice of Action (NOA)	A written notice that must be provided to Individuals to inform them that a requested Contracted Service was denied or received only a limited authorization based on medical necessity.
Notice of Determination (NOD)	A written statement sent to a Medicaid or non-Medicaid client and his/her requesting Provider when outpatient or residential behavioral health services have been authorized by the King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) for the client. Additionally, NODs are sent to non-Medicaid clients in all the instances in which a Medicaid client would get a NOA. The content of the NODs mirrors the content of the NOA except for those instances where non-Medicaid clients have different rights.
Older Adult	A person 60 years of age or older.
Opiate Substitution Treatment Services (OST) (BARS 566.59)	Provision of treatment services and medication management (methadone, etc.) to individuals addicted to opiates. Treatment is defined as follows: 1. Assessment; 2. Treatment services to opiate dependent individuals; 3. Prescribing and dispensing of methadone or other Department of Social and Health Services (DSHS) Division of Behavioral Health (DBHR)-approved substitute drug in opiate substitute programs approved in accordance with Washington Administrative Code (WAC) 246-341 or its successor. Both withdrawal management and maintenance are included; Physical exams, clinical evaluations, individual or group therapy for the primary individual and their family or significant others, guidance counseling, and educational and vocational information. For the purposes of King County, OST is also referred to as Medication-Assisted Treatment (MAT).
Opiate Substitution Treatment	Assessment and treatment to opiate dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 21 C.F.R. Part 291, for opiate substitution services in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 1).
Opioid Treatment Program (OTP)	A designated program that dispenses approved medication as specified in 21 C.F.R. Part 291 for opioid treatment in accordance with WAC 246-341-0100.
Outpatient Treatment Services	Services that provide non-domiciliary/non-residential behavioral health assessment and treatment to individuals.

Outcome Measure(s)	Specific information that demonstrates what happens to individuals as a result of the behavioral health care they receive. Individual outcomes for behavioral health care under the King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO) are specifically defined for each client depending on age and the level of care they will receive.
Outreach and Engagement	Identification of hard-to-reach individuals with a possible behavioral health condition and engagement of these individuals in assessment and ongoing treatment services as necessary.
Payor	The entity (including company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of covered services rendered to clients.
Peer Bridger	A trained Peer Support specialist who offers Peer Support services to participants in state hospitals prior to discharge and after their return to their communities. The Peer Bridger must be an employee of an agency licensed by Department of Health (DOH) that provides recovery services.
Peer Support	Services provided by peer counselors to individuals under the consultation, facilitation, or supervision of a Mental Health Professional.
Personal Information	Information identifiable to any person including, but not limited to: information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.
Pregnant/Postpartum and Parenting Women (PPW)	Women who are pregnant; (ii) women who are postpartum during the first year after pregnancy completion regardless of the outcome of the pregnancy or placement of children; or (iii) women who are parenting children, including those attempting to gain custody of children supervised by Department of Children Youth and Families (DCYF).
Prepaid Inpatient Health Plan (PIHP)	An entity, under contract with the state and funded by prepaid capitation payments, that provides, arranges for, or otherwise has responsibility for the provision of any inpatient or institutional services for its enrollees and does not have a comprehensive (i.e. primary health care) contract.
Prevalent Languages	The Department of Social and Health Services (DSHS) prevalent languages are: Cambodian, Chinese, English, Korean, Laotian, Russian, Somali, Spanish, and Vietnamese.
Prevocational Services	Services based on individual need that prepares a person to seek work. Such services principally include improving skills in resume preparation, application writing, interviewing, and specific work-site-related behaviors such as punctuality, employer-employee relations, and hygiene.
Program for All-Inclusive Care of the Elderly (PACE)	A Medicare/Medicaid program for older adults offered through Providence Elder Care. This program allows frail elderly people who would qualify medically for a nursing home placement to live in their communities. A person enrolled in this program is not eligible for concurrent outpatient benefits.

Program for Assertive Community Treatment (PACT)	An evidence-based service delivery model for providing comprehensive community-based treatment to persons with the most serious and persistent mental illnesses that have not benefited from traditional outpatient programs. Key component elements include: team approach, small caseload, individualized treatment, fixed point of responsibility, in-vivo assistance, time-unlimited services, and 24/7 crisis response.
Progress Notes	Permanent record, entered into an individual's clinical record, of ongoing assessments of an individual's participation in and response to treatment, and progress in recovery. Progress notes include the date of treatment service duration, location, Provider credentials, diagnosis, modality and CPT code. See SERI Encounter Reporting Instructions (SERI) for encountering requirements.
Provider	The behavioral health care person(s) or agency including all physicians, clinicians, allied health professionals, and staff persons who provide health care services to clients.
Provider Profile	A compilation of information about a contracted Provider of King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) outpatient services. The profile includes populations served, clinical practice information, and clinical outcomes.
ProviderOne	The Health Care Authority's (HCA's) Medicaid Management Information Payment Processing System, or any superseding platform as may be designated by HCA
Psychiatric Emergency Services (PES)	Facility and staff at Harborview Medical Center (HMC) providing the full array of crisis triage services, 24 hours a day, 365 days a year.
Psychological Assessment	All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist
Psychotherapy	The client-centered treatment of emotional, behavioral, personality and psychiatric disorders based primarily upon verbal or non-verbal communication with the client in contrast to treatments utilizing chemical or physical measures. See Service Encounter Reporting Instructions (SERI) for encountering requirements
Quality Assurance (QA)	A focus on compliance to minimum standards (e.g., rules, regulations, contract terms) as well as reasonably expected levels of performance, quality, and practice.
Quality Improvement (QI)	A focus on activities to improve performance above minimum standards, reasonably expected levels of performance, quality, and practice.
Quality Management (QM)	A system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.
Recovery	Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Recovery House Residential Treatment	A program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with substance use disorder (SUD) in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, excluding Room and Board in a twenty-four (24) hour-a-day supervised facility in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 3.1).
Recovery-Oriented System of Care (ROSC)	A diverse and dynamic community with a healthy economy and environment where all people and businesses have an opportunity to thrive and where wellness and recovery from substance use disorders (SUDs) and mental illness is expected, honored, and celebrated.
Recovery Support Services	A broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term recovery from behavioral health disorders. Services may include: peer delivered motivational interviewing; peer wellness coaching; peer-run respite services; person-center planning; self-care and wellness approaches; Wellness Recovery Action Plan (WRAP); supported employment; peer health navigators; supportive housing; recovery community centers; whole health action management; wellness-based community campaign; mutual aid groups for individuals with co-occurring disorders; recovery coaching; shared decision-making; telephone checkups; warm lines; and peer-run crisis diversion services.
Regulation	Any federal, State, Local or King County Behavioral Health and Recovery Division (BHRD) regulation or ordinance
Rehabilitation Case Management	A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of an Individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination.

Residential Treatment Services	Services to provide substance use disorder (SUD) treatment for individuals and include room and board in a 24-hour-a-day supervised facility in accordance with State administrative regulations WAC 246-341 or its successors and as described by the American Society of Addiction Medicine (ASAM). The following levels of care may be provided in residential treatment:
	
	• ASAM Level 3.1 Clinically Managed Low Intensity Residential Treatment
	  ○ Recovery house treatment services
	  ○ Long-term residential treatment services
	• ASAM Level 3.3 Clinically Managed Population-Specific High Intensity Residential
	• ASAM Level 3.5 Clinically Managed High Intensity Residential
	  ○ Intensive inpatient
	  ○ Co-occurring residential
	• ASAM Level 3.7 Medically Monitored Intensive Inpatient Services
	  ○ Withdrawal management
	• ASAM Level 4 Medically Managed Intensive Inpatient Services
	  ○ Withdrawal management
	Note:
	  ○ Youth residential services include ASAM Levels 3.1, 3.5, 3.7
	  ○ Pregnant and parenting women (PPW) include ASAM Levels 3.3, 3.5
	  ○ Medication-Assisted treatment for Opioid Use Disorder (OUD) includes all residential treatment ASAM Levels

Resiliency	The personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives (Revised Code of Washington [RCW] 71.24.025).
Revised Code of Washington (RCW)	The laws of the state of Washington.
Room and Board	Provision for services in a twenty-four (24) hour-a-day setting including accessible, clean and well-maintained sleeping quarters with sufficient space, light and comfortable furnishings for sleeping and personal activities along with nutritionally adequate meals provided three (3) times a day at regular intervals. Room and Board must be provided consistent with the requirements for Residential Treatment Facility Licensing through Department of Health (DOH) (Chapter 246-337 WAC).
Routine Care	Services intended to stabilize, sustain, and facilitate client recovery within his or her living situation. These services do not meet the definition of urgent or emergent care.
Screening	The process by which Provider evaluates persons who present for service and determines the appropriate referral.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SBIRT is a comprehensive and integrated public health approach for early intervention and treatment of persons with, or at risk for developing, SUD. Screening using a validated tool quickly assesses the presence and severity of SUD. Brief intervention guides individuals through considering the physical and behavioral health impacts of drug and alcohol use and motivates behavior change. Referral to treatment connects individuals to the continuum of mental health and substance use disorder services, recovery supports, harm reduction education, and culturally-appropriate community resources.
Secure Detox Facility	A facility operated by either a public or private agency as defined in RCW 71.05.020 that provides involuntary treatment to individuals detained for substance use disorder (SUD) Involuntary Treatment Act (ITA) up to ASAM withdrawal management level 3.7.
Seriously Emotionally Disturbed (SED)	An infant or child from birth to age eighteen who has been determined to be experiencing a mental disorder as defined in Chapter 71.34 Revised Code of Washington (RCW), including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers, and who meets at least one of the following criteria: 1. Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years; 2. Has undergone involuntary treatment under Chapter 71.34 RCW within the last two years; 3. Is currently served by at least one of the following child serving systems: juvenile justice, child-protection/welfare, special education, or developmental disabilities; 4. Is at risk of escalating maladjustment due to: a. Chronic family dysfunction involving a mentally ill or inadequate caretaker; b. Changes in custodial adult; **c.** Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient or residential treatment, group or foster home, or a correctional facility.
Serious Mental Illness (SMI):	Persons age eighteen (18) and over who currently, or at any time during the past year, have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that has resulted in functional impairment which substantially limits one (1) or more major life activities such as employment, school, social relationships, etc.
Sexual Minority	A person who self-identifies as LGBTQI: 1. Lesbian; 2. Gay; 3. Bi-sexual; 4. Transgender; 5. Queer; or 6. Intersex

Single Case Agreement (SCA)	A contract between Behavioral Health and Recovery Division (BHRD) and an out-of-network Provider for a specific client, so that the client can see that Provider using their in-network benefits. The fees per session and duration of service is negotiated by BHRD and the Provider as part of the SCA.
Sobering Services	Shelter services designed to provide short-term (12 hours or less) emergency shelter, screening, and referral services to individuals who need to sleep off the effects of alcohol or drugs. Services include medical screening, observation, and referral to continued treatment and other services as appropriate.
Special Population Evaluation	An evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods.
Spenddown	Spenddown refers to the amount of medical expense for which the client is responsible. Spenddown occurs when the client's income and resources are above the limits set by the state for receiving Medicaid coverage.
Standard Supportive Housing (SSH)	SSH services are for clients who may require regular staff contact and the availability of staff 24 hours a day, 7 days a week, but who do not need the physical safety and structure of a residential facility. Clients may be housed in cluster or independent settings.
Stabilization Services	Services provided to Individuals who are experiencing a mental health crisis. These services are provided in the person's home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional. Stabilization Services include short-term (less than two (2) weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to Crisis Services; and b) other individuals determined by a Mental Health Professional to need additional Stabilization Services. Stabilization Services may be provided prior to an Intake Evaluation for mental health services.
Standard Supportive Housing (SSH)	SSH services are for individuals who may require regular staff contact and the availability of staff 24 hours a day, 7 days a week, but who do not need the physical safety and structure of a residential facility. Individuals may be housed in cluster or independent settings.
Stigma	Attitudes within most communities that view symptoms of mental illness or substance use disorder (SUD) as threatening and uncomfortable, and frequently foster negative attitudes and discrimination towards people experiencing behavioral health problems. Such reactions are common when people are willing to admit they have a behavioral health problem, and they can often lead to various forms of exclusion or discrimination – either within social circles or within the workplace. Social stigma is characterized by prejudicial attitudes and discriminating behavior directed towards individuals with behavioral health problems as a result of the label they have been given. Perceived stigma or self-stigma is the internalizing by the behavioral health sufferer of their perceptions of discrimination and can significantly affect feelings of shame and lead to poorer treatment outcomes.

Subcontract	Any separate agreement or contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to the contract.
Substance Abuse	A recurring pattern of alcohol or other drug use that substantially impairs an individual's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.
Substance Use Disorder (SUD)	A problematic pattern of use of alcohol and/or drugs that causes a clinically and functionally significant impairment. This includes use in situations in which it is physically hazardous, social or interpersonal problems related to use, failure to meet responsibilities at work school or home because of use, tolerance, withdrawal, using in larger amounts or for longer amounts of time, repeated attempts to control use or quit, much time spent using and physical or psychological problems related to use.
Substance Use Disorder (SUD) Assessment	A therapeutic process provided by a Substance Use Disorder Professional (SUDP) or SUDP Trainee (SUDPT) under the supervision of a SUDP designed to evaluate an individual to determine if the individual has a substance use disorder and determine placement in accordance with the ASAM Criteria (WAC 246-341-0610).
Substance Use Disorder Professional (SUDP)	An individual who is certified by the Washington State Department of Health (DOH) according to RCW 18.205.020 and the certification requirements of Washington Administrative Code (WAC) 246-811-030 to provide SUD services.
Substance Use Disorder Professional Trainee (SUDPT)	An individual working toward the education and experience requirements for certification as a substance use disorder professional, and who has been credentialed as a SUDPT.
Substance Use Disorder (SUD) Treatment Services	A broad range of emergency, withdrawal management, residential, and outpatient services and care. Treatment services include diagnostic evaluation, substance use disorder (SUD) education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling that may be extended to alcoholics and other drug addicts and their families, individuals incapacitated by alcohol or other drugs, and intoxicated individuals.
Substance Use Disorder Outpatient Treatment	Services provided in a non-residential substance use disorder (SUD) treatment facility. Outpatient treatment services must meet the criteria in Chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 1).
Substance Abuse	A recurring pattern of alcohol or other drug use that substantially impairs an individual's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.
Substance Abuse Block Grant (SABG)	The Federal Substance Abuse Block Grant Program authorized by Section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service Act.
Supervised Living (SL)	Any residential service program including but not necessarily limited to an Adult Family Home (AFH) or Congregate Care Facility (see separate definitions) in which staff provide 24-hour on-site supervision. Additional treatment services may be provided in this setting as part of the outpatient authorized benefit.

Supported Employment (SE)	An evidence-based practice that assists persons diagnosed with serious and persistent mental illness obtains and maintains community-integrated employment that pays at least minimum wage. The practice focuses on defining a participant's circumstances, capabilities, and level of motivation, then adds the supports to assist the participant in finding and retaining an appropriate job.
Supportive Housing Services	Includes eligibility screening, monitoring harm reduction activities, providing housing stabilization, crisis management, and case consultation and referral services for the purpose of linking individuals to support services. Services do not include direct treatment services.
System Collaboration	The organization and coordination of resources available through federal, state, and local human service systems responsible for serving individuals and their families. Strategic planning, consolidation of funding streams, and policy formation are examples of tools that promote system collaboration and integration.
System of Care	A comprehensive spectrum of behavioral health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.
Therapeutic Psychoeducation	Informational and experiential services designed to aid Individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the Individual as a primary support in the management of psychiatric conditions.
Tier Benefit	*See Case Rate.*
Transitional Age Youth (TAY)	An individual between the ages of fifteen (15) and twenty- five (25) years who present unique service challenges because they are too old for pediatric services but are often not ready or eligible for adult services.
Trauma-Informed Care (TIC)	TIC is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both Providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.
TTY or TDD	Teletypewriter (TTY) or Telecommunications Device for the Deaf (TDD). Both acronyms refer to a device that allows deaf individuals to make a telephone call directly, without the use of another person to interpret.
Urgent Care	Urgent care services are those services that, if not provided, would result in decomposition to the point that emergency care is necessary. Urgent crisis services must be initiated within 24 hours of the initial request from any source. Examples include Crisis and Commitment Services (CCS), Children's Crisis Outreach Response System (CCORS) services, inpatient diversion beds, and crisis stabilization services.
Urinalysis (UA)	Analysis of an individual's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a Provider who is exempted from licensure by the department of health: 1. Negative urine: a urine sample in which the lab does not detect specific levels of alcohol or other specified drugs; and 2. Positive urine: a urine sample in which the lab confirms specific levels of alcohol or other specified drugs.

Utilization Review (UR)	The process of evaluating the use of Provider services, procedures, and facilities by comparison with pre-established criteria.
Vocational Services	Services based on individual needs which support a person to gain and retain employment. Such services principally include vocational assessment, job development, job placement, and job coaching. Vocational services may also include medical diagnostics, training, transportation, and provision of tools, equipment and uniforms or work clothes.
Vulnerable Adult	An individual who lacks the functional, mental, or physical ability to care for oneself.
Wait List	A list of individuals for whom a later date for services has been scheduled due to lack of capacity. A person will be selected from the list to fill an opening based on the required order of precedence identified in the appropriate contract.
Waiting List Interim Services (WLIS)	Services offered to an individual denied or delayed admission to a treatment program on the basis of the lack of capacity of the program to admit the individual.
Waiver	The document by which Department of Social and Health Services (DSHS) requests sections of the Social Security Act be waived in order to operate a capitated managed care system to provide services to enrolled recipients.
Washington Administrative Code (WAC)	Regulations of executive branch agencies are issued by authority of statutes. Like legislation and the Constitution, regulations are a source of primary law in Washington State.
Washington Apple Health- Fully Integrated Managed Care (AH-FIMC)	The program under which a managed care organization (MCO) provides General Funds State (GFS) services and Medicaid-funded physical and behavioral health services.
Washington State Risk Needs Assessment	A tool that evaluates the level of risk, treatment needs, and protective factors across a number of domains for adjudicated juvenile offenders. This tool is used statewide by juvenile courts.
WATrac: Washington System for Tracking Resources, Alerts, and Communication	A web-based application serving the Washington Healthcare system by providing two distinct functions: 1) daily tracking of facility or organizational status and bed availability and, 2) incident management and situational awareness during disaster planning and response.
Wellness Recovery Action Plan (WRAP)	A self-management and structured recovery system designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist persons in achieving their own life goals.
Wraparound	A model of needs-driven and strengths-based planning through a facilitated team process. The client and family are supported by a team of people that includes natural/community supports and professionals, eventually evolving to a team of community supports.

Wraparound with Intensive Services (WISe)	A range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program is for individuals up to age 21 who are experiencing mental health symptoms that are causing severe disruptions in behavior and/or interfering with their functioning in family, school, or with peers requiring: a) the involvement of the mental health system and other child-serving systems and supports; b) intensive care collaboration; and c) ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.
Young Adult	A person who is 18, 19 or 20 years old.
Youth	A person from age 10 through 17 years old.
Youth Outpatient Treatment	Services that provide non-domiciliary/non-residential substance use disorder (SUD) assessment and treatment to youth and young adults ages 10 through 20.